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COUNTY COUNCIL OF THE WEST RIDING OF YORKSHIRE



*Sixty-sixth*  
**ANNUAL REPORT**  
OF THE  
COUNTY MEDICAL OFFICER

AND

*Forty-seventh*  
**ANNUAL REPORT**  
OF THE  
PRINCIPAL SCHOOL MEDICAL  
OFFICER

YEAR 1954

## WEST RIDING HEALTH COMMITTEE

(as at 31.12.54)

## 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).*

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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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Banks, Mrs. M. P.

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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Denton, Mrs. N.

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Hibbert, J.

Holt, R. B.

Hunter, Major J. C., M.C.

Illingworth, W. H.

Keers, Mrs. S. E.

McCreath, Mrs. M. E.

Metcalf, W. E.

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., B.E.M.

Waddilove, G.

Whitehead, H.

Wilkinson, H. S.

Yorke, J.

1 Vacancy

## WEST RIDING EDUCATION COMMITTEE

(as at 31.12.54)

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County Alderman W. M. Hyman

## VICE-CHAIRMAN

County Councillor J. Fuller Smith

## Representative Members:—

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Bambridge, H. J., O.B.E.

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Collier, J. H.

*(Vice-Chairman of the County Council).*

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Creighton, M.

Flavell, A.

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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Boland, C. W.

Bowes, J. E.

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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.

Metcalf, 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.

Wright, G., M.B.E.

1 Vacancy

## 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. (Section 27, National Health Service Act, 1946.)

**Public Health Sub-Committee.**—Matters relating to the Pharmacy and Poisons Act, 1933; Housing Act, 1936; Food and Drugs Acts, 1938-50; Nurses' Acts, 1943-45; Rural Water Supplies and Sewerage Act, 1944; Vaccination and Immunisation (Section 26), Venereal Diseases, Public Health Propaganda (Section 28), under the National Health Service Act, 1946; Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949-53; Food and Drugs (Milk, Dairies and Artificial Cream) Act, 1950; Shops Act, 1950; 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 the Local Health Authority under the Lunacy and Mental Treatment Acts and the Mental Deficiency Acts, and the care and after-care of persons suffering from mental illness. (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 other than mental illness, or the after-care of such persons. (Section 28, National Health Service Act, 1946, and the Public Health (Tuberculosis) Regulations, 1952.)

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 Minister of Health, and arrangements with Voluntary Organisations therefor. (Sections 29 and 30, National Assistance Act, 1948.)

Assistance grants to voluntary organisations providing meals or recreational facilities for old people. (Section 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.)

**Care of Mothers and Young Children and Nursing Services Sub-Committee.**—The duties of the County Council in respect of Nursing Homes (Sections 187-194) and Notification of Births (Section 203) under the Public Health Act, 1936; the care of mothers and young children (Section 22), domiciliary midwifery (Section 23), health visiting (Section 24), home nursing (Section 25) and domestic help (Section 29) services under the National Health Service Act, 1946; the Nursery and Child Minders Regulation Act, 1948; and the Midwives Act, 1951.

**Divisional, School Health and Dental Services Sub-Committee.**—All matters appertaining to the Divisional Health Administration (Section 111, Local Government Act, 1933); and the School Health and County Dental Services (Education Act, 1944).



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*To the Chairman and Members of the Health Committee.*

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present the Annual Report on the public health and preventive medical services in the West Riding Administrative Area for the year 1954.

The Report this year is on general lines as opposed to a survey report and follows the form prescribed by the Ministry of Health in Circular 28/54 dated 15th December, 1954.

Mention was made in the introduction to last year's Annual Report that new records in vital statistics could not be expected every year. This is borne out, in part at least, by the maternal mortality rate which shows a slight increase from 0.51 per 1,000 live and stillbirths to 0.89, while the death rate from tuberculosis of the lungs remains the same as the previous year at 0.16 per 1,000 estimated population. It is pleasing to record, however, that the infant mortality rate per 1,000 live births is again the lowest ever recorded in the Administrative County, being 28.0 as compared with 29.3 in 1953.

No case of smallpox occurred during the year. In the previous year there were 14 confirmed cases and as a result the number of vaccinations carried out at all ages showed a marked increase. The best time for primary vaccination is in infancy, but the percentage of children under one year of age vaccinated in the Administrative County in the year under review is below that for England and Wales.

The continued relative freedom from diphtheria is mainly due to immunisation of children at an early age followed by reinforcing injections later in childhood. During the year there were four confirmed cases of diphtheria. If this disease is to be kept in check it is of the utmost importance for parents to realise that the safety of their children, in relation to this disease, lies in immunisation.

It will be noted from the Report that whooping cough has been less prevalent during the year but it is not possible to say that this has been entirely due to whooping cough immunisation, although the number of children immunised under the Authority's scheme has increased. At the present time there are separate schemes and thus separate injections for immunisation against diphtheria and whooping cough. It would be of great advantage if these two procedures could be combined by the use of one approved vaccine. Investigations are proceeding to determine the value of a combined diphtheria and whooping cough vaccine but these take time and until a decision is made on a national basis by, or some guidance is received from, the Ministry of Health it is proposed to continue with the present schemes.

The scheme for B.C.G. vaccination of older school children made a start in five divisions during the year and met with a satisfactory response. Although B.C.G. vaccination is carried out as a measure for the prevention of tuberculosis under the National Health Service Act there is a close affinity with the Education service, and I am grateful for the ready co-operation received from Head Teachers in the introduction of the scheme to their schools. Details of the method of approach to parents, the explanatory leaflet and a summary of the results in the five divisions will be found on pages 36 and 37 of the Report.

With the decrease in deaths from infectious diseases and other infective conditions in children a study of the Table on page 14 giving the causes of deaths of children aged 1-5 years is illuminating, as it shows that accident is now the greatest single factor accounting for 17 deaths out of a total of 101. This is an example of the changing face of preventive medicine. In the quinquennium 1911-15 there were hundreds of deaths among young children from measles, whooping cough, diphtheria, tuberculosis, pneumonia, bronchitis and diarrhoea. Now that the infective conditions have been so successfully tackled we must make a determined effort to reduce the loss of life due to accident which accounted for 82 deaths in the period 1911-15 and though less in number now has not fallen during forty years in the same proportion. All the 17 deaths in 1954 would not be due to accidents in the home, which is the particular province of the health department, but by poster, leaflet, and Health Visitor teaching, parents are warned of common dangers to the young child playing alone or unsupervised for a few brief moments.

As part of the campaign against tuberculosis, Orders are made under The Food and Drugs (Milk, Dairies and Artificial Cream) Act, 1950, declaring parts of the country to be specified areas. One such Order was made in 1953 affecting parts of the Administrative County and two were made in 1954. In such specified areas it is illegal for any person to sell by retail for human consumption any milk other than pasteurised, sterilised or tuberculin tested. As a result of these Orders at the end of the year there were twenty-four county districts in such specified areas, the population affected being approximately 30 per cent. of that of the Administrative County. It is anticipated that further areas will be the subject of this valuable restriction during 1955.

In this County there must be many black acres owing to the amount of solids deposited on them as measured by the deposit gauges set up in various parts by the Authority and listed on pages 122 to 124. Of recent years there appears to have been some awakening of public concern in atmospheric pollution culminating in the setting up of a Committee of Inquiry under the Chairmanship of Sir Hugh Beaver. The Committee reported in November, 1954 with many recommendations to improve the position. The report is discussed in more detail on pages 119 to 121.

In April the Ministry of Health intimated that the distribution of Welfare Foods would from the 28th June be undertaken by Local Health Authorities. These foods had been distributed by the Ministry of Food from 370 local distribution points in the Administrative Area. The taking over of this function was an involved task and time was short, but I am pleased to report that it was



successfully and smoothly accomplished. All members of the staff are to be congratulated on the additional and painstaking work carried out by them which enabled this to take place, and thanks are also due to the most helpful co-operation of officials from the Regional Office of the Ministry of Food. A more detailed account of this new scheme will be found on page 44 of the Report.

An important feature of the year was a survey of existing premises used for clinic purposes. Before the second world war a scheme for building new clinics had been approved but only two had been erected. A fresh start was made after the war and a multiple clinic at Morley is nearing completion. The survey showed the need for new buildings of different types to serve districts of varying population and as a result a two-year building programme was approved by the Health Committee in January, 1955. It was considered that a multiple clinic was necessary to serve the areas of large population; a satellite clinic those areas of lesser population; and a small clinic to serve those areas where clinic premises were necessary, and although they would not be in constant use it was impossible to rent satisfactory accommodation. An elevation and a plan of the Morley Multiple Clinic are shown in the Report on page 45 and plans are also shown on page 46 of the satellite and small clinics.

The mobile clinic provided for the northern part of the County continues to serve its purpose successfully by bringing clinics for infant welfare and other services to the more remote parts of the area. A second mobile clinic is now on order for the southern part of the Administrative County.

During the year the number of Day Nurseries was reduced. A detailed report will be found on pages 47 to 49.

The training of mental defectives in a large county area is a problem as it is not always possible to find sufficient population within reasonable travelling distance to justify the provision of an Occupation Centre in each division. We are grateful to the County Boroughs within the geographical county and to one just outside for admitting some mental defectives to their Centres. This provision, however, is not sufficient and during the year much thought has been given to increasing the number of Centres owned by this Authority, if necessary by building. The new Centre at Hemsworth will be opened in 1955; sites for other new buildings have been selected and adaptations of existing buildings have been approved by the Authority. In the meantime, group training classes are provided and these give training, not of course daily but in some instances for several sessions a week, to 258 mental defectives. The waiting list for admission of defectives to institutional care was 247 against 274 at the end of 1953.

The number of divisions under the Authority's scheme for the Divisional Administration of the Preventive Medical Services was reduced to 29 during the year as opportunity was taken to amalgamate two existing divisions. Approval was also obtained during the year to the amalgamation of a further two divisions, but this was not effected as accommodation to combine the offices was not then available. When these approved amalgamations are completed the number of divisions will be 28 and a further amendment of the scheme was under consideration at the end of the year to reduce the number to 27. All the 89 county districts in the Administrative County are in the divisional scheme for administration of services under the National Health Service Act and in only one county district is the Medical Officer of Health not also the Divisional Medical Officer.

During the year the West Riding Executive Council requested the appointment of a Sub-Committee of the West Riding Health Committee to meet their representatives to discuss measures of co-operation between these two branches of the National Health Service. As a result of this meeting at which matters concerning the relationship of general medical practitioners to the Health Visiting, Home Nursing and Midwifery Services were frankly discussed steps were taken to increase the value of the Local Health Authority Services to medical practitioners. One measure adopted was to provide telephones in the homes of Health Visitors so that discussion could take place directly between the family doctor and the Health Visitor on children and other persons with whom both were concerned. At the end of the year 113 Health Visitors had been provided with telephones. It is hoped that this co-operation between the branches of the National Health Service will grow, and I am very pleased to report that at a joint meeting in March, 1955 the unanimous view was that the arrangements already made were progressing satisfactorily. A Standing Sub-Committee comprised of representatives of the County Medical staff and General Practitioners representing the West Riding Executive Council with power to deal with any problems affecting co-operation, reporting where appropriate to the West Riding Health Committee, has been formed and already has proved most useful.

The demands on the Home Help Service continued to grow and as in previous years the biggest percentage of service was given to the chronic sick, aged and infirm. From the 1st April, 1954, the establishment of Home Helps was increased from 600 to 700 in order to meet the rising need.

In conclusion I should like to acknowledge my indebtedness to other officers of the County Council for their friendly and unfailing co-operation, and to all members of the staff of the County Health Department for their loyal and helpful assistance.

I am,

Yours faithfully,

J. WOOD-WILSON.

County Medical Officer.



## PART I

### VITAL STATISTICS

#### Area and Population

	Municipal Boroughs and Urban Districts	Rural Districts	Adminis- trative County
Area (acres) — See note below.....	380,328	1,229,431	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-1954).....	1,162,000	438,000	1,600,000

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 from 380,334 to 380,328 and increased that of Rural Districts from 1,229,425 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.

#### Population Trends

In this country during the past fifty or sixty years there has been a progressively increasing number of older people in our population. It is generally accepted that as the birth rate has declined considerably in the past generation or so, as compared with the high rates experienced in the nineteenth century, and mortality, especially among the younger ages, has also decreased, the nation is ageing fairly rapidly. To put it another way, since the turn of the century there has been a continuous increase in the proportion of children who are surviving to old age and consequently there has been a considerable change in the age structure of the population.

In the 1951 Census Report for Yorkshire, West Riding, the Registrar-General commented as follows:—

“The main factors which determine the age pattern of the 1951 population of the West Riding are the decline in fertility and the outward net migration, which have both taken place since the end of the last century. Numbers in the middle age-groups tend to be larger now than those at younger ages because they are the survivors of a period when annual births were more numerous. This is a feature of a population which has been ageing which applies generally throughout the country and is not peculiar to the West Riding. The numbers aged 0—4 in the population, both of the West Riding and the country generally, are proportionately higher than in the two following quinary age-groups, reflecting the exceptionally high numbers of births of 1946 and 1947.”

The table overleaf shows the main features of the sex and age distribution for the Administrative County between the years 1901 and 1951.

During the period 1901 to 1951 it will be seen that while the percentage of children under 5 years of age in the total population has decreased from 11.7 to 8.8 the proportion of older people, 65 years and over, has increased from 4.1 to 10.5. The effect of the lower birth rates since the end of the first World War is shown in the reduction in the percentages of persons under 45 years of age; these have progressively declined until the increased birth rate in the 1940s gained ground. The sex and age distribution is also affected appreciably by the war deaths of the two world wars and while no reliable figures of war deaths for the Administrative County are available their effect is partially reflected in the preponderance of females in the age groups of 15-44 and 45-64. At the latter ages the impact of physical deterioration and lessening resistance to disease begins to make itself felt and the superior longevity of women must also contribute to the excess. This tends to compensate for the phenomenon of the greater proportion of male to female births.

It would be misleading to think that as a result of the great advances in medical and health services we are all going to live to be centenarians; an examination of the statistics reveals that from the beginning of the century the greatest improvement in the length of life is in children of school age, followed by children under 5 years of age, then young adults. At 35 years and onwards the improvement is not so great, the improved expectation of life diminishing with increasing age so that a man of 65 years has very little added (approximately one year) and, in the case of women, even with their apparent longevity, the improvement at 65 years is only around three years. It is interesting to find that in 1901 in the Administrative County the number of people aged 95 and over was 22; in 1951 however the figure had risen by a further 55.



## POPULATION OF THE WEST RIDING ADMINISTRATIVE COUNTY

	Under 5 years				5 and under 15 years				15 and under 45 years			
	Males	Females	Persons		Males	Females	Persons		Males	Females	Persons	
			Number	Per cent. of Total Population			Number	Per cent. of Total Population			Number	Per cent. of Total Population
1901 Census	84,859	86,261	171,120	11.7	151,919	153,229	305,148	20.9	348,703	356,921	705,624	48.3
1911 Census	86,738	86,484	173,222	10.9	158,445	159,611	318,056	20.1	380,506	385,547	766,053	48.3
1921 Census	68,849	67,468	136,317	9.1	147,014	145,638	292,652	19.4	339,354	368,576	707,930	46.9
1931 Census	59,278	58,309	117,587	7.8	130,802	128,628	259,430	17.2	346,879	359,627	706,506	47.0
1947 R.G.'s. Estimate	68,017	64,663	132,680	8.6	108,043	103,933	211,976	13.7	321,003	343,757	664,760	43.0
1951 Census	71,229	68,073	139,302	8.8	115,013	111,028	226,041	14.2	330,823	339,704	670,527	42.2

	45 and under 65 years				65 years and over				Total		
	Males	Females	Persons		Males	Females	Persons		Males	Females	Persons
			Number	Per cent. of Total Population			Number	Per cent. of Total Population			
1901 Census	106,893	112,614	219,507	15.0	26,763	32,820	59,583	4.1	719,137	741,845	1,460,982
1911 Census	125,069	131,103	256,172	16.2	31,249	40,128	71,377	4.5	782,007	802,873	1,584,880
1921 Census	142,410	147,769	290,179	19.2	35,834	45,467	81,301	5.4	733,461	774,918	1,508,379
1931 Census	156,505	166,413	322,918	21.5	43,781	53,835	97,616	6.5	737,245	766,812	1,504,057
1947 R.G.'s. Estimate	174,624	198,438	373,062	24.2	71,278	90,654	161,932	10.5	742,965	801,445	1,544,410
1951 Census	182,194	204,508	386,702	24.3	71,570	94,976	166,546	10.5	770,829	818,289	1,589,118

As regards future trend of population, although no recent estimates have been made for the Administrative County the age structure of the County is very similar to that of England and Wales and for the country it has been estimated that, with certain assumptions (i.e. declining birth and death rates etc.), the percentage of persons aged 65 and over in the total population will be 14.6 in 1973 and 16.0 in 1993. There will be, of course, changes at other ages and in 1973 it is estimated that the proportion of persons under 15 years of age will be 20.0 per cent. of the total and the population in the working age group 15-64 years will be 65.4 per cent.

As mentioned previously, the ageing of the population arises to a certain extent as a result of a declining number of births. The reduction in mortality, however, also plays a big part so that, in spite of fewer babies being born, more and more are growing up to older ages. Although the advances in medical and health services have greatly reduced the number of deaths from infectious diseases and other diseases of childhood and have also reduced the mortality from tuberculosis and pneumonia in the young adults and middle years of life, much less has been achieved towards the prevention of the chief killing diseases in the older age groups — heart disease, cancer and cerebral haemorrhage. Some improvement in mortality at the older ages has, however, taken place and no doubt, as our knowledge increases, will improve further. It is, however, apparent from the above that there is only a slight increase in the number of years a person might expect to live and it is only the gradual elimination of the killing diseases of youth and middle age that is enabling more and more people to reach the older age groups.

It has been estimated that probably more than 95 per cent. of old people live in private dwellings, many of them leading independent lives, either by themselves or with their relatives, and there is much to be said for maintaining this sturdy independence even though an increasing burden may be placed upon our domiciliary services.

### Summary for 1954

The live birth rate was 15.1; the stillbirth rate per 1,000 live and still births 26; the live premature birth rate per 100 live births 6.6. The death rate from all causes was 11.9; diphtheria 0.001; whooping cough 0.004; measles 0.002; meningococcal infections (cerebro-spinal or spotted fever, etc.) 0.01;



acute poliomyelitis (infantile paralysis) 0.004; tuberculosis of the lungs (respiratory system) 0.16; other forms of tuberculosis 0.02; respiratory diseases 1.16; cancer 2.01; heart and circulatory diseases 4.54. Infant mortality was 28 and maternal mortality per 1,000 live and still births 0.89.

A comparison of the figures for the past 65 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
1954	15.1	11.9	0.08	0.16	0.02	1.16	2.01	26	0.91	28

\* 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 16.



### Births and Infant Mortality

The number of live births in 1954 was 24,164 (12,494 males, 11,670 females) the crude birth rate per thousand of the population being 15.1 compared with 25,026 births and a rate of 15.7 in 1953 and 24,506, 15.4, in 1952.

The trend in the birth rate is following a similar pattern to that experienced after the first world war; in 1920 and 1921 the rate increased, then, apart from minor fluctuations, progressively fell until it reached relative stability in the six years immediately preceding the last war when the rate remained between the limits of 15.0 and 15.5. Since the peak of 1947 when there were 32,747 births registered with a rate of 21.5, apart from 1953 when there was a slight increase over the previous year, the birth rate has again progressively declined, and, unless prevailing circumstances change considerably, it would appear that shortly a position of comparative stability around 15.0 will be reached.

Illegitimate live births in 1954 numbered 881 which is at the rate of 36 per thousand total live births. Although this rate has declined only slightly (38 per thousand in 1953 and 39 for both 1952 and 1951), it compares favourably with rates of 49 and 45 per thousand for 1949 and 1950 respectively.

The number of stillbirths relating to the Administrative County was 642, an increase of 9 over the total for 1953. The rate per 1,000 live and stillbirths was 25.9 compared with 24.7 in 1953 and 24.6 in 1952. The increase in the rate is not peculiar to the Administrative County and for England and Wales the rate of 23.4 shows an increase of 0.9 over the previous year.

Excess of births over deaths (natural increase of population) was 5,085 in 1954 compared with 6,522 in 1953, 6,234 in 1952 and 8,762 for the average of the ten years 1940-49. The figures below show that the reduction in the infant mortality rate has appreciably offset the decline in the birth rate:—

Period	Birth Rate	Average Annual Number of Births	Average Annual Number of Deaths of Infants under one year of age	The addition to the population at end of one year
1890-1899	30.2	42,526	6,547	35,979
1900-1909	27.5	40,673	5,651	35,022
1910-1919	22.5	34,522	3,851	30,671
1920-1929	20.2	30,682	2,530	28,152
1930-1939	15.5	23,677	1,476	22,201
1940-1949	18.1	27,044	1,270	25,774
1950	16.3	25,898	904	24,994
1951	15.8	25,113	798	24,315
1952	15.4	24,506	736	23,770
1953	15.7	25,026	733	24,293
1954	15.1	24,164	677	23,487

Deaths of infants under 1 year of age numbered 677 giving a mortality rate per 1,000 live births of 28.0 which was, as has been the case in recent years, the lowest rate yet recorded for the Administrative County. In 1948 there was a pronounced improvement in infant mortality which reduced the rate to 39 from 45 for the preceding year; since that time it has progressively declined although the rate of reduction from year to year has not been so great.

The trend of the infant mortality rate since the beginning of the century is shown in the following table:—

Period	Average Infant Mortality Rate	Period	Average Infant Mortality Rate
1900-1909	139	1940-1944	51
1910-1919	112	1945-1949	43
1920-1929	82	1950-1954	31
1930-1939	62		



The mortality of infants at various periods in the first year of life is shown below. The mortality among boys is always higher than among girls and is a phenomenon which to some extent helps to equate the sexes for generally there are more boys born than girls.

	Number of Deaths							Deaths per 1,000 Live Births						
	1948	1949	1950	1951	1952	1953	1954	1948	1949	1950	1951	1952	1953	1954
<i>Male Infants</i>														
Under 4 weeks ...	339	323	319	297	285	265	252	22.9	23.1	23.8	22.8	22.6	20.3	20.2
4 weeks—3 months ...	112	94	88	72	46	62	61	7.6	6.7	6.6	5.5	3.6	4.8	4.9
3—6 months ...	99	94	76	61	47	56	52	6.7	6.7	5.7	4.7	3.7	4.3	4.1
6—12 months ...	80	73	48	53	38	43	36	5.4	5.2	3.6	4.1	3.0	3.3	2.9
Total under 1 year	630	584	531	483	416	426	401	42.6	41.7	39.7	37.1	32.9	32.7	32.1
<i>Female Infants</i>														
Under 4 weeks ...	266	259	203	176	205	200	189	18.8	19.7	16.2	14.6	17.2	16.7	16.2
4 weeks—3 months ...	84	68	57	51	45	43	37	5.9	5.2	4.6	4.2	3.8	3.6	3.2
3—6 months ...	85	61	69	54	36	27	32	6.0	4.6	5.5	4.5	3.0	2.2	2.7
6—12 months ...	64	65	44	34	34	37	18	4.5	4.9	3.5	2.8	2.9	3.1	1.6
Total under 1 year	499	453	373	315	320	307	276	35.2	34.4	29.8	26.1	26.9	25.6	23.7
<i>All Infants</i>														
Under 4 weeks ...	605	582	522	473	490	465	441	20.9	21.4	20.2	18.8	20.0	18.6	18.3
4 weeks—3 months ...	196	162	145	123	91	105	98	6.8	6.0	5.6	4.9	3.7	4.2	4.0
3—6 months ...	184	155	145	115	83	83	84	6.3	5.7	5.6	4.6	3.4	3.3	3.5
6—12 months ...	144	138	92	87	72	80	54	5.0	5.1	3.5	3.5	2.9	3.2	2.2
Total under 1 year	1129	1037	904	798	736	733	677	39.0	38.2	34.9	31.8	30.0	29.3	28.0

The Table below gives a more detailed analysis of the mortality in infants (male and female) under 4 weeks of age in the years 1948 to 1954.

	Number of Deaths							Deaths per 1,000 Live Births						
	1948	1949	1950	1951	1952	1953	1954	1948	1949	1950	1951	1952	1953	1954
Under 1 day .....	209	237	193	176	229	198	184	7.2	8.7	7.5	7.0	9.3	7.9	7.6
1—7 days .....	236	203	218	221	183	190	193	8.2	7.5	8.4	8.8	7.5	7.6	8.0
1—4 weeks .....	160	142	111	76	78	77	64	5.5	5.2	4.3	3.0	3.2	3.1	2.7
Total under 4 weeks .....	605	582	522	473	490	465	441	20.9	21.4	20.2	18.8	20.0	18.6	18.3

The number of neo-natal deaths (infants under four weeks of age) assigned to the Administrative County in 1954 was 441 with a resultant rate per 1,000 live births of 18.3, the lowest rate yet recorded, but it is still above the corresponding rate for England and Wales, 17.7. Although the total infant mortality rate has declined considerably since 1948, the neo-natal mortality rate has not decreased in the same proportion, so that, if further reductions in the infant death rate are to be achieved, increasing attention must be focussed on the neo-natal period. The death rate among infants in the first day of life remains within the limits of between 7 to 9 per thousand live births and it is estimated that about 75 per cent. of these deaths are due to immaturity, post-natal asphyxia and atelectasis, and birth injury; congenital malformations account for a further 10 per cent.

## Deaths

The number of deaths from all causes assigned to the Administrative County in 1954 was 19,079 (9,959 males, 9,120 females), an increase of 575 on the number for 1953, and yielding a rate per thousand of the population of 11.9 compared with 11.6 in 1953, 11.5 in 1952 and is the same as the average rate for the five years 1949-53.

The age and sex distribution of the population varies from area to area and crude death rates in themselves do not give a true comparison of mortality when comparing different areas. For instance, of two areas or districts, the one containing the larger proportion of elderly people will almost certainly have the higher crude death rate, in spite of the fact that the general health conditions of its population may be the better of the two. In order to compare the mortality factors operating in one area with those of other areas and for the country as a whole, an adjustment to the crude rate to make allowances for the differing constitution of the population must be made.

The adjusted rates from all causes for the past five years for the aggregates of Boroughs and Urban Districts, Rural Districts and for the Administrative County along with the rates for England and Wales is given in the following table:—



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
1954	12.8	11.4	12.5	11.3

The following table shows the number of deaths in 1954 in the Administrative County classified according to age and cause:—

Cause of Death	Age at Death								Total
	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	
1. Tuberculosis, respiratory .....	1	1	1	12	70	113	44	19	261
2. Tuberculosis, other .....	—	1	4	1	9	9	—	2	26
3. Syphilitic disease .....	—	—	—	—	4	27	18	6	55
4. Diphtheria .....	—	1	—	—	—	1	—	—	2
5. Whooping cough .....	6	1	—	—	—	—	—	—	7
6. Meningococcal infections .....	2	7	1	—	—	3	2	—	15
7. Acute poliomyelitis .....	1	—	2	2	2	—	—	—	7
8. Measles .....	—	1	2	—	—	—	—	—	3
9. Other infective and parasitic diseases	2	1	3	—	10	8	4	3	31
Total—Infective and Parasitic Diseases, exc. Tub.	11	11	8	2	16	39	24	9	120
10. Malignant neoplasm, stomach .....	—	—	—	—	17	203	220	173	613
11. Malignant neoplasm, lung, bronchus .....	—	—	—	—	26	246	148	45	465
12. Malignant neoplasm, breast .....	—	—	—	—	29	127	73	57	286
13. Malignant neoplasm, uterus .....	—	—	—	1	15	94	40	22	172
14. Other malignant and lymphatic neoplasms	1	6	8	8	84	511	496	491	1,605
15. Leukaemia, aleukaemia .....	—	4	4	6	10	20	19	6	69
Total—All forms of Cancer .....	1	10	12	15	181	1,201	996	794	3,210
16. Diabetes .....	—	1	—	—	9	27	50	32	123
17. Vascular lesions of nervous system .....	—	—	3	2	45	474	991	1,431	2,946
18. Coronary disease, angina .....	—	—	—	—	50	816	1,030	840	2,736
19. Hypertension with heart disease .....	—	—	—	—	2	79	170	221	472
20. Other heart disease .....	—	—	2	14	80	385	766	1,975	3,222
21. Other circulatory disease .....	—	—	1	1	15	106	198	518	839
Total—Heart and Circulatory Diseases	—	—	3	15	147	1,386	2,164	3,554	7,269
22. Influenza .....	4	2	2	5	5	19	24	35	96
23. Pneumonia .....	100	15	4	5	14	84	131	213	566
24. Bronchitis .....	32	6	2	—	19	298	358	416	1,131
25. Other diseases of respiratory system	7	2	3	—	18	58	43	30	161
Total—Diseases of the Respiratory System incl. Influenza and excl. Tuberculosis	143	25	11	10	56	459	556	694	1,954
26. Ulcer of stomach and duodenum .....	—	—	—	1	9	59	57	51	177
27. Gastritis, enteritis and diarrhoea .....	21	8	1	2	4	16	14	12	78
28. Nephritis and nephrosis .....	—	1	3	10	34	70	50	55	223
29. Hyperplasia of prostate .....	—	—	—	—	—	13	37	67	117
30. Pregnancy, childbirth, abortion .....	—	—	—	4	17	1	—	—	22
31. Congenital malformations .....	124	13	7	5	13	13	3	1	179
32. Other defined and ill-defined diseases	362	12	27	17	98	288	277	484	1,565
33. Motor vehicle accidents .....	—	7	11	26	37	41	19	26	167
34. All other accidents .....	14	10	17	18	54	89	81	191	474
35. Suicide .....	—	—	—	8	31	80	25	13	157
36. Homicide and operations of war .....	—	1	1	1	4	4	—	—	11
Total—Accidents, Suicide and Violence	14	18	29	53	126	214	125	230	809
Total—All Causes .....	677	101	109	153	834	4,382	5,388	7,435	19,079

As mentioned previously, the proportion of elderly people in the County is increasing and this is reflected in the mortality figures; two thirds of the total deaths were of persons 65 years or over, 39 per cent. were 75 years or over, and more and more attention is being focussed on the diseases of middle and old age. The diseases given in the table below accounted for 15,122 of the 19,079 total deaths, which is 79 per cent., an increase of 1.8 per cent. over the previous year:—

	Death rates per 1,000 population				
	1950	1951	1952	1953	1954
Heart and circulatory diseases ... ..	4.39	4.72	4.35	4.26	4.54
Cancer ... ..	1.83	1.80	1.92	1.88	2.01
Vascular lesions of nervous system ... ..	1.59	1.72	1.74	1.76	1.84
Bronchitis and pneumonia ... ..	1.07	1.35	1.01	1.10	1.06
(a) Totals of the above ... ..	8.88	9.59	9.02	9.00	9.45
(b) Death rate — all causes ... ..	11.80	12.74	11.49	11.62	11.92
Percentage col. (a) to col. (b) ... ..	75.3	75.3	78.5	77.5	79.3



During the year 7,269 deaths were classified as being due to coronary disease, angina, hypertension with heart disease, other heart disease, or other circulatory disease; these deaths comprised over 38 per cent. of the total deaths and, of course, the majority were of old people. Indeed, only 165 deaths classified to this group were of people under the age of 45 years. The number of deaths from the above causes and the mortality rates per 1,000 of the estimated population in each of the five years 1950-54 are given below:—

Year	Coronary disease, angina		Hypertension with heart disease		Other heart disease		Other circulatory disease		Total	
	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate
1950	2,037	1.28	495	0.31	3,751	2.36	698	0.44	6,981	4.39
1951	2,234	1.41	511	0.32	4,017	2.53	733	0.46	7,495	4.72
1952	2,370	1.49	376	0.24	3,482	2.19	691	0.43	6,919	4.35
1953	2,364	1.49	404	0.25	3,330	2.09	684	0.43	6,782	4.26
1954	2,736	1.71	472	0.30	3,222	2.01	839	0.52	7,269	4.54

Deaths from cancer, including leukaemia and aleukaemia, numbered 3,210 (approximately 17 per cent. of total deaths), an increase over the previous year of 220. The death rate from this disease, apart from minor fluctuations, has increased steadily for many years; in 1954 it was 2.01, the highest ever recorded, being now more than double what it was forty to fifty years ago. Although there may be other factors also, it is not unlikely that part of this increase is due to improved methods of diagnosis and part due to there being more persons in the population of "cancer age", that is, over 45 years of age.

The number of deaths from cancer, according to sex and site, for the past five years is given in the following table:—

	Number of Deaths														
	1950			1951			1952			1953			1954		
	M.	F.	P.	M.	F.	P.	M.	F.	P.	M.	F.	P.	M.	F.	P.
Stomach	294	290	584	302	228	530	358	218	576	298	242	540	349	264	613
Lung, Bronchus	280	57	337	302	58	360	335	60	395	381	63	444	404	61	465
Breast	1	250	251	—	253	253	—	284	284	5	283	288	1	285	286
Uterus	—	142	142	—	166	166	—	157	157	—	156	156	—	172	172
Other Malignant and Lymphatic Neoplasms	820	725	1,545	855	636	1,491	899	681	1,580	811	680	1,491	886	719	1,605
Leukaemia, Aleukaemia	30	19	49	26	31	57	30	32	62	33	38	71	29	40	69
Total, All Sites	1,425	1,483	2,908	1,485	1,372	2,857	1,622	1,432	3,054	1,528	1,462	2,990	1,669	1,541	3,210

It will be seen from the above that, with the exception of cancer of the breast, leukaemia and aleukaemia, the number of deaths for each site shows an increase over the previous year.

A striking feature is the increase in the number of deaths from cancer of the lung and bronchus and, while the increase over 1953 was only 21 deaths, it was 128 (38 per cent.) above the number for 1950—the increase being more marked in males than females. Intensive research is being undertaken to determine the cause of cancer and until more is known about this disease it is essential to minimise potential risks. Atmospheric pollution may yet be proved to be an associated factor involved in the causation of lung cancer and I hope that the coming into operation of the Government's "Clean Air Bill" will not be long delayed.

The number of deaths classified to vascular lesions of the nervous system, (cerebral haemorrhage and cerebral thrombosis) was 2,946, 140 more than in 1953 and 178 more than the number for 1952. The number of deaths from this disease has progressively increased over recent years and in 1954 was equivalent to a rate of 1.84 per 1,000 of the population compared with 1.76 for 1953 and 1.74 for 1952. Like heart disease and cancer, it is a condition which mainly affects older people and, of the 2,946 deaths in 1954, 991 were of persons between the ages of 65 and 74 years while 1,431 were aged 75 years or over.



Bronchitis and pneumonia, while retaining their relative importance as two of the principal causes of death, caused fewer deaths in 1954 than in 1953. The number of deaths assigned to this group was 1,697 in 1954, 1,747 in 1953 and compares favourably with the average for the four years 1950-53 of 1,804 deaths. Included in the total deaths of 1,697 for 1954 were 132 deaths of infants under 1 year of age but by far the majority, nearly two thirds of the total, were persons 65 years of age and upwards.

Deaths from motor vehicle accidents, all other accidents, suicide, homicide and operations of war, which may be grouped together under the general heading of "violence", decreased slightly in 1954 as compared with the previous year. The number of deaths in recent years from this group of causes was as follows:— 1950, 757; 1951, 766; 1952, 713; 1953, 828 and 1954, 809.

Included in the above figures are deaths resulting from accidents in the home and, while no precise figures are available, it is estimated that some 200 deaths annually in the Administrative County are attributed to this cause and indeed in the country as a whole the number of deaths has varied little from year to year. Many of these deaths are caused by lack of care or ignorance of the correct precautions and if these fatalities are to be reduced our propaganda efforts in this field must be intensified.

Although there were two more deaths in 1954 than in 1953 from all forms of tuberculosis, the death rate remains the same at 0.18 per thousand of the population which is the lowest ever recorded for the County.

After having no deaths from diphtheria assigned to the Administrative County in the years 1951-53 it is disappointing to have to report that in 1954 there were two deaths from this disease. One was of a little girl of 4 years who had not been immunised, the other, a woman aged 58 years, who had contracted diphtheria when a child and, in spite of the lapse of time, the death has been assigned to this cause in accordance with the rules of International Classification of Deaths.

### Child Mortality

The number of deaths of children between the ages of 1 and 5 years was 101 and, once again, it is the lowest number ever recorded for the Administrative County. Although the reduction in mortality as compared with 1953 was 19 deaths and a decrease of 35 for the average for the five years 1950-54, there is still a number of deaths occurring which might be prevented.

Enormous reductions in the total number of deaths have taken place over the past forty to forty-five years but the decrease from certain causes—congenital malformations and accidents—has not been at the same rate. It should be pointed out that, in spite of all our propaganda efforts, violent causes, which accounted for one death out of six in 1945-49, still had the same ratio in 1954, while the number of deaths from cancer now shows an upward trend.

The table below gives the number of deaths of children aged 1-5 years from the various causes in the Administrative County:—

Cause of Death	Annual Averages for Quinquennia					1950	1951	1952	1953	1954
	1911-15	1927-31	1935-39	1940-44	1945-49					
Measles ... ..	439	107	27	18	10	3	8	2	4	1
Whooping cough ... ..	167	67	29	20	11	3	10	5	6	1
Diphtheria ... ..	110	47	51	32	5	1	—	—	—	1
Other infective and parasitic diseases, excl. tuberculosis ... ..	54	45	18	13	7	13	12	2	10	8
Tuberculosis, respiratory ... ..	47	13	5	4	4	1	3	—	—	1
Tuberculosis, other ... ..	201	82	37	39	30	15	16	13	10	1
Cancer ... ..	3	5	4	6	4	8	12	8	8	10
Heart and circulatory diseases ... ..	4	3	2	1	1	—	—	1	1	—
Influenza ... ..	6	43	10	11	4	2	2	2	3	2
Pneumonia ... ..	457	321	121	85	42	24	22	27	8	15
Bronchitis ... ..	150	42	10	17	9	2	8	4	8	6
Other diseases of respiratory system	49	15	6	5	3	6	1	2	—	2
Diarrhoea and other digestive diseases ... ..	248	45	38	23	17	3	3	2	5	8
Congenital debility, malformations, premature births, etc. ... ..	12	9	7	10	12	9	21	10	10	13
Accidents ... ..	82	54	50	47	38	39	29	28	23	17
Other causes ... ..	323	119	52	45	30	32	28	17	24	15
All causes ... ..	2,352	1,017	467	376	227	161	175	123	120	101

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	1.53
Year 1952	1.15
Year 1953	1.17
Year 1954	1.01

The rates for 1911-15, 1927-31 and 1951 are based on the census populations for 1911, 1931 and 1951 respectively. Those for 1952, 1953 and 1954 are based on estimated populations.



## Maternal Mortality

The number of deaths classified to pregnancy, childbirth and abortion recorded for the Administrative County in 1954 was 22, an increase over 1953 of 9 deaths. Included in the total were two deaths where the interval between the maternal condition and death was stated to exceed 12 months. The resultant rate per thousand live and stillbirths was 0.89 compared with 0.51 in 1953 (which was the lowest rate ever recorded for the County) and 0.80 in 1952; it is also slightly above the average rate of 0.81 for the five years 1949-53, but even so, it is less than half the rate of ten years ago and is only a fifth of the rate recorded twenty years ago. In 1954, 73 of the 89 Districts in the Administrative County had no maternal death.

The number of maternal deaths and the average maternal mortality rates for the two quinquennial periods 1945-49 and 1950-54 for each of the Public Health Divisional Areas are given in the following table:—

Division	5 years 1945-49			5 years 1950-54			Percentage decrease in rate for 1950-54 on that for 1945-49
	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	4,854	12	2.47	4,189	3	0.72	70.85
2	1,932	4	2.07	1,625	1	0.62	70.05
3	5,006	9	1.80	4,123	6	1.46	18.89
4	5,751	10	1.74	4,991	2	0.40	77.01
5	5,930	6	1.01	5,076	1	0.20	80.20
6	2,758	1	0.36	2,388	—	—	100.00
7	1,824	6	3.29	1,826	—	—	100.00
8	5,743	5	0.87	4,885	1	0.20	77.01
9	3,988	5	1.25	3,414	5	1.46	*16.80
10	4,344	3	0.69	3,753	3	0.80	*15.94
11	6,278	10	1.59	5,127	6	1.17	26.42
12	5,624	7	1.24	5,025	2	0.40	67.74
13	4,106	3	0.73	3,474	4	1.15	*57.53
14	3,861	3	0.78	3,116	3	0.96	*23.08
15	4,643	7	1.51	3,988	3	0.75	50.33
16	4,979	8	1.61	3,900	2	0.51	68.32
17	4,266	2	0.47	3,531	3	0.85	*80.85
18	5,047	6	1.19	4,196	3	0.71	40.34
19	4,850	7	1.44	4,078	1	0.25	82.64
20	7,383	9	1.22	5,927	9	1.52	*24.59
22	6,988	10	1.43	6,480	6	0.93	34.97
23	6,923	14	2.02	6,318	5	0.79	60.89
25	7,806	8	1.02	6,626	4	0.60	41.18
26	4,463	3	0.67	4,017	3	0.75	*11.94
27	4,347	7	1.61	3,528	4	1.13	29.81
28	5,970	11	1.84	5,198	6	1.15	37.50
29	3,753	8	2.13	3,652	3	0.82	61.50
30	6,605	5	0.76	5,695	6	1.05	*38.16
31	8,238	12	1.46	7,751	10	1.29	11.64
Total Admin. County	148,260	201	1.36	127,897	105	0.82	39.71

\* Percentage increase.

† Division No. 24 was abolished as from 1st May, 1954, and the County Districts comprising it were included in Division No. 25 as from that date. The statistics shown above for Division No. 25 are for the Division as so enlarged.

In perusing the above figures it should be borne in mind that the mortality rates are based on a small number of deaths and the addition or deduction of even one death could have an appreciable effect upon the rate. In five of the eight Divisions which showed an increased rate, there was the same number of deaths in each quinquennial period, the increase in the rate being due to fewer births. In the remaining three Divisions the increase in the number of deaths in each case was only one. The table, however, does show the areas in the County which have contributed to the decrease in the County rate from 1.36 in 1945-49 to 0.82 in 1950-54 and which 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 26 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
1954	*	*	22	*	*	0.89

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

## 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, 1953); 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 27, the following table shows the number of cases in 1954 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)	1,040	976	1,501	1,755	36	17	20	7	2,880	2,694	5	10
	2,016		3,256		53		27		5,574		15	
Final numbers after correction												
Under 1 year ...	3	5	149	169	—	1	—	—	117	116	—	—
1—2 years ...	77	71	326	366	4	—	—	—	631	553	—	1
3—4 " ...	267	206	428	494	6	4	4	—	776	784	—	—
5—9 " ...	549	565	552	640	7	3	7	1	1,283	1,162	1	—
10—14 " ...	80	93	23	35	3	1	2	2	35	41	—	—
15—24 " ...	38	5	4	9	6	3	2	1	18	8	—	2
25 and over ...	10	18	16	38	4	2	—	1	9	15	—	—
Age unknown...	3	3	1	2	—	—	—	—	6	4	—	—
Totals (all ages)	1,027	966	1,499	1,753	30	14	15	5	2,875	2,683	1	3
	1,993		3,252		44		20		5,558		4	
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)	620	526	6	3	809	768	22	20	139	168	31	27
	1,146		9		1,577		42		307		58	
Final numbers after correction												
Under 5 years...	78	78	3	—	291	258	3	2	2	—	10	11
5—14 years ...	76	81	1	3	280	214	10	5	2	7	6	4
15—44 " ...	170	137	1	—	121	182	3	4	31	42	2	3
45—64 " ...	188	112	—	—	32	35	3	4	68	77	2	3
65 and over ...	104	110	—	—	8	14	1	—	35	41	—	—
Age unknown...	4	6	—	—	7	12	—	—	1	1	—	—
Totals (all ages)	620	524	5	3	739	715	20	15	139	168	20	21
	1,144		8		1,454		35		307		41	

	Numbers Originally Notified		Numbers After Correction	
Smallpox ...	...	...	...	...
Puerperal Pyrexia ...	...	...	131	131
Ophthalmia Neonatorum ...	...	...	17	17
Chicken Pox ...	...	...	694†	not corrected
Malaria ...	...	...	9	9

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



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

Disease	Number of corrected notifications					(Chicken Pox not corrected)			
	1946	1947	1948	1949	1950	1951	1952	1953	1954
Scarlet Fever ... ..	2,369	2,764	3,863	3,191	2,506	1,792	2,176	2,991	1,993
Whooping Cough ... ..	4,451	3,424	6,201	3,947	7,669	6,933	5,865	5,821	3,252
Diphtheria ... ..	551	221	153	66	32	10	4	1	4
Measles ... ..	1,883	21,739	16,545	16,489	15,763	25,194	13,938	19,853	5,558
Acute Pneumonia (primary or influenzal) ...	1,324	1,188	1,308	1,456	1,207	1,739	1,366	1,585	1,144
*Meningococcal Infection ...	71	78	56	60	55	57	50	37	41
Acute Poliomyelitis (paralytic) ...	1	351	46	224	150	90	103	101	44
Acute Poliomyelitis (non-paralytic) ...	—	—	—	—	41	58	28	25	20
*Acute Encephalitis (infective) ...	2	2	1	2	6	5	6	7	4
*Acute Encephalitis (post infectious) ...	—	—	—	—	3	14	1	3	4
Dysentery ... ..	127	108	208	73	1,117	837	370	455	1,454
Ophthalmia Neonatorum ... ..	46	82	51	37	39	29	23	20	17
Puerperal Pyrexia ... ..	104	85	98	98	125	128	151	141	131
Smallpox ... ..	—	—	—	—	—	—	—	14	—
Enteric or Typhoid Fever (excluding Paratyphoid) ...	14	9	18	3	9	—	2	2	5
Paratyphoid Fevers ... ..	50	16	10	11	4	62	4	10	30
Erysipelas ... ..	366	347	409	429	405	312	273	302	307
†Chicken Pox ... ..	443	550	432	827	465	797	1,350	739	694
§Malaria ... ..	28	11	6	2	1	2	5	14	9
‡Food Poisoning ... ..	‡	‡	‡	329	346	138	192	329	276
Tuberculosis:—									
Respiratory ... ..	1,204	1,233	1,246	1,478	1,297	1,296	1,337	1,223	1,084
Other Forms ... ..	432	389	407	431	348	285	296	247	206
Total (Tuberculosis) ...	1,636	1,622	1,653	1,909	1,645	1,581	1,633	1,470	1,290

\* 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

Corrected notifications of scarlet fever numbered 1,993, 998 less than in 1953, and apart from 1951, when there were 1,792 cases, it is the lowest number recorded since 1944 when correction of notifications came into general use. The infection continues to be mild and over 40 per cent. of the cases occurred during the first quarter of the year. As is usual with this disease, it was most common in children under 10 years of age; nearly 80 per cent. of the notifications being in the age group 3—9 years. The case, or attack rate, that is the number of cases per 1,000 of the population, in the Administrative County was 1.25 (compared with 0.96 for England and Wales). The County Districts with the highest rates were:—Silsden U.D. 8.73; Penistone U.D. 5.03; Dearne U.D. 3.98; Earby U.D. 3.89; Mexborough U.D. 3.31; Meltham U.D. 3.10; Colne Valley U.D. 3.01.

## Whooping Cough

Whooping cough was less prevalent during the year than it had been in the previous eight years. Final notifications numbered 3,252 compared with the annual average, since notification was introduced in 1940, of 5,019. Approximately two-thirds of the cases occurred in the first half of the year and weekly figures showed that the incidence kept at a high level from January to May, the peak (157 cases) being reached in the second week in April, then progressively declining to the year end. The disease, in the main, attacked infants and children under 10 years of age and there appears little doubt that the immediate deaths represent only a part of the mortality really attributable to it; the respiratory conditions following an attack being often responsible for much ill-health as well as a number of deaths.

The attack rate in the Administrative County per 1,000 of the population in 1954 was 2.03 compared with 3.66 in 1953; the corresponding rates for England and Wales being 2.39 in 1954 and 3.58 in 1953. The Districts which experienced the highest rates in 1954 were:—Kiveton Park R.D. 11.39; Darfield U.D. 9.64; Wombwell U.D. 8.47; Saddleworth U.D. 8.40; Ossett M.B. 6.40; Tadcaster R.D. 6.11; Sedbergh R.D. 6.01; Horsforth U.D. 5.66; Mexborough U.D. 5.05; Denholme U.D. 5.02.

**Whooping Cough Immunisation.**—10,074 children were immunised against whooping cough during the year under the Authority's scheme, compared with 8,520 for the year 1953. Unlike the scheme for diphtheria immunisation, the arrangements are not publicised and children are only immunised at the request of the parents.



The present position regarding whooping cough immunisation must be regarded as unsatisfactory. The Ministry of Health issue diphtheria antigen free to local health authorities in connection with their schemes for diphtheria immunisation, and also initiate propaganda material for use in advertising in local newspapers. In the case of whooping cough immunisation, the local health authority with such a scheme, and not every local health authority has one, must provide at its own expense the immunising material; also the Ministry of Health does not provide any propaganda material. The reason for the difference is no doubt due to the carrying out of trials on the efficiency of whooping cough vaccine particularly when combined with other prophylactics, for example, diphtheria and tetanus. These trials have been going on for some years and it would be most helpful if the Ministry would make a pronouncement on the results at an early date.

## Diphtheria

During the year there were four corrected notifications of diphtheria and, of these, only two were of children under 15 years of age. There were two deaths, one of an un-immunised child and the other, a woman of 58 years who had the disease when a child and whose death, in spite of the lapse of time, has been classified to diphtheria in accordance with the revised international procedure.

The number of children who received immunisation during 1954, 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
1954	15,207	5,013	20,320	22,515

It will be noted that there was an increase in 1954 in the number of children who completed a full course of immunisation but the number of children immunised before their first birthday is still far too low. It appears to be impossible to convince many modern parents that a high level of immunisation is still necessary to safeguard against a recurrence of the disease amongst children. Leaflets and birthday cards are sent to parents, the health visitors talk to them in an attempt to convince them that immunisation is worth-while, and advertisements of immunisation clinic sessions are inserted in the press, but much apathy exists and it appears to be too much trouble for parents to take their children to the family doctors or to the clinics.

The immunisation state of the child population in the Administrative County as at the 31st December each year for the years 1948 to 1954 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
1954	55,990	45.2	217,052	87.5	273,042	73.4

## Measles

The number of corrected notifications of measles was 5,558 representing an attack rate for the Administrative County of 3.47 per 1,000 of the population, compared with 19,853 notifications and a rate of 12.47 for 1953. As with whooping cough, measles is a disease which, in the main, attacks infants and children; the age distribution of the cases being 4.2 per cent. in infants under 1 year; 49.4 per cent. in the age group 1 and under 5 years and 44.0 per cent. in the 5 and under 9 years group; only 2.4 per cent. were 10 years of age and over. In 1954 there were 3 deaths but, like whooping cough, there must be a large amount of ill-health from its respiratory sequelae as well as many childhood deaths classed on certificates to bronchopneumonia, other diseases of the respiratory system etc. While clinicians of experience state that in recent years the virus of measles has shown a reduction of virulence, so that the true haemorrhagic form has disappeared, to-day more and more parents are realising that the disease can be serious in children and now that, under the National Health Service, there is no financial barrier, it is a matter of satisfaction that medical attention is being sought more promptly and frequently. The County Districts in which measles was most prevalent, with the attack rates per 1,000 of the population, were as follows:—Tickhill U.D. 28.91; Thorne R.D. 24.00; Hemsworth U.D. 14.59; Stocksbridge U.D. 13.87; Harrogate M.B. 12.36; Kiveton Park R.D. 12.00; Cudworth U.D. 11.50; Mexborough U.D. 9.88; Meltham U.D. 9.69; Bentley with Arksey U.D. 8.92; Doncaster R.D. 7.47; Nidderdale R.D. 7.47.



## Meningococcal Infection

### (*Cerebro-Spinal Fever*)

During the year, confirmed cases of meningococcal infection numbered 41, which, with the exception of 1953 when there were 37 notifications, is the lowest number recorded since 1939.

Young children would appear to be especially susceptible to the disease; the age distribution followed a similar pattern to that of recent years, and approximately 50 per cent. of the cases were in children under 5 years of age.

It is known that some outbreaks have been associated with overcrowding and bad ventilation but, as the cases in 1954 were scattered over the County and the majority were single ones, it would be unwise to draw firm conclusions, especially when, according to the 1951 Census, the number of persons per dwelling in those County Districts where more than one case arose did not differ greatly from the average for the County as a whole nor the average of the Districts in which there was no case.

## Acute Poliomyelitis

### (*Infantile Paralysis*)

The number of corrected notifications of acute poliomyelitis received during the year was 64 which is a considerable reduction on that for previous recent years. While it is pleasing to note that cases of the non-paralytic form declined from 28 in 1952, 25 in 1953 to 20 in 1954, it is of greater satisfaction to find that the cases suffering paralysis fell from 103 in 1952, 101 in 1953 to only 44 in 1954.

As is usual in this country, the incidence increased in the late summer and autumn, the highest number of cases in any one week (6) being notified during the last week of October.

The age distribution, in the main, conformed to that of recent years and again the disease was more prevalent in males. The term "infantile paralysis" would appear to be a misnomer for, whereas there was only one case with paralysis in an infant under 1 year of age, six cases with paralysis were over 25 years of age. The cases were distributed over the County, mostly in ones or twos, no District having more than five during the year.

Extensive research is still proceeding in this country and abroad along various lines. Although the causal agent, a filterable virus, is known, there is much which we do not know about the disease. Our knowledge of the mode of spread is incomplete; many vehicles have been suspected but nothing conclusive has yet been found. While we can exercise general principles to control the spread of the disease (isolation of the patient and control of contacts who had been with him during the infectious stages of the illness), efforts are being intensified in an endeavour to find a satisfactory immunizing preparation so that the disease does not appear at all and the results of tests being undertaken at the moment in the United States of America are awaited with keen interest. No promise of quick or complete success is made and, with this in mind, the Chief Medical Officer of the Ministry of Health, in his annual report for 1953, stated:—

"It is salutary to remember that the first attempt at preparing a vaccine against poliomyelitis was made as long ago as 1935, and since then there have been several unsuccessful—and unfortunate—trials. Much patient work will yet be needed before poliomyelitis is controlled and we must beware of proclaiming victory before the battle is even properly joined."

## Acute Encephalitis

Eight confirmed cases (4 infective, 4 post infectious) were notified during the year, compared with ten in 1953 and seven in 1952. The cases, single ones, arose in widely separated Districts. The post infectious form may include cases of encephalitis which either accompany or follow one of the commoner infectious diseases (measles, mumps, chickenpox, whooping cough etc.) and as deaths from encephalitis are classified, according to international coding, to the underlying infection concerned, there is no easy method by which the number of deaths can be traced.

## Dysentery

There was a marked increase in the incidence of dysentery during the year; corrected notifications (1,454) reached the highest recorded total for the County since notification of the disease was introduced in 1928. This increased incidence is not peculiar to the Administrative County but is in keeping with that experienced throughout the country. Notifications by quarters and sex were as follows:—

	M.	F.	Total
1st Quarter	190	202	392
2nd Quarter	327	327	654
3rd Quarter	115	89	204
4th Quarter	107	97	204

As to age incidence, the notifications in 1954 closely resembled the pattern of recent years; notifications at 0—4 years were 37.8 per cent. of the total; at 5—14 they were 35.6 per cent. giving



a total for those under 15 years of age of 71.8 per cent. of the whole. Twenty per cent. were in the age group 15—44. These figures do not by any means represent the true incidence of this widespread infection as many mild cases are symptomless or have only minor upsets and are not seen by the family doctor and, therefore, not notified.

The 1,454 notifications were distributed over the County as follows:—

<i>Division No.</i>	<i>Number of Cases</i>	<i>Division No.</i>	<i>Number of Cases</i>	<i>Division No.</i>	<i>Number of Cases</i>
1	38	11	5	22	54
2	—	12	52	23	38
3	203	13	14	25	52
4	215	14	30	26	4
5	13	15	59	27	10
6	98	16	4	28	4
7	1	17	20	29	2
8	5	18	148	30	32
9	61	19	112	31	134
10	1	20	45		

Dysentery often appears to be prevalent where people gather together in close communities and it seems highly probable that the spread is mainly from person to person rather than from any food borne infection. For every clinical case, symptomless excretors probably exist who, unless traced and brought under treatment, could further the spread of the disease.

Much of the increased incidence was due to infection with *Shigella Sonnei* and many of the cases arose in outbreaks in day nurseries, mental hospitals and day and residential schools.

Commenting on an outbreak in Division No. 3 (Keighley M.B.) Dr. H. M. Holt, the Divisional Medical Officer, writes as follows:—

"This outbreak was the development of a few sporadic cases occurring during the previous year, not until the latter half of January, 1954 did it assume formidable proportions; between 19.1.54 and 31.3.54 148 notifications of *Shigella Sonnei* dysentery were received, of these 66 were bacteriologically confirmed.

The outbreak was first discovered by the Public Health Department in one of the Day Nurseries, the nature of the organism was identified, all the Nursery contacts were rectal swabbed as also the family contacts.

On the 1st March, 1954 the attention of all general practitioners in the district was drawn to the existence of this outbreak and a line of treatment suggested. At the same time a 'notice' was inserted in the local newspaper as follows:—

*'Borough of Keighley — Infectious Disease*

A germ frequently giving rise to diarrhoea is at present menacing the population of Keighley, numerous cases come to notice showing no symptoms at all, the danger is that the germ may gather strength as it moves from individual to individual and I counsel all who may be affected:—

1. To seek Medical Treatment.
2. To wash their hands after using the Lavatory.
3. To wash their hands before taking a meal or handling the baby — to do this regularly if engaged in the food distribution industry.

All cases were mild and the outbreak took a fairly normal course and faded to insignificant proportions in the last quarter of the year.

It may be of interest to add that all cases were visited as a matter of routine and instructed as to the precautions that should be taken. The publicity given in the press and the co-operation of general practitioners contributed to the quelling of the outbreak.

The early identification of active cases and their immediate treatment are the only profitable means by which an outbreak of this nature can be brought under control, the spread of infection by symptomless carriers remains a constant menace but comfort can be taken in the knowledge that the subjugation of active cases reflects a corresponding diminution in the number of carriers."

*Shigella Sonnei* was also responsible for many of the cases in outbreaks in Division No. 4 (Shipley) and Division No. 18 (Brighouse). The outbreaks were thoroughly investigated and, while no firm conclusions were reached, the mode of spread appeared to be from hand to hand and suggestive of faulty personal hygiene.

The lack of, or faulty, personal hygiene cannot be stressed too strongly and it is apparent that the best opportunities for large scale spread are offered in institutions where the individuals are either too young or too old and enfeebled to be relied upon to carry out the simple yet essential precaution of thoroughly washing their hands after every visit to the toilet.

With regard to the 98 confirmed cases in Division No. 6, Dr. R. A. W. Procter, the Divisional Medical Officer, has provided the following information:—

"In Division No. 6, comprising the Otley and Ilkley Urban Districts and the Wharfedale Rural District, there was a total of 98 proved cases of Dysentery (43 male and 55 female) reported during the year 1954.

The first notifications were received from Scalebor Park Mental Hospital, Burley-in-Wharfedale, in February, 1954, where a small outbreak of 11 cases occurred in a ward of elderly females. This was dealt with by the Hospital Authorities and we had every reason to suppose that the outbreak was under control. The only secondary cases were four members of one family who were infected in Otley by one member who was on the staff at Scalebor Park Hospital. No further cases came to light.



Towards the end of March, 1954, 9 positive cases occurred among student nurses at One Oak Hostel, Ilkley. Fortunately the Easter holiday supervened and the girls went to their homes and were placed under the medical supervision of their own doctor and the local Divisional Medical Officer and were not allowed to return to the hostel until tests had proved that cure had been complete.

On the 17th May, 3 cases of gastro-enteritis were reported in Otley and these proved to be sonne dysentery. Investigations brought to light a considerable number of other suspicious cases centered on the nursery section of the Otley Newall Infants' School. It was found that cases of diarrhoea had been occurring among members of the staff and children for a period of over 2 weeks and investigation of all children absent from school revealed a total of 33 cases of clinical dysentery. A search for the probable cause of infection brought to light a symptomless carrier on the school meals staff of the school. She was suspended from work and given treatment until a laboratory test proved that she was free from infection. Another food-handler at the Weston Lane School also had suspicious symptoms which proved to be sonne dysentery and she also was sent off work until tests proved her freedom from infection. It was necessary to take similar action in connection with two men employed in bakers' shops.

The Otley outbreak gradually diminished and finished at the end of June.

Dysentery in Division No. 6, therefore, resolved itself into 3 separate outbreaks; the Scalebor Park outbreak in February, the One Oak Hostel outbreak in March and April and the Otley outbreak in May and June.

In addition to the above, proved cases of dysentery occurred in connection with the children going to the Occupation Centre at Branshaw View, Keighley and also in the case of a nursery nurse employed in a neighbouring division.

In the second half of the year only a few sporadic cases were reported."

Dr. J. Lyons, who is Divisional Medical Officer for Division No. 19 (Todmorden M.B., Hebden Royd, Ripponden and Sowerby Bridge Urban Districts and the Rural District of Hepton), makes some interesting observations on outbreaks in his Division:—

"Sonne Dysentery was unusually prevalent in this division during 1954. In all 112 cases were statutorily notified from the five constituent county districts, but there is evidence to indicate that the total number of cases was, in fact, considerably higher. The disease spread for the most part in a sporadic fashion, with the noteworthy exception of a localised outbreak of considerable size in the rural hillside Cragg Vale area in the Hebden Royd District.

The Cragg Vale outbreak first came to the notice of the Health Department towards the end of March, 1954, when 15 cases of diarrhoea were reported from the Cragg Vale County Primary School. The onset of symptoms in the 15 schoolchildren was almost simultaneous, highly suggestive of a food-borne outbreak. Bacteriological examination of faeces confirmed in all cases that the sonne dysentery organism was responsible, but efforts to isolate the same organism from school meals, milk and water supply were unsuccessful, nor were any of the adults handling the food at school found to be carriers. The disease spread to other children in the school and to other members of the family at home. The number of children on roll at the school at the time of the outbreak was 84, of whom 25 were in due course confirmed as suffering from sonne dysentery. In 13 of the 25 cases clinical and bacteriological evidence of the disease was later found in one or more of the parents and other home contacts. In a few instances, especially where the standard of hygiene in the family was low, every member of the household was affected, but in general the spread was limited to one or two only of the family. The total number of adults infected was 14, and the total number of cases ascertained in the Cragg Vale area was 60, equally divided between the sexes. Infants under the age of 12 months numbered three only.

The disease in general took a fairly mild course, and there were no deaths. The cases in the Cragg Vale area did, however, appear to be rather more severe than those occurring in the more compact urban communities—an impression which was supported by one of the local general practitioners. This may be due to the fact that the Cragg Vale community is relatively isolated and had not to our knowledge been previously troubled with this disease.

The control of the Cragg Vale outbreak was carried out on orthodox lines. All ascertained cases (or suspected cases) were visited by the Sanitary Inspector, whether or not a statutory notification had been received, and inquiries were made into the possible sources and spread of the disease. Wherever possible specimens of faeces were obtained from other members of the household, including adults, special attention being devoted to those engaged in food handling. As a result of informal action, one publican, two dairymen and one butcher were persuaded to take special precautions. The dairymen were requested to send their milk for pasteurisation, and they co-operated readily. All contacts were advised of the way in which dysentery spreads, and were told of the importance of ensuring that their hands were scrupulously scrubbed and washed after visiting the toilet and before touching food. The fact that there was no major spread of the disease from Cragg Vale to surrounding districts speaks well for the good sense and co-operation of the Cragg Vale community.

"The spread of diseases of this kind can only be checked by a higher standard of personal hygiene. The practice of thoroughly washing the hands after every visit to the toilet would, if universally adopted, take us a long way towards the complete elimination of dysentery and allied infections (including the more common types of food poisoning) and even, to some extent, of poliomyelitis. The importance of the training of young children in the elementary rules of cleanliness by parents and teachers is underlined. The use of communal towels is probably a factor in the spread of infection, and representation was made last year to the Education Authority for their replacement in schools by individual towels. At the same time an appeal was also made to the public through the press for the use of individual towels in the home. Furthermore, pending action by the Education Authority, parents were asked to provide their children with individual towels to be used at school. The vast majority of parents co-operated, but it was noticeable that those few children who were in the greatest need of individual towels were often without them, and it is clear that this approach to the problem is not the complete answer."

Knowledge of the epidemiology of this disease is still incomplete as is also the reason why the disease should burn low for a while and then suddenly flare up in outbreak proportions. Much more research is needed into sonne dysentery and its method of spread and the Committee of the Public Health Laboratory Service on this subject has been studying it throughout the year.

Dr. J. M. Watt, Divisional Medical Officer for Division No. 31, which comprises Maltby U.D. and the Rural Districts of Kiveton Park and Rotherham, gives the following report on an outbreak which commenced in his Division in May and continued throughout the summer, terminating in October:—



"After three years in which there were never more than six notifications of dysentery, there was a sudden outbreak of cases in May, 1954 which continued for six months. All three districts were affected, but the majority of cases were in the Thurocroft parish where 70 cases developed out of a total of 134.

The dysentery was of a mild type. In children the symptoms lasted for about a week; in adults the illness was only of two or three days' duration and in many cases the patients were not confined to bed.

Our greatest difficulty was in clearing up carriers who tended to harbour the infection for months. This was a particular embarrassment among school children and food handlers.

All dysentery contacts had bacteriological examinations carried out and particular attention was paid to food handlers, teachers and nurses in charge of children. The family doctors were given immediate particulars of all laboratory reports received and co-operated closely by giving treatment to carriers.

The Sanitary Inspectors visited all food premises in the three districts and carried on an intensive campaign for extra cleanliness and care.

Two contacts, who were food handlers, were excluded from work until they were proved to be free from infection and all school children were excluded from school until three negative specimens were obtained.

The outbreak terminated in October and no further cases were discovered in the last two months of the year."

Dysentery is a puzzling disease in many ways; while flies and dust may contribute, lack of cleanliness and defective personal hygiene would appear to be largely responsible for its spread, and I cannot stress too strongly the importance of thorough cleanliness, both personal and in the preparation and handling of food, which remains the principal safeguard against all forms of the disease.

### Ophthalmia Neonatorum

Ophthalmia neonatorum is defined in the Regulations as "a purulent discharge from the eyes of an infant commencing within twenty-one days from the date of its birth" and unless prompt and skilled treatment is given it could lead to impaired vision or even total blindness. During the year 17 cases of the disease were notified and received treatment. In none was vision impaired.

### Puerperal Pyrexia

The number of notifications of puerperal pyrexia during the year was 131 which compares favourably with the numbers notified during the past three years that the revised definition of puerperal pyrexia has been in force.

Experience showed that there was a need to modify the definition of the condition in the Regulations of 1926-28 and 1939 as it was found to be ambiguous and, in addition, the use of various drugs now freely available may have the effect of reducing temperature promptly and so of preventing an infection from becoming notifiable. The definition was accordingly amended to read "puerperal pyrexia means any febrile condition occurring in a woman in whom a temperature of 100.4°F. or more has occurred within fourteen days after childbirth or miscarriage" and came into operation as from 1st August, 1951.

### Smallpox

There was no case of smallpox notified during the year.

**Vaccination against Smallpox.**—Vaccination is offered to the parents or guardians of all young children during the first months of life and is carried out either by the Medical Officer at the Infant Welfare Clinics or by the family doctor at the surgery or in the home.

The following table shows the number of vaccinations and re-vaccinations performed during the years 1951-1954 from which it will be seen that after the large increase in the number of vaccinations performed during 1953, when 14 confirmed cases of smallpox were notified in the Administrative County, as compared with the previous two years, the number of vaccinations in 1954 fell to normal proportions. With regard to the number of vaccinations in the age group "under 1", an increase is recorded as compared with the figures for 1951 and 1952, but the position is still unsatisfactory and it is hoped to stimulate still further the interest in infant vaccination.

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
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
1954	5,379	1,019	351	424	797	7,970	—	1	44	245	1,238	1,528



One case of post-vaccinal encephalitis was reported. The baby made rapid progress in hospital and was in normal health within a few days.

The County Council's scheme under the National Health Service Act was amended in 1953 to provide for the vaccination of certain workers in the cotton industry. A large proportion of the workers concerned were vaccinated during the outbreak of 1953, and, consequently very few were vaccinated in 1954, but re-vaccination will be offered during 1955 and at two-yearly intervals thereafter. In addition, arrangements have been made for the owners of cotton mills to be approached each year in order that new employees who handle cotton up to and including the carding stage might be offered vaccination within a reasonable time after taking up employment.

### Enteric (Typhoid) Fever

Of the five cases of enteric fever which were notified, all of which were in the fourth quarter of the year, one was in Kirkburton U.D.; one in Tadcaster R.D.; one in neighbouring Osgoldcross R.D. and two in Knottingley U.D.

The Kirkburton case was a boy of 12 years who attended a local grammar school but, in spite of intensive investigation, the source of the infection was not traced. The notification in Tadcaster was of a young woman who lived in a land army hostel and worked at a farm in the neighbouring Osgoldcross Rural District. Investigations revealed that in the case of the farmer's wife both stool and urine tests were positive and she was admitted to hospital and successfully treated there. A 14 years old schoolboy from Knottingley was admitted to hospital with general illness and after Widal examination the diagnosis of typhoid fever was made. Stool and urine tests were carried out on all known contacts and it was found that the boy's mother was a positive carrier of the disease. The mother was also admitted to hospital and remained there for over two months; even after prolonged treatment she was still found to be positive and after consultation between the consultant and the family doctor it was finally agreed to let her return home on the understanding that the most stringent precautions should be taken. Various theories as to the source of the infection were examined but no positive proof could be found.

### Paratyphoid Fever

Of the thirty confirmed notifications of paratyphoid fever an outbreak involving 18 cases occurred in August to October in Queensbury and Shelf. They all arose in a small area of approximately 200 yards radius in the village of Shelf and in spite of intensive investigation the source of the infection was not found but it was believed to be from a chronic carrier who sporadically introduced infection into the area commencing in late July.

Dr. R. F. O'Sullivan, Medical Officer of Health for Queensbury and Shelf U.D., has provided the following comments on the outbreak:—

"On 12th August, 1954, a boy of 8 years was admitted to hospital for investigation of a persistent pyrexia which had commenced on August 5th and did not respond to penicillin. Para B organisms were subsequently isolated from his stools and the first case of paratyphoid was established. All general practitioners in the area were warned straight away of the occurrence of this case.

The boy's home was immediately visited by the Medical Officer of Health and Sanitary Inspector and it was found that the father and other brother were away on holiday but stools from his mother, who had suffered from abdominal colic and diarrhoea for two days at the identical time the son's illness had started, were submitted for examination and proved to be positive Para B. She was immediately removed to isolation hospital. When the father and other son returned their stools were examined and they were placed under close surveillance. In both cases the stools proved positive for Para B although both of them were fit and well in every respect clinically.

Here then was a complete household of four down with Para B. We had hoped it was going to be a family outbreak and we had meantime set the usual routine in motion for this type of emergency. All the local general practitioners were notified by phone of the cases personally and brief descriptions given of the scant clinical signs in which the disease appeared to disguise itself. The Medical Officer of Health of the area in which the father and son had spent their interrupted holiday was notified, and subsequent investigations in that area were negative—the father and son had not infected anyone there.

It was first thought that the mother may be the carrier in that she was in hospital in Halifax for a confinement in 1946 and suffered with diarrhoea during that time. This time coincided with an outbreak in the Halifax area of Para B but a Widal test carried out showed that her infection was a recent one as was evident from the titre of her agglutinins.

Whilst full scale investigation was being carried out in every possible line to identify the source of infection of this family outbreak, the next case occurred. This case lived about 200 yards away and complained of influenza-like pains and aches and felt feverish; he vomited and had diarrhoea. He had the illness for a few days before calling in his doctor on the 16th August, the same doctor who attended the first case, and who was by this time alert to the possibility of further cases arising. Stool examination proved positive for Para B and he was admitted to hospital. His family and other contacts were examined clinically and by stool culture; all were negative as were also two further stool cultures for each contact.

This man, our fifth case, worked in a mill in the area. This mill was served by a canteen, but this patient had his food in a small shop which cooked dinners especially for the mill workers. We examined stools repeatedly from everyone in the mill and the shop. We examined again and again stools from the canteen workers. We swabbed water closet pedestals, drinking water utensils and many items of food and drink—all were negative. Neither could we find any common link between our first cases and this case, neither food nor food handler. We now knew that this was no family outbreak and a wider epidemiological net was thrown round the area as the danger of a major epidemic was obvious.



Meanwhile, on 26th August, our sixth case occurred, a little girl, an only child aged 7 years. She was feverish, had headaches and looked so like the others that on being seen was immediately admitted to hospital as a suspect. She was positive for Para B. She had been ill for six days with vague aches and pains, with feverishness and nausea, she had no diarrhoea. Her mother and father were negative with three successive stool cultures. Full investigation of her direct movements and contacts in the 10-14 days previous to her illness proved negative. We cultured old and new tame mice droppings from the house in which she had eaten food 12 days before her first symptoms, all to no avail, not a single positive culture. All her friends, family and other contacts were likewise negative. We continued with every possible line of approach—we had ruled out the commonest vehicles repeatedly and although we considered that either a milk or water origin was unlikely, we repeatedly sampled them and scores of other articles of diet.

On August 29th the next case occurred which was really a textbook case, even to the 'rose spots' and some splenomegaly. This was an only daughter aged 20 years who lived with her mother and father. The daughter had been ill since 21st August with headache, pyrexia and stomach upset; she was not very ill at any time, so, while she was at home from work and not too ill to move about, she prepared the food for the father and mother both of whom went out to work each day.

Both mother and father were positive for Para B and were also admitted to hospital. The Widals of these two symptomless excretors proved them to be recently infected so that the case to case infections were now like that of the first family—the principal food handler infects the family. On the other hand our sixth case, the little girl of 7 years was too young to handle the family food or to prepare it while case number 5, being a young man with an active wife and no children, was unlikely to handle food other than his own, so none of his contacts was positive.

Although up to the present time we had maintained close collaboration with the Director of the Public Health Laboratory it was thought that we should have a conference so that 'the scene of the crime' might again be thoroughly scrutinized. The position that morning (30.8.54.) was that we had seven cases of Para B infection in four families. The most detailed inquiry in each case including very many visits and pages of well tried questionnaire writing had shown no food or food handler common to all the cases but some were common to two or more. Tap water sampling was again done wherever different mains were introduced—all were negative.

On re-questioning the first family it was ascertained that two milk supplies were obtained—one heat treated and one raw milk. We investigated them both and found that the raw milk was delivered by their next door neighbours, a man and wife and there was some suspicion of vague illness present in these milk vendors during the week immediately previous to the start of the outbreak.

Stool samples from man and wife were positive for Para B. They were immediately admitted to hospital and their milk round was stopped under Section 20 (Milk and Dairies Regulations, 1949) pending full investigation. Samples of the milk were repeatedly negative and on tracing the milk to its source at the farm from which it was produced, full investigation of the farm dwellers and workers gave negative findings. In fact anyone who had anything to do with either the production, bottling or sale of the milk—all these were repeatedly negative apart from the husband and wife, who delivered it from door to door. It was a farm bottled T.T. milk and although the milk bottles were handled and delivered by husband and wife from door to door not a single case could be traced positive from these two infected people. They subsequently proved to be excretors in that they were not ill nor could we trace any definite history of positive illness nor did the Widal test suggest the possibility of them being carriers, and disinfection of their home and milk equipment was carried out, and a close watch kept on the milk round. The sending of these two milk vendors to hospital was a blow to their livelihood and we now noticed a marked reticence amongst the food handlers and other shop keepers to co-operate with stool samples. In fact we had a great deal of trouble getting their specimens and I had felt we may be forced to seek legal aid to obtain further stool specimens, otherwise control of this outbreak would be in jeopardy.

From the pattern of infection it appeared that infected food was still the vehicle and further samples of confectionery, bread, flour etc. were taken as well as fuller milk and milk vendor investigation.

From these investigations a positive case was discovered, he was the only child of a confectioner and every possible item of food and other vehicle of possible infection was investigated in the shop in question with negative results. Likewise the mother and father gave three consecutive negative stools. Wholesale suppliers of commodities to the shop were investigated and all were negative. We took it then that this boy's infection was picked up outside his own home and luckily again he was not able to infect either the confectionery in the shop or his parents' food.

The schools in the area had closed outside the period of possible incubation of the infection and we were therefore spared further cases from that source.

It did appear that someone, probably a carrier, was either in the area in question sporadically infecting food in the small area of 200 yards radius, or was coming into the area at weekends or other haphazard periods and handling food, infecting one or two people and leaving before we could lay the blame at his or her feet. The surrounding areas of Bradford and Halifax were co-operating with us wholeheartedly in following up names and addresses of suspects who visited the area in question and each suspect was negative.

Four days after the last case our next case was notified on suspicion—vague feverish illness with headache—no diarrhoea or abdominal symptoms—he was subjected to stool culture and was positive. He was a boy of 5 years of age. All his family and other contacts, as well as his food, milk, water and any conceivable item we could possibly invoke, were investigated. His brother was also positive and although the first boy was clinically ill, his brother was not—he was an excretor—possibly a pre-clinical or a sub-clinical case.

During this same period a boy aged 5½ years was notified as a suspect case. He too was positive. His family and contacts and all the food in the house were all negative and a full history of the food he had taken during the 14 days previous to his earliest possible signs or symptoms—all were negative. By now we had got to case number 15 and although we had some idea as to the possibility of which cases infected one another, we were still at a loss as to who was still introducing further new infection. We continued investigating milk vendors, flour, synthetic cream, tap water and minerals.

Another case or two were notified as suspects but investigation proved them to be negative. We were at the stage when we would investigate on the most trivial evidence to see if we could determine where the infection arose in the first place. At this stage another boy aged 11 years complained of headache and was seen by his doctor who found he had been feverish and off his food. Stool culture was positive for Para B. All the lad's friends and family were investigated. The entire families of each of his contacts were investigated and one other positive case was found.

He was 9 years old—he had not had any contact with the previous case but his brother had. The brother was repeatedly negative as indeed were all the other contacts but the lad who had no established contact was positive—again pointing to a common source of infection. This 9 year old boy was not ill but just excreting the organisms. We did establish that one shop in the area had in fact supplied several articles or



commodities, not necessarily a food commodity, to each of the households except to that of case number 5. Full scale investigations were again used to determine the possibility of this shop being in any way implicated. Items of food varying from lollipops to licorice allsorts were all free from pathogens. So were stools from the entire household. On Monday, 20th September, 1954, in view of the breakdown of what had appeared a good case on paper against this shop it was decided to sample the three remaining food shops in this affected area, which throughout the outbreak had been tightly confined to a circle of approximately  $\frac{1}{4}$  mile diameter, with no spread outside this area. It was also decided to swab the sewers.

When laying the sewer swabs, it was decided, as school had opened on 6th September, 1954, to lay one in the inspection chamber covering all the school closets and urinals. We were fortunate when considering the swabbing of the sewers in that we had fairly complete and accurate maps of the sewers, manholes and afferent drains. Without these the work would have been impossible.

Much difficulty was now being experienced in getting true statements and specimens from persons approached; wild rumours flew round the village from the second week of the outbreak onwards and even routine visits by Health Department Officials caused suspicion to fall on the persons visited.

The first batch of sewer swabs showed a positive one on 28.9.1954 and by following this up we were able by 15.10.1954 to trace the infection to one of two houses. Stools from all the occupants of these two houses gave us a positive case, an old pensioner suffering from chronic bronchitis but otherwise well. He hardly ever went out of doors and lived with his wife. She was negative. He was a symptomless excreter and he was admitted to hospital for treatment. He was not a carrier and was quickly cleared of his infection. All his contacts were negative—his relations who visited him occasionally were all negative. Food, milk and water supply were all negative and since many of them conformed to the pattern of foods previously investigated it was depressing to go over old ground again with negative results.

However the presence of no further pathogens in further sewer swabs showed that we had come to the end of the epidemic.

All the Para B organisms were Phage type 1 except one, which for some unexplainable reason was Phage type Taunton.

We learned much from the outbreak:—

(1) It was like a jigsaw puzzle with so many pieces missing that the pattern of infection was impossible to follow.

(2) It was so mild an illness that many true cases must have been missed. How many, we shall never know. What became of them I cannot say, except that they are no longer excreting the organisms otherwise they would have appeared in the sewers which were diligently swabbed.

(3) The handling of food was the simplest method of spread—luckily many of those infected were youngsters who did not normally handle the food of others, and therefore their families escaped infection. On the other hand, the fact that while the youngsters were infected and other members of the family were not infected, this points to infection coming from outside the family and what simpler method than by food bought and eaten out of doors rather than in their own homes.

(4) Gastro-intestinal symptoms were minimal and almost absent, although the infection is an alimentary one the symptoms were mainly systemic—the toxic manifestations being uppermost. The incubation period appeared to be about 10 days.

(5) Only one case had the classical enteric fever syndrome with rose spots and splenomegaly.

(6) What of the food handlers? Broadly speaking they were willing to co-operate with stools and specimens for investigation, but when they realised the implications of being found positive, viz. closure of store, or discontinuance of milk round, they no longer co-operated and frankly refused to comply with our wishes regarding specimens for pathological examination. Their livelihoods came first.

At one period I thought that I would be forced to invoke legal aid under the Public Health (Infectious Diseases) Regulations, 1953, in order to pursue our investigations. However a friendly visit to the persons involved, with explanation, and reminding them of our powers should the need arise, was successful in obtaining the necessary specimens.

(7) In spite of full statements having been issued to the Press from the Health Department, the proceedings of the Council Meetings were open to them to report and interpret as they wished. The help we got from the Press was negated by the inaccurate reporting of verbal statements made in the open Council Chambers.

(8) The sewer swabs were a great help in finally tracing down and eradicating the last of the infection. We are more than fortunate in having our entire area plotted for such sewer investigations. I am of the opinion that much greater use can be made of this procedure."

A smaller outbreak occurred in Normanton U.D. and neighbouring Castleford U.D. and Osgoldcross R.D. in April and May but, although intensively investigated, neither the source, nor a common factor, was discovered.

The first case coming to light was on April 30th of a young boy from Castleford who had symptoms of an obscure nature for about a week and, on admission to hospital and subsequent blood and faeces examination, proved to be positive Paratyphoid B. Intensive sampling of faeces and examination was carried out but none of the contacts was found to be infected.

A child of 3 years from Normanton had been sent to hospital as an acute appendicitis case and, after a few days, that is, on 3rd May, the diagnosis of Paratyphoid was made. Investigations were immediately instituted and they revealed that an elder child in the family aged 9 years was a carrier and he too was sent to Isolation Hospital. At this point it seemed that an outbreak of the disease was imminent and all general practitioners in the area were notified. As a result of this notification information was received of a number of persons in Normanton who were suffering from symptoms of enteric origin but only one of them, a middle aged man who had been ill for a week or two with vague, ill-defined symptoms, was found to be suffering from this disease.

This was followed by the Osgoldcross case, a 12 year old boy who had been admitted to hospital suspected to be suffering from meningitis. As lumbar puncture investigations did not confirm this disease a Widal test was done which indicated paratyphoid infection. It seemed likely that he was admitted to hospital before he became a faecal excreter of the organism and it may well be due to this that no further cases arose in that District. Repeated stool examinations on the remaining members of his family all proved to be negative and none of them showed signs of illness.



Shortly afterwards, on May 11th, a further notification was received of a girl of 14 years from Normanton who had been sent to hospital as a case of acute appendicitis, but on examination proved to be positive Paratyphoid. There were, then, from Normanton U.D., three actual clinical cases of the disease and a fourth who was a symptomless carrier.

In all cases immediate investigations were made, stool and urine specimens were obtained and examined, bedding was stove, and all avenues of possible infection were explored. With the co-operation of Dr. Little, the Director of the Public Health Laboratory in Wakefield, swabs were placed in the sewers in Normanton, both main and tributary, but with negative results.

It appeared that in all probability the source of infection in all cases was spread by one and the same person and not unlikely that the culprit lived outside the area.

Of the other cases notified in the County, three were in Sowerby Bridge U.D., one in each of the second, third and fourth quarters of the year and, again in spite of thorough investigations, it was not possible to trace the source of infection; the remainder were sporadic cases in widely separated districts.

### Food Poisoning

Allied to dysentery is the subject of food poisoning and it is disappointing to record that the number of notifications after correction for revised diagnoses was 276, in addition to which 109 cases, which were not notified, were ascertained during the course of investigations into certain outbreaks making a total of 385; in 1953 the corresponding figures were 329 confirmed notifications, 37 ascertained cases, a total of 366. As in the case of dysentery, there may have been a considerable number of mild cases which did not receive medical attention and, consequently, were not notified.

There were 23 outbreaks (an outbreak being defined as two or more related cases in persons in different families) comprising 241 cases and, of the 15 outbreaks in which the causal agent was identified, salmonella organisms were found to be responsible for the majority of cases. The 144 single cases were spread over the County and apparently were not connected with any outbreak.

Food poisoning is, to a great extent, a preventable disease and, while increasing attention is being given to places of communal feeding, everyone can play their part within their homes by paying particular attention to the preparation and handling of food and, what is most important, maintaining a high standard of personal hygiene.

The relevant statistics for 1954 are given in the table below:—

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	—	—	3	1	4	—	1	—	—	—	3	—	—	1	—	1	
2	—	1	—	—	1	—	1	—	—	—	*3	2	+70	—	—	—	
3	—	1	—	1	2	—	—	—	—	—	—	—	—	—	2	2	
4	—	—	4	24	28	—	4	—	—	—	+48	—	—	2	8	10	
5	1	1	6	2	10	—	—	—	—	—	—	—	—	—	18	18	
6	8	1	7	2	18	—	—	—	—	—	—	—	—	—	—	—	
7	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
8	1	1	8	1	11	—	—	1	—	—	2	—	—	6	3	9	
9	—	—	—	5	5	—	—	—	—	—	—	1	5	—	—	—	
10	—	—	1	—	1	—	—	—	—	—	—	—	—	1	—	1	
11	—	2	2	—	4	—	1	—	—	—	2	—	—	2	—	2	
12	2	—	1	1	4	—	—	—	—	—	—	—	—	3	1	4	
13	—	2	2	—	4	—	—	—	—	—	—	—	—	2	2	4	
14	—	—	5	—	5	—	—	—	—	—	—	—	—	3	2	5	
15	1	3	13	—	17	—	—	—	—	—	—	—	—	17	—	17	
16	—	—	—	2	2	—	—	—	—	—	—	—	—	—	2	2	
17	—	—	4	3	7	—	—	—	—	—	—	—	—	3	4	7	
18	4	1	3	1	9	—	—	—	—	—	—	2	§19	3	2	5	
19	—	4	2	3	9	—	—	—	—	—	—	—	—	—	9	9	
20	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
22	7	3	11	13	34	—	1	1	—	1	22	1	7	—	5	5	
23	—	—	6	—	6	—	—	—	—	—	—	—	—	6	—	6	
25	—	7	6	—	13	—	—	—	—	—	—	—	—	13	—	13	
26	—	—	2	1	3	—	—	—	—	—	—	—	—	3	—	3	
27	—	—	3	—	3	—	1	—	—	—	3	—	—	—	—	—	
28	—	—	24	—	24	—	1	—	—	—	24	—	—	—	—	—	
29	5	3	—	2	10	—	—	—	—	—	—	1	5	—	5	5	
30	2	—	—	2	4	—	—	—	—	—	—	—	—	4	—	4	
31	2	2	33	1	38	—	2	—	—	—	19	1	9	5	5	10	
	33	32	146	65	276	—	12	2	—	1	126	8	115	76	68	144	

\* Includes 2 cases ascertained during the course of investigations.

+ Cases not notified but ascertained.

§ Includes 20 cases not notified but ascertained during the course of investigations.

¶ Cases not notified but ascertained.

|| Includes 15 cases not notified but ascertained during the course of investigations.



### Venereal Diseases

The after-math of World War II produced a big increase in the total number of new patients of both sexes attending Special Treatment Centres. Since then there has been a fairly steady diminution in numbers each year. At the present time complacency is the danger, and it is well to stress that there is still a considerable reservoir of infection to be eliminated.

Table A below shows the numbers of new cases of syphilis, gonorrhoea and other conditions in West Riding Administrative County residents attending Special Treatment Centres from 1938 to 1954. Column 6 reveals that the total number of new cases in 1954 was slightly more than in the pre-war year. Comparing 1938 with 1954 new cases of syphilis and gonorrhoea were fewer in number but other conditions increased by more than 100 per cent.

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	1,295
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
1954	178	152	330	1,189	1,519

More revealing from an epidemiological point of view is Table B which shows the numbers of new cases diagnosed in each quarter of 1953 and 1954 and the stage and type of syphilis.

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.					
	1953	1954	1953	1954	1953	1954	1953	1954	1953	1954	1953	1954
31st March ...	4	2	37	37	—	—	13	6	44	26	326	312
30th June ...	4	3	33	39	—	—	13	9	49	38	287	298
30th September ...	1	—	42	42	—	—	9	8	50	46	286	288
31st December ...	—	2	43	26	1	—	14	4	39	42	329	291
Total ...	9	7	155	144	1	—	49	27	182	152	1,228	1,189

Table C gives the names of the various Special Treatment Centres at which new patients from the Administrative County attended during 1954 and the numbers of cases of each disease diagnosed. The largest number attended the clinic at Clayton Hospital, Wakefield, but this is probably accounted for by the large West Riding population around the city. On aggregate over the whole Administrative County the ratio of new cases of syphilis to gonorrhoea is 1:2:1. On this basis gonorrhoea would appear to be relatively more prevalent around Barnsley, Doncaster, Halifax and Rotherham than in other areas.

New Cases (Treatment Centres). Table C.

Name of Special Treatment Centre	Syphilis	Gonorrhoea	Other Conditions	Total
Barnsley Clinic, Queen's Road	7	14	71	92
Bradford St. Luke's Hospital	15	12	109	136
Burnley Victoria Hospital	1	3	9	13
Dewsbury General Hospital	17	5	86	108
Doncaster Royal Infirmary	22	34	164	220
Goole Bartholomew Hospital	3	3	16	22
Halifax Royal Infirmary	5	13	56	74
Harrogate General Hospital	7	6	44	57
Huddersfield Royal Infirmary	11	4	53	68
Keighley Victoria Hospital	16	4	88	108
Leeds General Infirmary	19	15	155	189
Oldham Boundary Park General Hospital	—	3	9	12
Rotherham, 12, Frederick Street	14	18	70	102
Sheffield Jessop Hospital	1	—	1	2
Sheffield Royal Hospital	6	1	20	27
Sheffield Royal Infirmary	4	—	13	17
Sheffield City General Hospital	—	—	—	—
Wakefield Clayton Hospital	26	16	207	249
York County Hospital	4	1	18	23
Total	178	152	1,189	1,519



It will be appreciated that the figures given in the above tables do not represent the actual incidence of venereal diseases in the Administrative County. The numbers given include only those patients who registered at a Special Treatment Centre or those who attended any of the 14 General Practitioners in the V.D. Scheme. Venereal Diseases are not notifiable so that patients treated by other General Practitioners are not included. Nevertheless by comparing the figures with those of previous years a reasonably accurate guide to the trends in the incidence of the various diseases can be obtained.

The total number of new cases from the Administrative County attending Special Treatment Centres during 1954 was 1,519, a decrease of 105 compared with the previous year. Syphilis, gonorrhoea and other conditions were all fewer in number.

New cases of all stages of both acquired and congenital syphilis showed a reduction in number. The apparent incidence of early (infectious) syphilis has continued to fall and for the first time ever in the records of this department there were no cases of congenital syphilis in babies. The following figures illustrate the remarkable diminution in the number of new cases of early syphilis both acquired and congenital during recent years:—

Year	Early Acquired Syphilis	Congenital Syphilis under 1 year
1949	158	7
1950	76	4
1951	58	4
1952	19	1
1953	9	1
1954	7	—

The year 1954 also produced another record—the number of new cases of gonorrhoea was only 152. The previous lowest figures being in 1951 when there were 171 cases.

The reduction is probably due to several factors including better education of the public in the dangers of untreated venereal disease, improved methods of diagnosis and treatment and the thorough and successful follow up of all sexual contacts of infectious patients. This is a remarkable achievement especially when one notes that 8 years ago there were more than seven times as many new cases of gonorrhoea.

Non-gonococcal urethritis is the only type of disease treated at Special Treatment Centres which is increasing in prevalence. Before the second World War this condition was relatively uncommon but during recent years more and more cases have been found and in 1954 approximately one in five of all the new male patients were found to be suffering from it. The exact aetiology of non-gonococcal urethritis is still obscure but there is abundant evidence to show that, in the vast majority of cases, it is acquired venereally.

**V.D. Social Work.**—The staff consists of four whole time Social Workers who are all state registered nurses with Health Visitors Certificates. They work under the immediate direction of a Consultant Venereologist who acts as adviser in venereal diseases to the County Council and is responsible to the County Medical Officer for V.D. prevention and after care in the Administrative County. The clerical and statistical work is in the hands of a confidential clerk-typist.

The County has been divided into four areas and each V.D. Social Worker traces the contacts, follows up the defaulters and is on the staff of one or more of the Special Treatment Centres in her area in order to carry out the clinic social work. Three of the areas are coterminous with the County Boroughs of Dewsbury, Doncaster and Wakefield, and by arrangement the three Social Workers undertake similar duties in these County Boroughs. This scheme operates smoothly as the Social Worker is able to cover the whole district from which patients attending the main clinic in her area are drawn.

Contact Tracing

Table D.

Total No. of contacts reported	91				
Located and examined		80			
Not infected			67		
Infected			13		
Already under treatment				1	
Brought under treatment				12	
Syphilis					10
Gonorrhoea					2
Located		9			
Not examined			3		
Transferred to other authority			6		
Not located		2			
Insufficient information			2		
Unable to locate			—		



Two main methods are used at Special Treatment Centres in arranging the examination of contacts of known cases of venereal disease. (1) A contact slip, bearing the clinic address, the patient's reference number and the Ministry of Health code diagnosis, is given to the patient. The patient is instructed to hand the slip to the contact with the advice that he or she should attend the nearest Special Treatment Centre as soon as possible. No figures are available to show the number of patients brought under examination in this way. (2) If the contact fails to attend within a week or two or if the patient is unwilling or unable to see the contact then the help of the Social Worker is obtained. By considerate friendly handling of the patient and sympathetic understanding of his or her problems the Social Worker is able to help the patient and at the same time obtain as much information as possible about contacts. The latter are traced and advised to attend a Special Treatment Centre for examination. In this important and difficult work the Social Worker must be always tactful and discreet. Credit for at least part of the fall in the apparent incidence of venereal diseases in recent years must be given to the Social Workers for the excellent work they have done in contact tracing.

Table D gives details of the number of contacts dealt with by the Social Workers and the results obtained.

## Defaulters.

Table E.

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
419	300	67	9	43	494	680

As a part of the socio-medical work at the clinic the V.D. Social Workers are concerned with the follow-up of patients suffering from V.D. who have ceased to attend before completion of treatment or tests of cure.

As a general rule in the first place, the Social Worker writes to the defaulting patient asking him or her to re-attend and enclosing the letter in a plain envelope. If this is unsuccessful the Social Worker will try to see and speak to the patient in private (see Table E). In doing so she finds out the reason for non-attendance and advises and helps the patient to re-attend.

## Ante-natal cases.

Table F

Patients						Contacts of patients		
No. of positive reports on specimens from ante-natal clinics	No. investigated by Social Workers	No further action necessary	No. referred direct to S.T.C.	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
41	39	9	2	30	2	46	5	41

\*Of the 5 contacts found to be infected, 4 were adults with late syphilis and one was a congenital syphilitic boy aged 8 years.

During the year the V.D. Social Workers had 860 interviews with doctors and 1,755 miscellaneous interviews.

From 1950 to 1953 inclusive the Pathologists in charge of the main laboratories serving the County gave the Consultant Venereologist the names of doctors sending in specimens of blood which on examination proved to be positive for syphilis.

If the specimen came from a General Practitioner or hospital we wrote to the doctor or medical officer offering the services of one of the V.D. Social Workers to assist in the socio-medical aspects and the tracing of contacts. Experience showed that the Social Workers were often able to help in the difficult and delicate situations which arose but in no circumstances did they act without the authority of the doctor. Although the patient's name was not disclosed, some Pathologists have taken the view that in future this information should be restricted to ante-natal cases only (see Table F). This step will make the work of the preventive services less effective and a few cases of syphilis, which under the former arrangement would have been brought under treatment, will remain undetected until the ravages of the disease take their toll.

In ante-natal cases, in order to avoid any delay which might be harmful to the developing foetus, the V.D. Social Workers are asked to offer immediately their help to the doctor. Generally, unless the expectant mother has a history or clinical signs of syphilis arrangements are made for a repeat blood specimen to be tested before the doctor refers her to a Special Treatment Centre. In addition on receiving confirmation of the provisional diagnosis, the examination of the patient's contacts is arranged.



## Tuberculosis

**Deaths from Tuberculosis.**—There were 287 deaths from tuberculosis (261 respiratory and 26 non-respiratory), an increase of 2 compared with last year, which does not affect a repetition of the lowest recorded death rate of 0.18 (0.16 respiratory and 0.02 non-respiratory) equalling the rates for England and Wales. Details of the deaths 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	—	1	1	—	—	1	4	8	44	26	91	22	38	6	13	6	191	70	261
Non-Respiratory	—	—	1	—	1	3	—	1	4	5	4	5	—	—	1	1	11	15	26
Total	—	1	2	—	1	4	4	9	48	31	95	27	38	6	14	7	202	85	287

The war against tuberculosis, a disease described by John Bunyan as “the captain of the men of death”, has been waged persistently and relentlessly since the German Congress on Tuberculosis held in Berlin in May, 1899. The success which has attended the efforts of all engaged in the work, aided by scientific discoveries and developments, has perhaps achieved its first objective in the dramatic reduction in the death rate. This has not been accompanied by a similar rapid reduction in notifications and it is this aspect which now presents the most serious problem. Until this phase changes, there will be an ever increasing tuberculous population, presenting a threat of infection to the remainder of the community. We are also reminded that the extent of injury and impairment caused by a disease is not revealed in vital statistics and one could wish for a new standard of measurement. A more graphic representation would be a portrayal of the aggregation of invalidism—absence from work—expenditure on prevention, treatment, care and after-care in all their many facets—loss of productive capacity—a picture which would cause dismay alike to the humanist and to the economist.

**Notification of Tuberculosis.**—There were 1,244 primary notifications of new cases of tuberculosis arising during the year and 46 supplemental notifications, making a total of 1,290 as compared with 1,470 (1,415 primary and 55 supplemental) notifications in 1953. These figures show the first appreciable reduction in the notification of respiratory tuberculosis in the past ten years, although it is as yet too soon to suggest that we are about to reap the benefit of the vigorous anti-tuberculosis measures which have been prosecuted during the immediate post-war years. Details of the sex, age groups and form of disease of the 1,290 new cases 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	4	6	18	19	12	45	46	116	94	123	81	39	10	613	
Respiratory, Females	2	1	10	27	24	57	75	119	54	32	18	10	6	435	
Non-Respiratory, Males	—	—	5	19	19	5	2	11	7	7	3	3	1	82	
Non-Respiratory, Females	—	3	8	25	13	16	7	15	10	8	3	3	3	114	
														1,244	
SUPPLEMENTAL															
NOTIFICATIONS:—															
Respiratory, Males	—	—	—	—	—	—	—	—	2	1	7	7	4	21	
Respiratory, Females	—	—	—	—	—	—	—	2	—	4	3	3	3	15	
Non-Respiratory, Males	—	1	—	—	—	—	—	1	—	1	—	—	1	4	
Non-Respiratory, Females	—	—	—	1	—	—	—	1	1	2	—	—	1	6	
														46	

The sources of information of the supplemental notifications were Local Registrars (21 respiratory, 2 non-respiratory); transferable deaths from the Registrar General (9 respiratory, 3 non-respiratory) and posthumous notifications (6 respiratory, 5 non-respiratory).

**POSTHUMOUS NOTIFICATIONS.**—The supplemental notifications show a total of 46 cases in which the knowledge that the patient was suffering from Tuberculosis was not received until after the death of the patient. To ensure that all cases are notified before death is perhaps an unapproachable ideal, but enquiries have been instituted with a view to ascertaining the reason in each case in order to exclude the human error insofar as this is possible. The results of this investigation are shown in the following table:—



## I. Information Obtained from Local Registrar's Death Returns.

Patient			Cause of Death.	Remarks.
Sex	Age	Resp. or Non-Resp.		
M	75	Resp.	Myocardial failure. Myocardial degeneration. Pulmonary tuberculosis.	Chest physician not entirely satisfied about diagnosis.
F	63	Resp.	Exhaustion. Pulmonary tuberculosis (Chronic).	General practitioner assumed case had been notified prior to his taking up practice in this area; apparently case of considerably long standing.
M	59	Resp.	Pulmonary tuberculosis. Chronic Rheumatoid Arthritis.	Not known. Private doctor has now left the district. Family examined. Daughter of deceased notified as respiratory tuberculosis case.
F	30	Resp.	Bilateral Pulmonary Tuberculosis.	Admitted to mental hospital 14th May, 1953, from neighbouring authority.
F	32	Resp.	Pulmonary tuberculosis.	Admitted to mental hospital 1st March, 1954, from neighbouring area.
				In both these cases, it was presumed that the cases had been notified before admission. No transfer of notification was made by the Medical Officer of either area from which the patients were admitted.
F	85	Resp.	Broncho-pneumonia (tuberculous). Hypertension. Arterial degeneration. P.M. (INQUEST).	Tuberculosis only came to light at Post mortem.
F	80	Non-Resp.	Lupus.	An old long-standing case. Medical practitioner was under the impression that the case had been notified previously.
M	65	Resp.	Pulmonary tuberculosis.	Diagnosis first made at post-mortem examination. Follow up of contacts by T.B. Health Visitor.
M	61	Resp.	Tuberculous Broncho-Pneumonia.	Diagnosis first made at post-mortem examination. Follow up of contacts by T.B. Health Visitor.
M	58	Resp.	Toxaemia and heart failure following tuberculo silicosis.	Diagnosis not made until after post mortem examination. Discussed with Consultant T.O. who saw the patient regularly at the Chest Clinic and who is doubtful about the diagnosis. About 15 sputum tests were negative and the T.O. did not consider that contacts needed follow-up.
F	42	Resp.	Myocardial failure due to Myocardial degeneration due to Pulmonary tuberculosis.	Diagnosis not made until after post mortem examination. Home contact, a male aged 68 years, visited but refused to attend the chest clinic.
M	38	Resp.	Pulmonary tuberculosis.	In-patient of mental hospital since 1944. Found to have tuberculosis in 1951 and transferred to another hospital. Returned to mental hospital in 1953 consequent upon his pulmonary conditions being latent. Said by medical superintendent to have been notified as a case of tuberculosis in 1951, but no trace can be found and he was never on the Divisional Medical Officer's register prior to death.
M	34	Resp.	Pulmonary tuberculosis.	In-patient of mental hospital since 1949. In 1953 developed pneumonia with pleural effusion. Diagnostic aspirations performed and each specimen sent to laboratory returned negative results. Visiting physician and radiologist unable to confirm pulmonary tuberculosis but both advised precautionary measures and further investigation. Condition at all times suspicious but positive findings never returned. Final illness was a progressive physical deterioration and, in the opinion of the medical staff, consistent with a chronic fibrotic condition of the lungs due to tuberculosis. In consequence, cause of death returned as pulmonary tuberculosis. Not notified as a case of tuberculosis owing to indefinite laboratory findings.
F	59	Resp.	Pulmonary tuberculosis.	Originally notified as a case of tuberculosis in 1927 and removed as "recovered" in 1947. Referred back to chest clinic in 1950. Re-activity not confirmed but kept on register as an observation case. Last attended January, 1953—no physical signs. Negative sputum since 1937. In view of lack of confirmation of diagnosis no further action taken.
F	58	Resp.	Pulmonary tuberculosis.	In mental hospital over a period of years. No family contacts.
F	72	Resp.	Pulmonary tuberculosis.	In mental hospital over a period of years. No family contacts.
F	46	Non-Resp.	Tuberculosis of spine.	Doctor states under medical care for many years and prior to his taking over practice. He had assumed that case had been notified.



## I. Information Obtained from Local Registrars' Death Returns. (Cont.)

Patient			Cause of Death.	Remarks.
Sex	Age	Resp. or Non-Resp.		
M	68	Resp.	Bilateral suprarenal gland T.B. (Addison's disease). Pulmonary tuberculosis and silicosis (P.M.).	Deceased did not seek medical attention and family and own doctor were unaware of disease until post mortem. Contacts referred to chest clinic for examination.
M	60	Resp.	Pulmonary tuberculosis.	On enquiry it was found that the patient was first notified when living elsewhere in 1949. He was seven months in sanatorium. He moved to another address prior to moving to this area and his transfer was not received by the Divisional Medical Officer.
M	65	Resp.	Congestive heart failure due to pulmonary T.B. and pneumoconiosis, contacted in course of his employment. P.M. Misadventure.	Patient died in September, 1954, but it was not until December, 1954, that death was reported on local registrar's returns. P.M.—chest physician had no knowledge of patient prior to death. Possible contacts were followed up by Health Visitor.
F	48	Resp.	Tuberculous Lymphon of Mediastinum with Pleural Effusion T.B. Tuberculous cervical adenitis.	No definite diagnosis. Contacts traced and examined.
F	47	Resp.	Cachexia. Pulmonary Tuberculosis.	G.P. under the impression that this had been notified some years ago by D.T.O. Contacts traced and referred to Chest Clinic.
F	76	Resp.	Pulmonary Tuberculosis. Toxaemia from pressure sores.	Cause of death only established after post mortem. Contacts traced and referred to chest clinic.

## II. Information Obtained from Registrar General's Transferable Deaths.

Patient			Cause of Death.	Remarks.
Sex	Age	Resp. or Non-Resp.		
M	66	Resp.	Pulmonary tuberculosis.	Tuberculosis discovered on X-ray whilst patient was in a general hospital. Medical officer at general hospital was under the impression that this case would be notified by the chest physician. Subsequently admitted to chest hospital.
M	76	Resp.	Pulmonary tuberculosis and chronic gout.	Not known why this case was not notified. Due to age, no further action taken.
M	78	Resp.	Auricular fibrillation. Myocardial degeneration. Chronic fibroid pulmonary tuberculosis.	Diagnosis not positively established prior to death.
F	70	Resp.	Miliary tuberculosis of lungs, spleen and kidneys.	Not discovered until after post mortem examination. All contacts were X-rayed and no further cases were found.
M	69	Resp.	Pulmonary tuberculosis.	Not discovered until after post mortem examination. As there were no known near relations of this man and in view of his age, no further action was taken.
M	60	Resp.	Subdural hæmorrhage. Gross anæmia. Pulmonary tuberculosis.	Patient died in general hospital where post mortem examination was carried out. Not diagnosed prior to this. Investigation showed that the only contact was the deceased's daughter who was living permanently in the area of another authority. Medical Officer of Health advised.
M	67	Resp.	Toxaemia. Advanced tuberculosis.	Died six days after admission to general hospital. Obviously a long-standing case of tuberculosis and it was assumed that notification had already been made. Discussed with the medical officer concerned. Patient lived alone and no contacts to be followed up.
F	6	Non-Resp.	Tuberculous Peritonitis. Mongolism.	Condition not known. Follow up of contacts.
F	35	Non-Resp.	Meningitis. Tuberculosis. (After post mortem).	Admitted to hospital as a "medical urgency" and died there seven days later. It appears that only after the P.M. was it known that tuberculosis was the cause of death.
F	73	Resp.	Toxic myocarditis. Chronic fibroid phthisis.	Living out of area (temp.).
M	61	Resp.	Tuberculous broncho pneumonia. Cardiac failure.	Diagnosed in general hospital.
F	29	Non-Resp.	Abdominal T.B.	Found by post mortem examination.



## III. Information Obtained from Posthumous Notifications.

Patient			Cause of Death.	Remarks.
Sex	Age	Resp. or Non-Resp.		
F	78	Resp.	Pulmonary tuberculosis.	Rapid fatal illness, cause of which found at post mortem. All contacts examined.
M	74	Non-Resp.	Acute pulmonary oedema. Lt. ventricular failure.	Not diagnosed until death. Notified as perineal T.B. of sinuses. Contacts visited by T.B. Health Visitor. Appointments given to attend chest clinic.
M	72	Resp.	Tuberculosis of cervical vertebrae and right lung.	Disease only diagnosed at post mortem. Patient had been in Institution for many years.
F	48	Non-Resp.	Addison's Disease.	Not known but posthumous notification was forwarded from general hospital where patient died.
M	51	Resp.	Bilateral suprarenal tuberculosis. Bilateral caseating pulmonary tuberculosis.	Only diagnosed on post mortem in hospital after admission for undiagnosed illness. Contacts traced and seen by Chest Physician. Son notified as pulmonary tuberculosis.
F	53	Resp.	Haemoptysis due to bilateral pulmonary tuberculosis.	Found dead on arrival at hospital after collapse from haemoptysis. Nature of disease revealed only on post mortem examination. Contacts traced. Son now notified as pulmonary tuberculosis.
M	49	Non-Resp.	Primary tuberculosis. Peritonitis.	Changed general practitioner during period under which diagnosis was under investigation and in some doubt. General practitioner under whose care this patient subsequently came believed the case to have been notified prior to transfer to him. Contacts traced.
M	76	Resp.	T.B. Peritonitis. Pulmonary Tuberculosis. Chronic Peptic Ulcer. Senility.	Not discovered until after post mortem examination. All the contacts were X-rayed and no further cases were found.
M	31	Non-Resp.	Tuberculous meningitis.	Patient died in Royal Infirmary where post mortem examination carried out. Not diagnosed prior to this. Contacts followed up and arrangements made for them to attend chest clinic.
M	1½	Non-Resp.	Tuberculous meningitis.	Cause of death not known until after post mortem. This child was removed to Children's Hospital with meningitis and the cause of death was certified after a P.M.
M	60	Resp.	Broncho-pneumonia. Tuberculosis.	Diagnosed in hospital. Died very shortly after admission. Notification arrived Divisional Office after death.

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 10,359, an increase of 8 compared with the previous year. The following table summarises the revision of the registers in the respective divisional areas:—

Div. No.	Number of cases on register 1/1/54				Number of cases added to register				Number of cases removed from register				Number of cases remaining on register 31/12/54				No. of cases remaining on Register	
	Respiratory		Non-Resp.		Respiratory		Non-Resp.		Respiratory		Non-Resp.		Respiratory		Non-Resp.		Total	Per 1000 Pop'n
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
1	157	106	50	53	30	19	3	2	19	8	4	4	168	117	49	51	385	6.6
2	55	46	13	19	13	7	6	3	10	10	2	—	58	43	17	22	140	6.1
3	174	138	53	30	23	12	6	8	15	28	11	6	182	122	48	32	384	6.9
4	206	137	34	46	26	22	2	5	20	15	3	2	212	144	33	49	438	6.5
5	199	121	42	57	39	32	6	6	32	16	9	14	206	137	39	49	431	6.0
6	99	66	14	10	29	23	5	4	29	16	3	2	99	73	16	12	200	5.8
7	34	26	6	9	11	10	—	1	9	3	1	—	36	33	5	10	84	3.4
8	198	139	33	56	28	32	4	9	34	21	3	9	192	150	34	56	432	5.7
9	75	71	27	27	17	12	5	4	18	15	8	5	74	68	24	26	192	3.9
10	132	121	29	42	12	17	1	—	18	20	10	9	126	118	20	33	297	6.6
11	227	163	33	44	23	22	3	9	37	31	11	11	213	154	25	42	434	7.1
12	204	147	38	63	33	18	2	6	28	10	1	6	209	155	39	63	466	8.4
13	73	44	16	26	13	19	3	6	12	7	8	10	74	56	11	22	163	3.9
14	73	43	18	28	9	7	1	4	8	3	1	6	74	47	18	26	165	4.2
15	76	77	37	28	8	10	1	2	8	8	3	2	76	79	35	28	218	4.5
16	135	111	26	22	11	13	1	6	13	9	6	4	133	115	21	24	293	5.5
17	166	104	60	74	14	14	9	9	87	56	52	54	93	62	17	29	201	4.1
18	202	135	50	27	31	30	8	4	23	14	15	7	210	151	43	24	428	7.3
19	178	128	46	33	30	27	7	7	25	17	8	11	183	138	45	29	395	7.0
20	188	136	60	67	61	22	16	12	37	21	16	20	212	137	60	59	468	5.2
22	362	240	113	79	61	29	4	6	20	12	3	4	403	257	114	81	855	10.0
23	232	164	30	46	31	16	3	3	17	5	4	1	246	175	29	48	498	7.9
25	237	193	40	28	26	29	3	4	40	28	7	5	223	194	36	27	480	6.4
26	106	78	29	24	17	14	—	2	13	7	4	5	110	85	25	21	241	5.3
27	131	113	47	30	31	26	5	3	22	12	5	—	140	127	47	33	347	8.9
28	171	145	57	47	32	34	3	6	32	15	10	4	171	164	50	49	434	7.6
29	123	135	29	31	33	21	—	1	17	13	1	—	139	143	28	32	342	10.2
30	229	197	38	27	46	29	1	5	34	27	15	6	241	199	24	26	490	8.0
31	216	132	51	45	19	24	6	5	25	9	1	5	210	147	56	45	458	5.6
	4,658	3,456	1,119	1,118	757	590	114	142	702	456	225	212	4,713	3,590	1,008	1,048	10,359	6.5



Divisional Medical Officers have received 2,328 notifications (1,181 admissions and 1,147 discharges) relating to patients admitted to, or discharged from, treatment in 78 hospitals as follows:—

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
Bierley Hall Hospital, Bradford .....	7	12	—	—	9	9	—	—	—	1	—	—	—	1	—	—
Bradford Royal Infirmary .....	1	2	—	2	2	2	—	3	—	—	2	—	—	1	1	—
Bradley Wood Sanatorium, Huddersfield .....	13	6	—	—	14	11	—	—	—	—	—	—	—	—	—	—
City General Hospital, Sheffield .....	6	1	1	—	7	1	1	—	—	—	1	—	—	—	—	—
Commonside Sanatorium, Sheffield .....	—	8	—	—	—	7	—	—	—	—	—	—	—	—	—	—
Crimicar Lane Hospital, Sheffield .....	9	—	—	—	11	—	—	—	—	—	—	—	—	—	—	—
Crookhill Hall Sanatorium, Conisbrough .....	65	2	—	—	58	1	—	—	—	—	—	—	—	—	—	—
Davos-Platz, Switzerland .....	8	7	—	—	7	5	—	—	—	—	—	—	—	—	—	—
Dronfield Hospital, Sheffield .....	—	—	3	4	—	—	3	4	—	—	—	—	—	—	—	—
Gateforth Sanatorium, Hambleton, nr. Selby .....	44	—	—	—	36	1	—	—	1	—	—	—	—	—	—	—
Huddersfield Royal Infirmary .....	3	2	—	—	5	2	—	—	7	2	6	2	5	1	5	2
Kendray Hospital, Barnsley .....	—	—	—	2	—	—	1	2	—	—	2	1	—	—	3	1
Killingbeck Hospital, Leeds .....	48	22	2	1	52	30	—	—	1	1	—	—	2	1	—	—
King Edward VII Hospital, Rivelin Valley Road, Sheffield .....	—	1	—	—	—	—	—	—	3	—	5	4	2	1	5	2
Leeds Road Hospital, Bradford .....	—	24	—	—	—	18	—	—	—	—	—	—	—	—	—	—
Mill Hill Isolation Hospital, Huddersfield .....	3	7	—	—	7	12	—	—	—	—	—	—	—	—	—	—
Northowram Isolation Hospital, Halifax .....	30	2	2	1	32	4	—	—	1	—	—	—	—	—	—	—
Oakwood Hall Sanatorium, Moorgate, Rotherham .....	23	9	2	1	23	14	1	3	—	—	—	—	—	—	—	—
Papworth Hospital, Cambridge .....	4	—	—	—	3	3	—	—	—	—	—	—	—	—	—	—
Scotton Banks Sanatorium, Knaresborough .....	16	84	2	9	5	96	1	3	—	8	2	1	—	9	1	2
Seacroft Hospital, Leeds .....	13	2	9	5	10	—	7	6	3	1	—	—	—	—	1	—
Shelf Sanatorium, near Halifax .....	22	26	1	1	23	25	—	1	1	—	—	—	—	—	—	—
Snapehorpe Hospital, Wakefield .....	4	5	—	—	1	—	—	—	—	—	—	—	—	—	—	—
St. George's Hospital, Rothwell, nr. Leeds .....	—	6	—	—	—	7	—	—	—	—	—	—	—	—	—	—
The Hospital, Grassington, nr. Skipton .....	63	52	—	—	59	31	—	1	4	4	—	1	1	—	—	—
The Hospital, Middleton-in-Wharfedale, nr. Ilkley .....	94	63	15	23	125	69	15	22	7	10	7	3	9	4	8	5
Tickhill Road Isolation Hosp. and San., Doncaster .....	19	14	—	—	14	10	—	—	—	—	—	—	—	—	—	—
Wath Wood Isolation Hospital .....	17	26	—	—	12	21	—	—	—	1	—	—	—	—	—	—
Whitley Grange Sanatorium, Dewsbury .....	12	7	—	—	13	3	—	—	—	—	—	—	—	—	—	—
Winter Street Hospital, Sheffield .....	4	8	3	1	4	10	3	1	—	—	—	—	—	—	—	—
*Miscellaneous .....	27	16	4	2	26	12	3	9	3	5	5	10	3	7	7	5
	555	414	44	52	558	404	35	55	31	33	29	23	22	25	31	17

\* The miscellaneous cases were under treatment at Arthington Hospital, Leeds; Boundary Park General Hospital, Oldham; Bradford Children's Hospital; Castle Hill Sanatorium, Cottingham; Catterick Military Hospital; Chaderton Hospital, Racefield, Lancs.; Connaught Military Hospital, Hindhead, Surrey; Crossley Sanatorium, Kingswood, Lancs.; Dewsbury General Hospital; Doncaster Royal Infirmary; Fairfield Sanatorium, York; Fielden Hospital, Todmorden; Halifax General Hospital; Herzl-Moser Hospital, Leeds; Iscoid Park Colony, Shropshire; Kilton Hospital, Worksop; Leeds General Infirmary; Liverpool Royal Infirmary; Lodge Moor Hospital, Sheffield; Marguerite Hepton Memorial Orthopaedic Hospital, Thorp Arch; Military Hospital, Caroglen, Glasgow; Montagu Hospital, Mexborough; Moorgate General Hospital, Rotherham; Moorview Hospital, Meltham; Otley General Hospital; Pinderfields General Hospital, Wakefield; Raywell Sanatorium, Cottingham; Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry; R.N. Hospital, Gosport, Hants.; Royal Ventnor Hospital, Isle of Wight; Ryegate Annexe, Sheffield, 10; Sheffield Children's Hospital; Sheffield Royal Hospital; Sheffield Royal Infirmary; Staincliffe General Hospital, Dewsbury; Strinesdale Sanatorium, Oldham; St. James's Hospital, Leeds; St. Luke's Hospital, Bradford; St. Luke's Hospital, Huddersfield; St. Olave's Hospital, Rotherhithe, S.E.16; Thornbury Children's Annexe, Sheffield; Thornton Lodge Sanatorium, Aysgarth; Westholme Isolation Hospital, Oldham; Wharfedale Hospital, Wadsley, Sheffield; Women's Hospital, Leeds; Wrightington Hospital, Appley Bridge, nr. Wigan; York City Hospital; York County Hospital.

**B.C.G. Vaccination of Contacts.**—Nine hundred and seventy-two persons, in close contact with known cases of tuberculosis, were afforded B.C.G. vaccination by Chest Physicians (722 in the Leeds Region and 250 in the Sheffield Region). In 884 cases, the vaccination was successful, in 7 it was not successful and in 81 cases the result had not been finally ascertained at the end of the year. More than one-third of the persons given this protection were children under 1 year of age.

	AGE GROUPS												All Ages
	Under 1 year Months.				Years								
	0—	1—	3—	6—	1—	2—	3—	4—	5—	10—	15—	20—	
Vaccinated:													
Male .....	61	35	49	31	53	45	33	24	92	64	16	2	505
Female .....	55	40	38	26	37	36	27	22	86	63	28	9	467
Total .....	116	75	87	57	90	81	60	46	178	127	44	11	972
Result of Vaccination													
Successful:													
Male .....	52	35	46	27	47	42	31	23	83	57	14	1	458
Female .....	48	38	35	24	32	34	25	20	74	59	28	9	426
Total .....	100	73	81	51	79	76	56	43	157	116	42	10	884
Unsuccessful	—	—	—	1	—	—	1	2	2	—	—	1	7
Not finally ascertained	16	2	6	5	11	5	3	1	19	11	2	—	81



**B.C.G. Vaccination of Older School Children.**—Following the issue in November, 1953, of Circular 22/53 of the Ministry of Health, a detailed scheme for the B.C.G. vaccination of thirteen-year-old school children was approved by the County Council early in 1954, and approval was subsequently given by the Ministry to the amendment of the existing scheme under Section 28 of the National Health Service Act.

The following is the outline of the scheme as submitted to the County Council:—

- (i) The preliminary tuberculin testing, the vaccinations and the post-vaccination testing will be carried out by designated medical officers on the staff of the County Medical Officer. Medical officers will, if necessary, be sent for training prior to the commencement of the scheme to recognised B.C.G. vaccination educational centres.
- (ii) B.C.G. vaccination will be offered through parents or guardians to children between the ages of thirteen and fourteen years.
- (iii) The consent in writing of the parent or guardian will be obtained to the preliminary tuberculin testing and the vaccination if found necessary.
- (iv) Parents or guardians will be given a leaflet explaining the purpose of the preliminary tuberculin testing and B.C.G. vaccination and giving instructions that they should consult the School Medical Officer or Chest Physician if they are anxious about the condition of the vaccinated arm.
- (v) Parents, teachers and general practitioners will be informed of proposals to offer B.C.G. vaccination in a Health Division of the Administrative County.
- (vi) After consultation with Head Teachers, a talk or discussion with the school children concerned will be arranged if considered advisable.
- (vii) It is intended that as soon as practicable one or more designated medical officers will be approved, after training if necessary, in each Health Division of the Administrative County. The scheme may start in one or two divisions but will be extended ultimately to cover the Administrative County.
- (viii) It is intended to make application to the Ministry of Health for Designated Medical Officers to be placed on the list of those approved to receive B.C.G. vaccine and intra-dermal testing material if possible direct owing to the large area of the local health authority.
- (ix) Records of abnormal vaccination reactions, constitutional disturbances or manifestation of tuberculous infection will be kept. The subsequent incidence of tuberculosis and type of lesion among vaccinated persons will also be recorded in order that statistical tables may be prepared.

It will be apparent from the foregoing that much preliminary work had to be done before actual vaccination could be commenced in any area. First selected school medical officers attended courses either at St. Mary's Hospital, Manchester, or Great Ormond Street Hospital, London, dealing with the technique of B.C.G. vaccination. To ensure the success of the scheme, it then became necessary in each area to enlist the full support and co-operation of the teachers, the general medical practitioners, and the parents. In some areas this was achieved by personal talks given by the Divisional Medical Officer. With a view to explaining the scheme to parents and in an attempt to overcome their objections to vaccination, a leaflet was prepared and issued to every thirteen-year-old child when the scheme was about to commence in a particular school or area. This leaflet is reproduced below:—

"Tuberculosis is a disease caused by a germ which can be picked up almost anywhere, but particularly in crowds. Most children encounter the germ at some stage in their lives but the defences of the body overcome it successfully without anyone realizing what has happened. This gives children some degree of natural protection against the active and dangerous form of tuberculosis which usually attacks its victims in later adolescent or early adult life.

"Only about half of the children reaching the age of thirteen have already encountered the germ of tuberculosis. The other half are those who are most likely to contract active tuberculosis later in life. Your child may be in this group and I am sure you will wish to do everything you possibly can to safeguard against the disease.

#### CAN YOUR CHILD BE PROTECTED?

"In recent years, following considerable medical research, vaccination against tuberculosis with B.C.G. has become a practical proposition. To those children reaching the age of thirteen who have not previously encountered tuberculosis it will give artificially the protection which the other children have acquired naturally.

#### HOW IS B.C.G. VACCINATION GIVEN?

"First it is necessary to make a test to determine whether your child needs vaccination. This consists of a harmless injection into the skin. In a few days a red mark may appear on the skin and from this the doctor will be able to tell whether vaccination is necessary. If the result of the test is positive, it means that your child has already acquired a natural resistance to tuberculosis and vaccination will not be necessary. If the result is negative, it may be necessary to repeat the skin test and if, after this second test, the result is still negative, it means that your child's resistance to tuberculosis is not strong enough and that vaccination should be carried out in the child's own interests.



"The vaccination itself is just as harmless as the skin test and again consists of a tiny injection into the skin of the arm. It is not painful and your child will not feel ill. About three weeks after vaccination a small red spot will appear which may become moist and ooze a little. This will heal and leave a small white scar. If you are at all concerned about the appearance of the arm, a word with the school medical officer who carried out the vaccination, or your own doctor, should remove any anxiety you may have.

"About six weeks after vaccination a final skin test is done to see if the vaccination has been successful.

#### WHAT YOU MUST DO.

"If you wish your child to receive B.C.G. vaccination, as I am sure you will, all you need do is to complete the consent form below and return it to the school or to the Divisional Health Office. Vaccination is free and will be given by one of the County Council's doctors, either at a clinic or in the school."

Under the scheme, general medical practitioners are informed of any child on their list who has been vaccinated.

The testing and vaccination is undertaken in either schools or clinics according to the numbers involved and the type of area.

In five of the Divisional Areas, Nos. 1 (Skipton), 9 (Wetherby), 10 (Goole), 11 (Castleford) and 31 (Rotherham), it was found possible to arrange for the scheme to commence in 1954, the first pre-vaccination tests being undertaken by the Skipton Division on the 6th September. Leaflets were circulated to the parents of 1,562 children; 4 children had already received protection as contacts and 944 accepted the offer of B.C.G. vaccination—an acceptance rate of 60.5 per cent. The acceptance rate in the five divisions ranged from 46.4 per cent. to 89.3 per cent. Four hundred and thirty-six children were successfully vaccinated.

In view of the limited extent in which the scheme was introduced during the year, the statistical resumé is given in detail below.

Details	Division No.					Total
	1.	9.	10.	11.	31.	
<i>Acceptances.</i>						
No. of 13-year old children on registers at beginning of year .....	501	162	600	1,070	1,118	3,451
No. of children offered tuberculin testing and vaccination if necessary .....	501	162	261	461	177	1,562
No. of children found to have been vaccinated previously .....	3	—	1	—	—	4
No. of acceptances .....	316	96	160	214	158	944
Percentage of acceptances .....	63.5	59.3	61.5	46.4	89.3	60.5
<i>Pre-vaccination Tuberculin Test.</i>						
No. of children tested .....	301	93	56	199	124	773
Result of test:—						
Positive .....	110	49	12	71	44	286
Negative .....	184	40	44	114	59	441
Not ascertained .....	7	4	—	14	21	46
TOTAL .....	301	93	56	199	124	773
Percentage positive .....	37.4	55.1	21.4	38.4	42.7	39.3
<i>Vaccination.</i>						
No. vaccinated .....	179	40	44	114	59	436
Reaction:—						
Positive .....	124	38	44	114	59	379
Negative .....	—	—	—	—	—	—
Not ascertained .....	55	2	—	—	—	57
TOTAL .....	179	40	44	114	59	436
Percentage positive, excluding those not ascertained who were awaiting the final test .....	100	100	100	100	100	100



**Mass Radiography.**—In a memorandum on Prevention of Tuberculosis issued by the Ministry of Health during the year, attention was directed to the need for the strategic use of mass radiography being a matter of consultation between the medical director and the medical officer of health of the local health authority. With the limited apparatus available in the two hospital regions and the large number of local health authorities making their competing claims, there is much to militate against this ideal, but it is pleasing to report that there is close co-operation, effected directly with the Regional Organiser in the Leeds Region and by local consultation between the medical directors and divisional medical officers in both regions.

Seventy-three thousand five hundred and forty-six persons from the Administrative County were examined by the mass radiography service (34,174 by units of the Leeds Regional Hospital Board and 39,372 by units of the Sheffield Regional Hospital Board). 198 (0.27%) were found to be suffering from active tuberculosis, 452 (0.61%) had signs of inactive tuberculosis, and in 1,552 (2.11%) other non-tuberculous abnormalities were discovered. Details are given in the following table.

## A. LEEDS UNITS

Survey undertaken at	No. Examined	Abnormalities Discovered			
		Tuberculosis		Other	Total
		Active	Inactive		
Barnoldswick ... ..	1,735	2	26	23	51
Gargrave ... ..	249	1	3	—	4
Skipton ... ..	1,502	2	13	20	35
Bentham ... ..	678	1	8	7	16
Castleberg Hospital ... ..	204	12	10	5	27
Hellifield ... ..	254	—	1	4	5
Ingleton ... ..	404	1	3	6	10
Settle ... ..	616	—	3	9	12
David Brown Ltd., Farsley ... ..	448	—	3	1	4
J.J.C. & L. Peate Ltd., Guiseley ... ..	1,337	1	4	12	17
Menston Hospital, Menston ... ..	2,495	36	33	27	96
Congregational Church Hall, Bridge Street, Otley ... ..	1,953	2	4	6	12
Convalescent Home, Ilkley ... ..	1,214	2	3	6	11
Tadcaster ... ..	1,183	1	3	4	8
Wetherby ... ..	900	2	1	6	9
Pollington ... ..	246	—	2	1	3
Rawcliffe Bridge ... ..	192	2	2	2	6
Rawcliffe Hall, Rawcliffe ... ..	158	8	—	—	8
Selby ... ..	1,596	—	7	5	12
Community Centre, Pontefract ... ..	1,908	2	4	4	10
Town Hall, Knottingley ... ..	760	—	6	2	8
Horbury ... ..	1,179	4	12	9	25
J. Blakeborough & Sons Ltd., Brighouse ... ..	737	2	9	2	13
St. John's Ambulance Hall, Brighouse ... ..	1,331	3	12	9	24
Hebden Bridge ... ..	1,279	—	6	8	14
Sowerby Bridge ... ..	1,614	4	4	4	12
Todmorden ... ..	1,993	3	8	4	15
Storthes Hall Hospital ... ..	2,810	25	37	42	104
The Drill Hall, Thongsbridge ... ..	1,711	1	11	9	21
South Kirkby ... ..	1,488	1	6	4	11
<b>TOTAL ... ..</b>	<b>34,174</b>	<b>118</b>	<b>244</b>	<b>241</b>	<b>603</b>

## B. SHEFFIELD UNITS

Chapelton ... ..	2,021	2	—	48	50
Lowwood's Ltd. ... ..	293	2	4	44	50
Samuel Fox's Ltd. ... ..	4,869	8	18	164	190
Cudworth ... ..	1,905	3	12	62	77
Dunford House, Wath ... ..	2,195	1	6	35	42
Manvers Main Colliery ... ..	1,686	3	11	57	71
Wath Main Colliery ... ..	938	4	10	48	62
Miners' Welfare Hall, Carcroft ... ..	1,502	4	9	62	75
Miners' Welfare Hall, Woodlands ... ..	2,252	3	13	91	107
Percy Jackson Grammar School, Adwick ... ..	611	—	1	2	3
Welfare Pavilion, Bentley ... ..	3,186	5	35	177	217
Armthorpe ... ..	1,782	3	6	58	67
Askern ... ..	1,528	1	11	58	70
Edlington ... ..	1,782	3	8	107	118
Rossington ... ..	1,540	1	5	49	55
Dunscroft and Stainforth ... ..	1,693	14	11	32	57
Moorends ... ..	1,607	6	9	36	51
Thorne ... ..	1,215	1	5	14	20
Baths Hall, Denaby Main ... ..	1,240	4	7	44	55
Conisbrough Child Welfare Centre ... ..	1,348	5	5	44	54
Mexborough Child Welfare Centre ... ..	2,880	4	18	47	69
Maltby ... ..	1,299	3	4	32	39
<b>TOTAL ... ..</b>	<b>39,372</b>	<b>80</b>	<b>208</b>	<b>1,311</b>	<b>1,599</b>
<b>TOTAL FOR THE COUNTY AREA</b>	<b>73,546</b>	<b>198</b>	<b>452</b>	<b>1,552</b>	<b>2,202</b>



The 1,552 non-tuberculous abnormalities revealed by the Surveys are classified as follows:—

	Leeds	Sheffield
Abnormalities of bony thorax and lungs ... ..	14	13
Chronic bronchitis and emphysema ... ..	9	252
Pneumonia (non-tuberculous) ... ..	6	53
Bronchopneumonia (non-tuberculous) ... ..	4	—
Bronchiectasis ... ..	48	49
Pulmonary fibrosis (non-tuberculous) ... ..	21	34
Pneumoconiosis (silicosis, etc.) ... ..	11	618
Pneumoconiosis accompanied by T.B. ... ..	1	—
Basal fibrosis ... ..	1	14
Pleural thickening ... ..	2	36
Pleural and interlobar effusion ... ..	2	4
Spontaneous pneumothorax ... ..	—	2
Intrathoracic new growth ... ..	8	11
Cardiovascular lesions—congenital ... ..	6	4
Cardiovascular lesions—acquired ... ..	51	187
Miscellaneous ... ..	26	32
Enquiries not completed ... ..	31	2

### Influenza

During the last quarter of the year there was a widespread epidemic of influenza type B in many areas in the County which, for the most part, occurred in school children. Details of the outbreak are given in the section of the Report dealing with The Health of the School Child.

The expected outbreak of influenza A which had been forecast to spread to this country from the Continent fortunately did not materialise.



## PART III

### MIDWIFERY AND MATERNITY SERVICES

#### Institutional Midwifery

Since the inception of the National Health Service Act, there has been a progressive rise in the number of institutional deliveries over the country as a whole, and this fact is often being associated with a fall in the maternal mortality rate. In the County, however, whilst four divisional areas had 80 per cent. or more of the total births taking place in hospital, the overall percentage of hospital confinements was 58, although within the administrative areas of the Leeds and Sheffield Hospital Boards, the figures were 65 per cent. and 46 per cent. respectively. It is interesting to note that in South Yorkshire where the industry is predominantly mining, the amount of institutional midwifery shows little increase from the days preceding the Act, domiciliary confinement tending to be traditional. One Divisional Medical Officer suggests that the low rate of hospital births is possibly due to the excellence of the domiciliary midwifery service in his area, the midwives being highly appreciated in the community; the standard of living of the average family in the area is high and with improved housing conditions, preference for home confinement is shown; the financial effect of the new maternity grant in favour of domiciliary delivery may be a contributory factor also.

There is a strong body of opinion that hospital delivery should be available to all who wish it, but it is extremely doubtful whether this could ever be economically possible. The Ministry of Health estimates that at the present time, hospital accommodation for 50 per cent. of all confinements should meet the requirements on medical and social grounds. So far as the County is concerned, however, examination of the table below would seem to indicate that in certain divisions, the proportion of hospital confinements depends more or less upon the number of beds available, rather than the need. Furthermore, the number of discharges from hospital to the care of the domiciliary midwife for completion of the lying-in period suggests a shortage of beds in some areas, with overbooking in areas where beds are adequately provided. If any marked reduction of still births and neonatal deaths is to be made, there must be greater utilisation of ante-natal beds in hospital.

Div. No.	Area	Total Births (Live & Still)	Percentage of Hospital Births	Div. No.	Area	Total Births (Live & Still)	Percentage of Hospital Births
1	Skipton	841	84	15	Batley	760	76
2	Settle	321	60	16	Rothwell	751	52
3	Keighley	770	74	17	Spensborough	668	81
4	Shipley	940	77	18	Brighouse	825	74
5	Horsforth	978	80	19	Todmorden	737	63
6	Otley	474	80	20	Colne Valley	1,093	70
7	Ripon	381	78	22	Wortley	1,253	59
8	Harrogate	957	82	23	Hemsworth	1,299	35
9	Wetherby	667	58	25	Barnsley	1,201	47
10	Goole	683	39	26	Wath	803	42
11	Castleford	1,004	57	27	Adwick le Street	739	41
12	Pontefract	1,020	49	28	Doncaster	1,066	41
13	Ossett	701	52	29	Thorne	700	38
14	Morley	587	74	30	Mexborough	1,159	45
				31	Rotherham	1,603	46
					Leeds Hospital Board Region	16,457	65
					Sheffield Hospital Board Region	8,524	46
					West Riding Administrative County	24,981	59

#### Domiciliary Midwifery

The National Health Service Act, in bringing the general practitioner into the field of the domiciliary midwifery service, has not interfered to any great extent with the responsibility of the midwife, so that any doubt which may have existed on the introduction of the maternity services that there would be a curtailment of her independence has been allayed. A falling birth rate coupled with the very generous provision of lying-in beds in hospital in some areas, has meant, however, the combining of the duties of some midwives with that of home nursing, and the curtailment of facilities for the district training of pupil midwives. That the service is working harmoniously is a testimony of good doctor-midwife relationship, and its success depends upon this, in combination with a good standard of work. There were 10,221 domiciliary births and of these, the medical practitioner was present at the time of delivery of 1,230 of them. It is frequently overlooked that the duties of the midwife go far beyond those of manipulative delivery of the infant which the following summary indicates:—

Clinic attendances	12,539
Ante-natal visits:—	
Domiciliary cases	72,484
Hospital cases	6,813
	79,297
Births attended	10,192
Hospital cases discharged from hospital prior to 10th day to care of midwife	4,905
Post-natal visits:—	
Domiciliary cases	193,583
Hospital cases	19,326
	212,909



The local supervising authority, under the Midwives Act, must exercise general supervision of practising midwives within its area, and for this purpose, this duty is delegated to the Divisional Medical Officer. There are two non-medical supervisors for the administrative county who assist the Divisional Medical Officer in the maintenance of an efficient service, by supervising the professional standards of the midwives in his area. The following is a summary of their work:—

Consultations with Divisional Medical Officers .....	121
Rounds with midwives, including labours .....	216
Visits to midwives .....	259
Investigation of puerperal pyrexia .....	61
Investigation of maternal death .....	1
Attendance at Relaxation Classes .....	40
Visits to hospitals and private maternity homes .....	16
Rounds with pupil midwives .....	23

There were 446 midwives who, in accordance with the rules of the Central Midwives Board, notified the County Council as the local supervising authority of their intention to practise. Of these, 268 were in the whole-time employ of the County Council, 160 were employed in institutions, whilst 18 were engaged in private practice.

A practising midwife must summon medical aid in all cases of illness or abnormality of the mother or child whether it be during pregnancy, labour or lying-in. 3,234 medical aid notices were issued during the year of which the following is a summary:—

#### PREGNANCY (569)

Abdominal pain ... ..	10	General condition ... ..	34	Threatened abortion ... ..	61
Abortion ... ..	157	Hydramnios ... ..	1	Toxaemia ... ..	115
Ante-Partum Haemorrhage ... ..	135	Malpresentation ... ..	26	Varicose Veins ... ..	5
Breast condition ... ..	1	Post maturity ... ..	12	Vomiting ... ..	7
Disproportion ... ..	5				

#### LABOUR (1,794)

Coma ... ..	1	Multiple delivery ... ..	5	Retained placenta ... ..	99
Episiotomy ... ..	7	Obstetric shock ... ..	9	Rigidity of cervix ... ..	2
Foetal distress ... ..	31	Obstructed labour ... ..	7	Ruptured perineum ... ..	1,120
General condition ... ..	14	Precipitate labour ... ..	4	Still-birth ... ..	20
Labial laceration ... ..	16	Premature labour ... ..	61	Uterine inertia ... ..	34
Malpresentation ... ..	83	Prolonged labour ... ..	249	Vaginal laceration ... ..	10
Maternal distress ... ..	11	Pyrexia ... ..	11		

#### LYING-IN (382)

Breast condition ... ..	56	Post-partum Haemorrhage ... ..	89	Subinvolution ... ..	5
Chest condition ... ..	10	Pyrexia ... ..	113	Thrombosis ... ..	4
General condition ... ..	28	Renal condition ... ..	4	Varicose veins ... ..	27
Offensive lochia ... ..	3	Shock ... ..	2	Vomiting ... ..	4
Phlebitis ... ..	37				

#### CHILD (489)

Abnormality ... ..	20	Death ... ..	2	Melaena ... ..	4
Asphyxia ... ..	22	Deformity ... ..	32	Prematurity ... ..	68
B.B.A. ... ..	7	Eye condition ... ..	113	Pyrexia ... ..	4
Chest condition ... ..	8	General condition ... ..	74	Skin condition ... ..	23
Convulsions ... ..	2	Haematemesis ... ..	4	Snuffles ... ..	6
Coryza ... ..	12	Haemorrhage ... ..	7	Umbilical condition ... ..	7
Cyanosis ... ..	35	Jaundice ... ..	31	Vomiting ... ..	5
		Mastitis ... ..	3		

**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. This service has, over the years, made a valuable contribution towards the reduction of maternal mortality.

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 domiciliary midwives in the employ of the authority are trained in the use of gas and air as a means of relief of pain during childbirth and for this purpose 296 machines are available; some midwives are also qualified in the use of pethidine. Of the 10,221 births, the undermentioned table indicates the percentage of cases in each administrative area in which an analgesic was utilised. In many of them, pethidine was used in conjunction with gas and air.



Division No.	Percentage receiving Analgesia		Division No.	Percentage receiving Analgesia	
	Gas and Air	Pethidine		Gas and Air	Pethidine
1	65	56	15	53	65
2	50	29	16	56	60
3	49	40	17	76	57
4	79	63	18	68	52
5	74	44	19	74	55
6	60	44	20	66	58
7	62	33	22	37	10
8	60	50	23	62	59
9	54	24	25	77	62
10	67	51	26	31	47
11	79	24	27	58	26
12	64	66	28	69	31
13	78	66	29	52	52
14	75	31	30	79	33
			31	30	60
			Leeds Hospital Region	66	51
			Sheffield Hospital Region	54	42
			W.R. Administrative County	60	47

**Post Certificate Instruction.**—Courses organised by the Royal College of Midwives were held during the year at Cardiff, Bristol and London, and 31 midwives attended. At a course on relaxation in childbirth organised within the department and held at Grantley Hall, 40 midwives were in attendance.

**Training of Pupil Midwives.**—The second period of the training of pupil midwives intending to obtain the midwives' certificate of the Central Midwives Board, demands a period of not less than three months being spent in domiciliary practice on the district. A number of the domiciliary midwives on the County staff are approved teachers for this type of training, and in association with the teaching hospitals of Nether Edge, Sheffield, and York, assistance was given in the training of 20 pupils.

### Ante and Post-natal Services

It is now generally known that these services can be provided by the hospital where the pregnant woman has been booked for institutional confinement, by the private practitioner or through the local health authority clinic and domiciliary midwifery services. It will be realised that if the interest of the patient is to be obtained, there must be active co-operation existing between these three separate bodies, and the difficulties which were encountered following the inception of the National Health Service Act in 1948, have been largely overcome. Various measures have been adopted to ensure general practitioner co-operation. At the first visit to the clinic, the practitioner is notified by the clinic doctor of the attendance of his patient, and also informed that in the event of any abnormality being found at subsequent visits, the case will be referred to him. At some of the clinics, the experiment of inviting the practitioner to the clinic to see his own patients has been tried successfully; in other areas, midwives attend sessions held in the practitioners' surgeries. Still closer midwife-practitioner relationship could be obtained if practitioners would only make themselves conversant with the statutory duties of the midwife, which place the responsibility on the midwife of undertaking regular ante-natal supervision even if this duplicates the examination of the practitioner.

Dr. J. C. MacWilliam, who holds a joint appointment with the County Council and the Sheffield Regional Hospital Board, is responsible for the ante-natal work in the clinics of the Council within the administrative division of Mexborough, and also for obstetrical duties associated with the maternity department of the Mexborough Montagu Hospital. This appointment has, from the local health authority point of view, proved a great asset by unifying the maternity services generally, within the area of responsibility, thereby inculcating team spirit and inspiring confidence; in the interest of the patient by placing the ante-natal clinic work in the hands of a medical officer keenly interested in prevention and thoroughly experienced in his specialty; by virtue of this unique appointment, beds are available in hospital to which he can, on consultation with the family doctor, admit abnormal cases from the clinics. It is gratifying to find a clinician so keenly interested in prevention and Dr. MacWilliam reports:—

"One of the most important aims of ante-natal care is the reduction and ultimate elimination of eclampsia. Pregnancy is a diet efficiency test and the incorrect type and quantity of food consumed contributes to this condition. For two years we have been recommending a diet of high protein and vitamin content, but low in carbohydrate. At the first visit of the expectant mother to the ante-natal clinic, she is presented with a diet sheet which is made up in menu form. At the same time, each patient is given tablets containing iron, calcium and vitamin D, and advised to take one tablet following each meal. Subsequently the tablets are withdrawn (unless there is contra indication) until the 28th week of pregnancy when medication is resumed until the end of the puerperium. There are groups in our population who do not enjoy optimum nutrition; this does not necessarily mean that the correct food is not available, nor that it cannot be afforded. Many must be taught how to cook properly and cookery classes are being arranged where the young primigravida will be taught simple cooking. I am happy to say that many health visitors and midwives are volunteering to join these classes and help the trained instructor."

At the end of the year, there were 153 ante- and post-natal clinics in operation. The number of expectant mothers who attended these clinics was 13,184 of whom 10,191 were new cases, and a total of 65,424 visits were made. Post-natal attendances were 2,007, representative of 1,760 women of whom 1,446 were new cases.



## PART IV

### CHILD WELFARE

Lowered infant mortality rates are often accepted as an indication that the child welfare service has outlived its usefulness, and whilst the service has played a most important part towards these reductions, it has only been one of the many factors which have contributed. It is frequently overlooked that of the deaths of infants under the age of one year, approximately 60 per cent. of them take place during the first four weeks, a time during which very few infants have had any benefit from this particular service.

That the service is of national benefit is indisputable, but the manner in which it is applied must require modification from time to time in order to secure greatest effectiveness. The place of the infant welfare centre within the present day service is one requiring most urgent modification, and the present practice of displaying for sale various types of dried milk and other infant foods is not only outdated, but is not in keeping with the principle of the Centre. This particular problem has been further accentuated by the use of the Centre as a means of distributing National Dried Milk and other welfare foods, formerly undertaken by the Ministry of Food. The welfare centre must be regarded as an educational institution in which the expectant and nursing mother can be taught the art of mothercraft and where the supervision of the health of children up to the age of five years can be undertaken. It is all too frequent to find that best attendances are made at the centres by mothers of first born infants, and as the family increases so do attendances decrease, unless something is wrong with any particular member; the effect of this is the need to apply selective home visiting. The Centre is invaluable as a means of providing routine medical inspection at periodic intervals of infants of pre-school age, when there is the opportunity of early ascertainment and correction of defect too frequently undetected until school entry.

Dr. Harvey, the County Pædiatrist, under the title of "The Family: The Unit of Child Health" reports—

"Some of the grosser preventable ills of childhood have been abolished or minimized in the last generation. The task remaining to us is thus less dramatic, targets are less obvious and trends less perceptible; rewards will come slowly and only with more painstaking study.

A child at risk can only be considered in the framework of his home. Chronologically, our estimating begins during the mother's first pregnancy; will she prove to have the good health, personality, mental endowments, ethical standards and adaptability to make a success of homecraft and parenthood. Is her husband a full partner, will they be defeated by possessive in-laws; will they be broken by slum circumstances. Is there still time to remedy shortcomings before the stringent testing of confinement and neonatal care. This outline already reveals two gaps, at least; first, the foundations for successful parenthood need laying long before marriage, to-day's maladjusted families will reproduce the like misery tomorrow; second, the children's doctor feels that he ought to have some contribution to offer ante-natally on the obstetrician's territory, but time and boundaries forbid. If only the family doctor can be both pædiatrist and obstetrician, with the interest, experience and time for prophylactic guidance, this second gap is very neatly closed.

Rehousing is not in itself the whole answer to the health problems of overcrowding, as a recent annotation on 'Slum Sickness' makes clear. Are all resources mobilized for enabling parents and children to outgrow the handicaps of a slum upbringing and attain more happy ideals of citizenship as they move into new surroundings; are the family too dependent on grandparents or too much bound by old habits to break clear. Overcrowding was apparently no novelty three centuries ago, as an old Puritan marriage counsellor advised, 'As the young bees do seek unto themselves another hive, so let the young couple another house . . . that whatsoever come, they may never fall into that unhappiest of unhappinesses, of either being tormentors of their parents or tormented by them.'

Zest is required for family-making, as well as health and housing, employment and in-laws; nurses and doctors are in the position to foster this zest for living in the minds of young parents. Our interest in their youngsters must be personal, our guidance attractive without browbeating, and if possible, our own example may help to sell the idea that there is no adult fun on earth like a family. The ideal clinic doctor and the ideal health visitor are maybe the ones with happy children of their own. All this, however, will fail to touch those couples whose sole interest in parenthood seems to be to prove their own fertility by conceiving a single offspring, and then lapsing into ostrich-eyed aversion from the tasks and skills of child-nurture. The escapism of a father and mother both working full (and differing) shifts, in mills, and on 'buses, bears hard upon the waif on grandmother's doorstep.

There is here a small but important preventable group of problems, parents of a defective first-born, whom we may have failed to reassure at the outset that the disaster is not familial, such as an accident of cerebral birth anoxia. Too often they undertake a morbid self-dedication limited to the protection of this child, instead of seeking wholesome addition to their family before obsession becomes fixed.

*Infant Dietary.*—Breast feeding still holds out the baffling psycho-somatic problem of most mothers declaring their milk failed on baby's fifteenth day of life. Shall we ever get this right while the midwife and health visitor are two different persons, or while supervision is split between hospital and home teams. We cannot expect family doctors to become crusaders until we offer them compelling evidence that success is possible.



During the year the vitamin content of fortified dried milks has attracted attention, and fresh evaluation of our whole programme of vitamin D administration seems to be needed, now that the great majority of infants over a month old are receiving these vitamin-fortified milks. For such children there seems to be no need for either ration cod liver oil or any additional concentrate, except during illness. Recommendations, however, will need to be broad enough to apply to children receiving unfortified fresh milk, as well as toddlers who have ceased taking dried milks. The mothers of breast fed babies will probably still be sufficiently sensible to give cod liver oil without argument. We may particularly deprecate the offering at clinics of extra vitamins as a sort of non-specific optimistic tonic for undiagnosed children who look somewhat off colour.

*Infant Management.*—Parents are still plagued by their conscience and the arbitrary rules they have picked up in matters of food forcing, sleep forcing and pot forcing. We have not the answer to the vexatious and frequent colic which robs many parents of the joy of their youngster in the first 3 months of life. By this time, the baby usually outgrows the colic, but the parents are unnerved for further progress."

#### CHILD ATTENDANCES AT WELFARE CENTRES

Group I under one year	Group II one to two years	Group III two to five years	Total
260,657	69,233	56,945	386,835

The attendances made by infants of Group I represent 16,812 children or 69 per cent. of the age group; Group II—15,317 or 60 per cent; Group III—14,931 or 20 per cent.

New infant welfare centres were opened at Carleton and Thorpe, whilst the Council approved of the purchase of a second mobile clinic to serve the needs of the rural populations in the southern part of the County. Details of the clinic premises and the services provided, as at the end of the year, are included on pages 52 to 74.

During the year, the Council gave consideration to a comprehensive report on the details of the existing 227 clinic premises within the Administrative County for the purposes of determining the need for improvement and for expansion of the facilities in respect of the child welfare, ante-natal, school health, mental health, dental and specialist services. An extensive survey was carried out in those areas for which there was evidence of urgent need, subsequent to which a decision was reached as to the type of clinic which would be necessary to meet the needs of the area concerned. Ultimately a two year building programme was formulated involving three types of clinics, a plan of each of which is shown on pages 45 and 46. The Council decision for building projects to be undertaken are at:—

Pontefract —multiple clinic  
Parson Cross—satellite clinic  
Selby — " "  
Normanton — " "  
Wombwell — " "  
Skipton — " "  
Airedale —small clinic

South Elmsall —small clinic  
Grimethorpe — " "  
Edlington — " "  
Horsforth — " "  
Goldthorpe — " "  
South Kirkby — " "  
Askern — " "

#### Distribution of Welfare Foods

In accordance with Ministry of Health Circular No. 10/54, arrangements were made for the local distribution of Welfare Foods to beneficiaries, previously undertaken by the Ministry of Food, to be taken over by Local Health Authorities. The distribution of these foods became the responsibility of the Local Health Authorities on 28th June, 1954. This was a matter of some magnitude, there being no less than 370 distribution points in the West Riding Administrative Area, but despite the short notice received the transfer was effected smoothly. The greater part of the distribution is carried out through Divisional Health Offices and Child Welfare Centres although some distribution is still made through the retail trade and private households under arrangements previously made by the Ministry of Food.

The first periodical return to the Ministry of Health covered the period 28th June, 1954, to 2nd January, 1955, and the following table shows the quantities of Welfare Foods distributed during this period:—

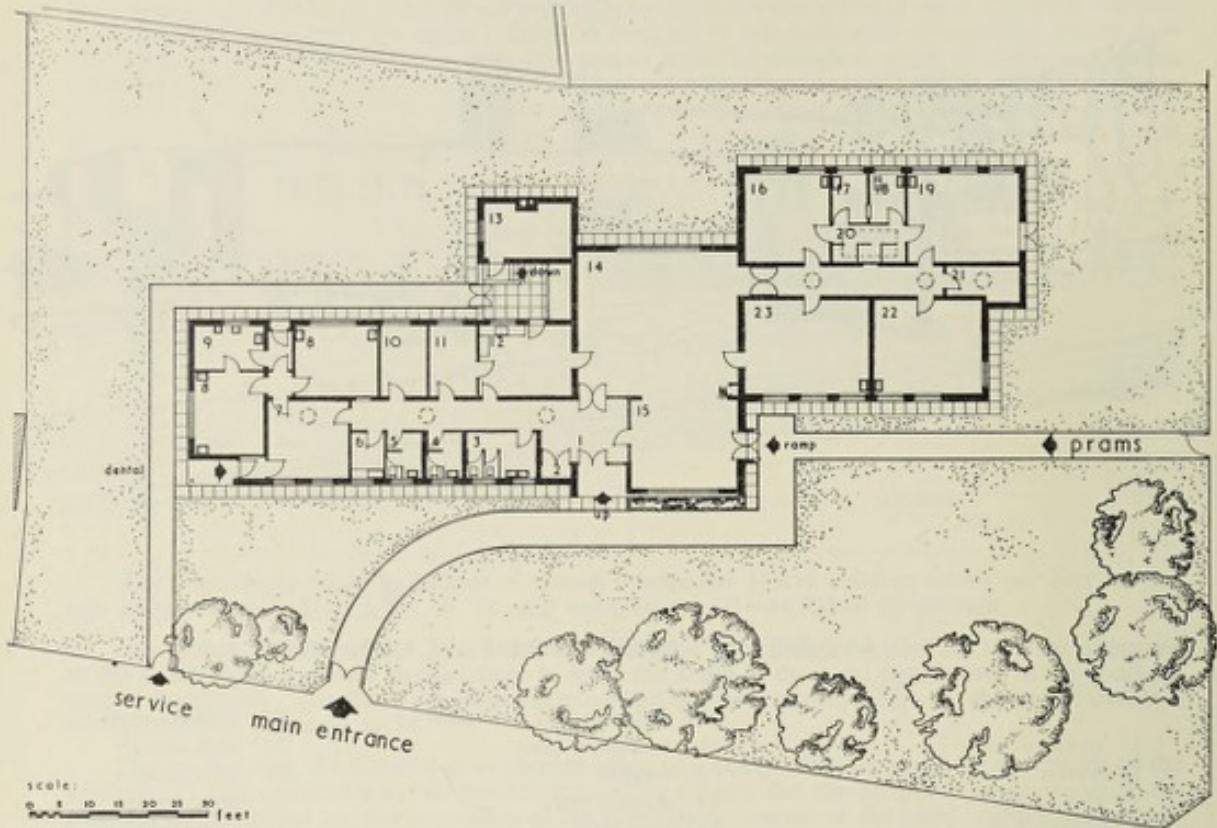
	National Dried Milk (tins)	Cod Liver Oil (bottles)	Vitamin A and D Tablets (packets)	Orange Juice (bottles)
Issued to beneficiaries against coupons ...	305,552	79,877	23,634	345,031
Issued to Institutions, Hospitals and Day Nurseries, but exclud- ing Schools ...	1,213	1,429	180	6,627
	306,765	81,306	23,814	351,658







## HEMSWORTH SATELLITE CLINIC



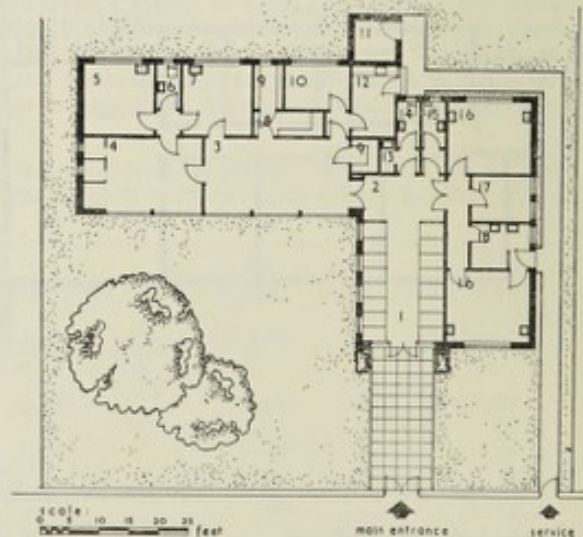
## KEY:

- |                       |                           |                            |
|-----------------------|---------------------------|----------------------------|
| 1 entrance hall       | 8 dental surgery          | 16 weighing and ante-natal |
| 2 meters              | 9 recovery room           | 17 duty room               |
| 3 female toilet       | 10 staff room             | 18 toilet                  |
| 4 staff toilet        | 11 store                  | 19 consulting room         |
| 5 boys' toilet        | 12 kitchen and food sales | 20 dressing cubicles       |
| 6 cleaners' store     | 13 boiler house           | 21 records                 |
| 7 dental waiting room | 14 waiting hall           | 22 specialist services     |
|                       | 15 prams                  | 23 minor ailments          |

## PROPOSED SMALL CLINIC

## KEY:

- |                           |                        |
|---------------------------|------------------------|
| 1 prams                   | 10 staff room          |
| 2 entrance hall           | 11 boiler house        |
| 3 waiting hall            | 12 kitchen             |
| 4 weighing and ante-natal | 13 cleaners' store     |
| 5 consulting room         | 14 female toilet       |
| 6 duty room               | 15 boys' toilet        |
| 7 clinic room             | 16 dental surgery      |
| 8 food sales              | 17 dental waiting room |
| 9 store                   | 18 recovery room       |





## Illegitimate Children

In ordinary circumstances, apprehension of an impending confinement might be regarded as a normal reaction, particularly when associated with the first pregnancy. However, in the case of the illegitimate pregnancy, the emotional stresses are much greater and necessarily call for even greater sympathy and understanding, without which there is added danger to the unborn child. The position in the community of the unmarried mother is a difficult problem, calling for the active co-operation of all interested parties. There is too often the tendency to sit in judgment on these cases when magnanimity would be more helpful.

There were 881 illegitimate births registered, of which 483 were males and 398 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	...	...	...	...	69
(b)	Ascertained by staff of the Health Department	...	...	...	...	468
(c)	Referred by Other Services	...	...	...	...	89
Total						626
2. Analysis of cases:						
(a)	Married	(i) with previous illegitimate children	...	...	...	70
		(ii) without previous illegitimate children	...	...	...	101
(b)	Unmarried	(i) with previous illegitimate children	...	...	...	111
		(ii) without previous illegitimate children	...	...	...	318
(c)	Widowed	(i) with previous illegitimate children	...	...	...	6
		(ii) without previous illegitimate children	...	...	...	20
Total						626
3. Ages:						
(a)	Under 20 years of age	...	...	...	...	118
(b)	20-25 years of age	...	...	...	...	230
(c)	26-30 years of age	...	...	...	...	123
(d)	31-40 years of age	...	...	...	...	145
(e)	Over 40 years of age	...	...	...	...	10
Total						626
4. Disposal:						
(a)	Cases Settled	(i) Marriage	...	...	...	30
		(ii) Baby died	...	...	...	28
		(iii) Grandparents taking baby	...	...	...	27
		(iv) Baby adopted	...	...	...	78
		(v) Baby fostered	...	...	...	11
		(vi) Mother keeping baby	...	...	...	410
(b)	Cases referred elsewhere	...	...	...	...	17
(c)	Cases not finally settled	...	...	...	...	25
Total						626

## Day Nurseries

The provision of a day nursery service for the care of children under the age of five years by the County Council, took shape following the war as a result of the taking over from the Ministry of Health of war-time nurseries which had been erected as a means of encouraging mothers to take up work in the promotion of the war effort. The year 1948 saw a further expansion of the service by the transfer to the Council of the nurseries administered by the former autonomous authorities. Subsequently, at the request of the Ministries of Health and Labour, five additional nurseries were built as a further encouragement to mothers to work in essential export industry, considered so necessary to help in the economic recovery of the country. Whilst the Council, in making nursery accommodation available to children of mothers who wished to go out to work, were always mindful of the fact that, as a health authority, their primary responsibility was that of the care of children in the maintenance of health and in consequence of this accepted policy, vacancies in nurseries were only available to the children of mothers going out to work, after health needs had been met.

At the beginning of the year, there were thirty day nurseries in operation, providing 1,275 places, although the Earby nursery, providing 40 places, was closed on the 12th February following the relinquishing of the requisition of the site upon which it was erected. The attendance returns of these nurseries were at that time revealing the fact that a large proportion of the children were from families in which both parents were either in full employment, or full-time and part-time of the father and mother respectively. The Council, in considering the general future policy of the nursery service, felt bound to have regard to the fact that the service was not only largely serving the needs of industry, which was not their function, but was also being used as a means of providing a joint



family income for both husband and wife. They were of the opinion that the time had arrived when the service should be planned primarily from the point of view of the health service, even to the extent of giving consideration to the opening of new nurseries where there was no accommodation available for the admission of children on health grounds. It was also felt that unless there were strong factors to the contrary, the proper place for the mother of a young child was at home. The early hours in which young children were taken from their beds to be admitted to nurseries was also condemned.

As from the 1st April, there was a reduction of the hours in which the nurseries should remain open, it being resolved that they should only operate between the hours of 8.30 a.m. and 4.30 p.m. This alteration did, in fact, cause inconvenience for some mothers, and a number of children were withdrawn from the nurseries as a result. It was further decided that the following nurseries be closed: Keighley, Woodbine; Shipley, Manor Lane; Shipley, Victoria Park; Shipley, Windhill; Yeadon; Guiseley; Burley-in-Wharfedale; Gildersome; Stourton; Brighouse, Ogden Lane; Harrogate, Station Avenue; and from the date of closure, those children in attendance at the remaining nurseries other than on grounds of health should be excluded, whilst the children attending for health reasons in the nurseries scheduled for closure be offered accommodation in neighbouring nurseries.

In August, Ministry approval for the closure of the nurseries was obtained, with the exception of Harrogate Station Avenue, but in respect of the Shipley nurseries, it was suggested that closure should be staggered so as to give mothers who were not in the priority category time to make other arrangements. Such approval was given on the understanding that the Council would keep under review the health of the children in nurseries generally, and in particular the health of those children whose mothers' hours of work were longer than the nursery hours. In respect of the children of mothers working longer hours than those for which nursery care was available, apprehension was understandable, for it might well be that the child would be left to the care of a neighbour or an older school child, with the probability of being left without adequate supervision until the mother returned from work in the evening.

A survey of the children was undertaken in October and for comparative purposes, the children were divided into two groups representing the children of mothers working longer hours than those in which the nurseries were open and those in which the mothers were working shorter hours. Each of these groups was subdivided into three age groups, i.e. babies, tweenies and toddlers. Weights were also obtained before the altered nursery hours became operative to give some indication as to whether shortened hours, with a consequent reduction of meals supplied in the nurseries, had any effect upon the progress of the children. The information obtained did not indicate that the change in nursery hours had had any effect upon the physical condition of the children. Some Divisional Medical Officers did hold the view, however, that shortly after the introduction of shortened nursery hours, there was a period in which there was halted progress, but this was ultimately rectified.

TABLE A

Physical standard and home conditions of the nursery children in October.

Home Conditions	Mother working longer hours than nursery open			Total	Mother working shorter hours than nursery open			Total
	Physical standard				Physical standard			
	Good	Satisfactory	Poor		Good	Satisfactory	Poor	
Good	29	13	1	43	62	53	—	115
Satisfactory	42	64	4	110	70	71	6	147
Poor	23	32	10	65	21	41	4	66
TOTAL	94	109	15	218	153	165	10	328

TABLE B

Comparative weights of children whose mothers are working longer or shorter hours than those of nurseries.

Age Group	Longer hours — Average weight						Shorter hours — Average weight					
	January		April		October		January		April		October	
	lb.	oz.	lb.	oz.	lb.	oz.	lb.	oz.	lb.	oz.	lb.	oz.
0 — 1	18	3	18	15	23	10	18	2	18	9	23	9
1 — 2	23	9	25	5	28	9	23	1	24	8	27	5
2 — 5	32	—	33	3	35	9	30	12	31	8	34	3



At the end of the year, there were 19 day nurseries being maintained by the County Council, providing 825 places. The average attendance at each is indicated in the following table:—

Division	Day Nursery	No. of Places Provided	Average Daily Attendance for the year
1	Barnoldswick .....	50	31
3	Keighley .....	50	21
4	Shipley: Manor Lane .....	50	31
4	" Saltaire .....	50	27
4	Bingley .....	50	31
4	Baildon .....	50	32
5	Stanningley .....	35	27
5	Horsforth .....	40	31
6	Ilkley .....	40	28
6	Otley .....	40	25
8	Harrogate: Station Avenue .....	40	25
8	" Albany Avenue .....	40	34
14	Morley: Lewisham Park .....	40	28
15	Heckmondwike .....	40	34
18	Brighouse: Wellholme Park .....	40	33
18	" Holme House .....	40	27
19	Todmorden .....	40	25
19	Hebden Bridge .....	40	28
19	Sowerby Bridge .....	50	30

### Premature Babies

Clinically a premature infant may be regarded as one which is born between the twenty-eighth and fortieth weeks of gestation; errors of calculation, however, have in the past tended to make the number of premature infants less than it actually was, which probably accounted for many cases of immaturity. Uniformity in the diagnosis of maturity so that all infants of a birthweight of 5½ lbs. or less are regarded as being premature, has allowed of great statistical accuracy, and a yard-stick by which can be measured the effect of after-care on survival. There is little doubt, however, that many poorly developed infants deemed to be prematurely born, are in fact full-term babies.

There were 1,608 premature births to mothers normally resident in the administrative county; this represents 6.6 per cent. of the total live births and from the following statistical table, it will be observed that there is a slight improvement in the overall survival rate, which is the highest recorded since the compilation of statistics in 1950.

Prematurity continues to be one of the greatest single causative factors of deaths in infants under the age of one year and constituted 57.3 per cent. of neo-natal deaths. There are certain ascertainable causes of this condition, about which preventive action can be taken, but in the main, no cause is known. It has been common belief that these unknown causes would become fewer as preventive treatment by way of improved economic and social conditions was undertaken although at present there is little evidence in substantiation.



THE FATE OF PREMATURE BABIES BORN IN THE YEAR 1954, TO MOTHERS NORMALLY RESIDING IN THE WEST RIDING  
ADMINISTRATIVE COUNTY AREA WHEREVER THE BIRTH TOOK PLACE

Total adjusted live births notified—24,356

Number of live premature births—1,608  
Number born dead—312

Percentage of premature live births to total live  
births—6.6

Weight Group lbs.	Number of Premature Births						Number Dying (Days of Survival)														Percentage survival in previous years						
	Born Alive					Born Dead	First Week							Second Week													
	A	B1	B2	C	Total		1	2	3	4	5	6	7	8	9	10	11	12	13	14		Over 14 up to 28 days					
																							A	B1	B2	C	Total
5-5½	218	6	196	256	676	27	9	4	3	—	—	2	—	—	1	—	—	—	1	1	1	1	96.7	94.8	94.9	95.5	96.3
4½-5	117	5	97	152	371	40	11	2	2	—	2	1	2	—	—	—	—	—	—	—	2	93.5	94.3	93.9	92.2	93.0	
4-4½	44	3	54	93	194	37	9	3	5	2	2	1	1	1	—	—	—	—	—	—	—	87.6	88.5	87.4	84.7	87.0	
3½-4	40	—	27	59	126	41	14	4	4	1	—	—	1	—	—	—	—	—	—	1	80.2	80.4	77.4	72.1	78.0		
3-3½	25	—	20	46	91	42	17	10	1	1	1	—	2	—	—	—	—	—	—	2	62.6	61.4	67.1	58.4	55.2		
2½-3	20	—	7	33	60	49	21	11	1	1	1	1	—	1	—	—	—	—	—	1	36.7	52.4	40.6	34.8	36.1		
2-2½	8	—	2	23	33	42	19	5	—	—	—	—	1	—	1	—	—	—	—	—	21.2	15.8	7.3	14.7	9.8		
1½-2	9	—	3	28	40	21	23	6	2	3	2	1	—	—	—	—	—	—	—	—	7.5	12.9	6.1	2.8	5.9		
1½ and under	3	—	2	12	17	13	14	2	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	3.7	—	8.3	
Total	484	14	408	702	1,608	312	137	47	18	10	7	7	6	4	2	—	—	—	1	1	7	84.6	83.7	82.6	82.7	83.3	
232																											
8																											



# 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 or where parents refuse to co-operate in  
 the inquiry ..... 203  
 1,223

Weight Group lbs.	Period of Survival — Number Dying at following periods of life																Surviving over 5 years
	Under 1 year	1 year and under 2 years	2 years and under 3 years	3 years and under 4 years	48 and 49 months	49 and 50 months	50 and 51 months	51 and 52 months	52 and 53 months	53 and 54 months	54 and 55 months	55 and 56 months	56 and 57 months	57 and 58 months	58 and 59 months	59 months and under 5 years	
5—5½	44	2	2	1	—	—	—	—	—	—	—	—	—	—	—	—	462
4½—5	33	2	—	1	—	—	—	—	—	—	—	—	—	—	—	—	230
4—4½	37	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	136
3½—4	38	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	70
3—3½	25	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	34
2½—3	33	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	14
2—2½	30	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	5
1½—2	15	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1½ and under	7	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	262	6	2	2	—	—	—	—	—	—	—	—	—	—	—	—	951
Percentage Survival	78.6	78.1	77.9	77.8	77.8	77.8	77.8	77.8	77.8	77.8	77.8	77.8	77.8	77.8	77.8	77.8	77.8

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















[illegible]



## 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 Whiteley Croft Pool-in-Wharfedale Church Room	—	—	—	—	—	Tues. p.m. ST	—	—	—	—	—	—	—	—	—
DIV. 7. (RIPON) Birstwith Mobile Clinic	—	Mon. p.m. (4 weekly) DMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	Cardiac see Div. 8
Bishop Monkton Mobile Clinic	—	Fri. p.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Bishop Thornton Mobile Clinic	—	Mon. a.m. (4 weekly) DMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Copt Hewick Mobile Clinic	—	Tues. p.m. (4 weekly) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Dacre Mobile Clinic	—	Mon. p.m. (4 weekly) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Darley Mobile Clinic	—	Mon. p.m. (alternate) DMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Galphay Mobile Clinic	—	Tues. a.m. (4 weekly) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Grewellthorpe Mobile Clinic	—	Tues. a.m. (4 weekly) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
High Grantley Mobile Clinic	—	Tues. a.m. (4 weekly) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Kirkby Malzeard Mobile Clinic	—	Tues. a.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Lofthouse Mobile Clinic	—	Mon. a.m. (4 weekly) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Markington Mobile Clinic	—	Mon. a.m. (4 weekly) DMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Mickley Mobile Clinic	—	Tues. a.m. (4 weekly) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
North Stanley Mobile Clinic	—	Tues. p.m. (4 weekly) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Nunwick Mobile Clinic	—	Tues. p.m. (4 weekly) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Pateley Bridge Methodist Buildings	—	Wed. p.m. (1st & 3rd) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Pateley Bridge Welfare Centre, Council Offices	Thurs. p.m. GP/HV(2)	Mon. p.m. ACMO/HV(2)	Mon. a.m. ACMO/HV Thurs. a.m. DMO/HV	Fri. a.m. ACMO/HV	Mon. a.m. ACMO/HV (2)	Wed. a.m. Fri. a./p.m. ST	—	—	—	—	As required HMO/HV	—	—	—	—
Ripon Alma House	—	—	—	Daily a.m. HV(2)	Mon. a.m. ACMO/HV (2)	—	—	—	—	—	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	—







## 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 Mon. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Bardsey Trustees Hall ...	—	Tues. p.m. (alternate) GP/HV(2) Tues. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Barwick-in-Elmet Methodist Schoolroom	With Infant Welfare	Thurs. p.m. (alternate) ACMO/HV(2) Tues. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Boston Spa West End Nursery School	With Infant Welfare	Wed. p.m. (alternate) ACMO/HV(2) Thurs. p.m. (alternate) ACMO/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Copmanthorpe Mobile Clinic ...	With Infant Welfare	Thurs. p.m. (alternate) ACMO/HV/CN Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Church Fenton Methodist Sunday School	With Infant Welfare	Thurs. p.m. (alternate) MO(RAF)/HV Fri. a.m. (alternate) GP/HV/CN	—	—	—	—	—	—	—	—	—	—	—	—	—
Church Fenton R.A.F. Station ...	With Infant Welfare	Fri. p.m. (alternate) ACMO/HV/CN Wed. a.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
East Keswick Mobile Clinic ...	With Infant Welfare	Tues. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Huby Mobile Clinic ...	With Infant Welfare	Tues. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
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. Tadcaster Multiple Clinic, Leeds Road ...	With Infant Welfare Wed. a.m. (alternate) Fri. p.m. (alternate) DMO/HV(2) M	Thurs. p.m. (alternate) GP/HV Tues. p.m. (alternate) ACMO/HV(2)	—	Wed. a.m. HV Tues. a.m. HV Thurs. a.m. HV	—	Thurs. a.m. ST	—	—	—	—	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











[illegible]









## 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	—	—	—	—	—	—	—	—	—	—	—	—	—
<b>DIV. 18. (BRIGHOUSE)</b>															
Brighouse Bonegate House	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Brighouse 10, Huddersfield Road ...	Tues. p.m. (alternate) ACMO/HV/ M	Wed. p.m. Thurs. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Brighouse Atlas Mill Road ...	Tues. p.m. Fri. p.m. HV Relax.	—	Mon. a.m. Thurs. a.m. HV	Daily HV	Thurs. a.m. ACMO/HV	Mon. a.m. p.m. Tues. a.m. ST	Fri. a.m. As required DMO/HV	—	Tues. a.m. HV	—	Thurs. a.m. (alternate) Fri. a.m. HMO/HV	Fri. p.m. (monthly) HMO/HV	—	—	E.N.T. Mon. a.m. (as required) HMO/HV
Elland St. Paul's School	Mon. p.m. (alternate) DMO/HV/ M	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	—	—	—	—	—	—	—	—	—	—
Greeland Clay House	Mon. p.m. HV Relax. (alternate) ACMO/HV/ M	Tues. p.m. GP/HV(2)	Mon. p.m. Tues. p.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	Tues. p.m. DMO/HV(2)	Tues. a.m. Fri. a.m. HV	Tues. a.m. Fri. a.m. HV	Fri. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Shelf Witchfield Chapel	Fri. p.m. (alternate) ACMO/HV/ M Relax.	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	—	—	—	—	—	—	—	—	—	—	—
<b>DIV. 19. (TODMORDEN)</b>															
Halifax Royal Infirmary ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Hebden Bridge Pitt Street	Fri. p.m. GP/HV/M(2) Tues. p.m. M(2) Relax.	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	Wed. a.m. (bi-monthly) HMO	—	—	—



[illegible]

## 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 Council Chambers	—	—	—	—	—	Thurs. p.m. ST	—	—	—	—	—	—	—	—	—
Honley Council Offices	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Honley High Street Methodist Church	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Honley Southgate Methodist Schools	—	Fri. p.m. GP/HV	—	—	—	Wed. p.m. (alternate) Mon. p.m. (alternate) ST	—	—	—	—	—	—	—	—	—
Huddersfield Divisional Education Offices	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Huddersfield Old Boys' Pavilion, Tandem, Waterloo	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Huddersfield Royal Infirmary	—	—	—	—	—	—	—	—	—	—	—	Fri. p.m. (4 weekly) HMO/HV	—	—	E.N.T. Mon. a.m. as required HMO/HV
Kirkburton Drill Hall	—	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. a.m. M Relax.	Tues. p.m. GP/HV Toddlers quarterly by arrangement ACMO HV Tues. p.m. GP/HV Toddlers quarterly by arrangement ACMO/HV Thurs. p.m. GP/HV Toddlers quarterly by arrangement ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Lithwaite Methodist Church, Stones Lane	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Marsden Conservative Club	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Marsden Mechanics' Institute	Thurs. p.m. (1st in month) ACMO/HV/ M Tues. a.m. M Relax.	Tues. p.m. GP/HV Toddlers quarterly by arrangement ACMO HV	—	Tues. a.m. HV	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Meltham Baptist School	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Meltham Oddfellows Hall	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—



[illegible]







## 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
Royston Wesleyan Sunday School, High Street ...	Tues. p.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, Burnsley Road ...	Thurs. p.m. With Infant Welfare DMO/HV/M	Thurs. p.m. DMO/HV	—	Thurs. a.m. HV (except 2nd)	Thurs. a.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—
Wombwell Public Library, Station Road ...	Tues. p.m. GP/HV(4)	Tues. p.m. GP/HV(4)	Mon. p.m. Fri. p.m. HV	Fri. p.m. HV (alternate)	Mon. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Wombwell Welfare Hall, Jump Wombwell The Gables ...	Mon. a.m. Wed. p.m. M(2) Relax.	Mon. p.m. GP/HV(2)	—	—	—	—	—	—	—	Wed. a./p.m. MH	—	—	—	Daily	—
Worsborough Methodist Church, Birdwell ...	Fri. p.m. (alternate) GP/HV/M	Wed. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Worsborough Methodist Chapel, Blacker Hill ...	Fri. p.m. M Relax.	Thurs. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Worsborough Ambulance Hall, Worsborough Bridge ...	Tues. p.m. (alternate) GP/HV/M	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	Thurs. p.m. GP/HV	Mon. p.m. Fri. p.m. HV	Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
DIV. 26, (WATH) Kilmhurst Church Hall ...	—	Wed. p.m. GP/HV(2)	—	—	Thurs. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	E.N.T. See Div. 30
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	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. Wed. p.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	—



Rock House	GP/HV/M(2)	GP/HV(2)	Mon. a.m. Thurs. a.m. HV	(alternate) ACMO/HV	a./p.m. ST	Wed. a.m. (monthly) DMO/HV/ (3)	Thurs. a.m. (monthly) DMO/HV (2)	Tues. a./p.m. MH	Thurs. a./p.m. (3rd in mth.) HMO/HV	See Div. 28	Mon. a.m. (monthly) HMO/HV	Daily	—
Waltham-on-Dearne Dunford House ...	Fri. p.m. M Relax. Fri. a.m. GP/HV(2)/ M(2) Wed. p.m. Fri. p.m. M Relax.	Mon. p.m. GP/HV(2)	Mon. a.m. Thurs. a.m. HV	Mon. a.m. (alternate) ACMO/HV	—	—	—	Wed. a.m. Thurs. a.m. Fri. a.m. MH	Thurs. a./p.m. (3rd in mth.) HMO/HV	—	—	—	—
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. Mon. p.m. ACMO/HV (2)/M(2) Mon. a.m. HV/M Relax.	Wed. a./p.m. HV(3)/M(2) and DMO a.m. and ACMO p.m. Thurs. a./p.m. HV(2)/M ACMO one session only	Mon. p.m. Wed. a.m. Fri. a.m. HV	—	Tues. a./p.m. ST	Wed. a.m. (monthly) DMO/HV/ (3)	Thurs. a.m. (monthly) DMO/HV (2)	Tues. a./p.m. MH	—	—	—	—	—
Carcroft Presbyterian Chapel, Owston Road ...	—	—	—	—	Thurs. a.m. ST	—	—	—	—	—	—	—	—
Carcroft Carcroft School ...	—	—	—	—	—	—	—	—	—	—	—	—	—
Doncaster Royal Infirmary ...	—	—	—	—	—	—	—	—	—	—	—	—	—
Doncaster Wood Street ...	—	—	—	—	—	—	—	—	—	—	—	—	—
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. (monthly) DMO/HV (2)	—	—	Thurs. a./p.m. (alternate) HMO/HV	—	—	—	—
Woodlands Infants' School ...	—	—	—	—	Thurs. p.m. ST	—	—	—	—	—	—	—	—
DIV. 28. (DONCASTER) Arnhorpe Miners' Welfare Institute	Tues. a.m. ACMO/HV(2) Tues. p.m. (2nd & 4th) ACMO/HV (2)/M	Thurs. p.m. GP/HV(2)	Wed. a.m. Fri. p.m. HV	—	—	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 Wed. p.m. ACMO/M	Mon. p.m. ACMO HV(2)	Mon. a.m. HV Thurs. a.m. (1st, 3rd & 5th) HV	—	—	—	—	—	—	—	—	—	—
Bawtry 25, Council Estate	—	Mon. a.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—
Brodsworth St. Leonard's and St. Jude's Church, Barnsley Road, Scawby ...	—	Tues. p.m. (alternate) HV weighing only	—	—	—	—	—	—	—	—	—	—	—





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## 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 Fri. p.m. GP/HV/M	Tues. p.m. GP/HV	—	Tues. a.m. HV Fri. a.m. except SC, HV Tues. a.m. HV Fri. a.m. except SC, HV	Thurs. a.m. before immunisation clinic Fri. a.m. (4th in mth.) ACMO/HV	—	Fri. a.m. (1st in mth.) ACMO/HV	—	—	Mon. a.p.m. MH	3 weekly as required HMO/HV	—	—	—	—
Dinnington Methodist Chapel, Laughton Road ...	—	Tues. p.m. GP/HV	—	—	—	Thurs. p.m. ST	—	—	—	Fri. a.m. MH	3 weekly as required HMO/HV	—	—	—	—
Kiveton Park Methodist Chapel, Wales Road ...	Thurs. p.m. (2nd in mth.) GP/HV/M	Mon. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Malby Walters Road ...	Wed. a.p.m. GP/HV/M	Mon. p.m. GP/HV	Tues. a.m. HV Fri. p.m. HV Oct.—Apl.	Tues. a.m. HV 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.m. HV Thurs. p.m. GP/HV Mon. p.m. GP/HV	Tues. a.m. HV Fri. p.m. HV Oct.—Apl.	Tues. a.p.m. except SC, HV	Wed. 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. a.m. Thurs. a.m. HV	Thurs. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	As required HMO/HV	—	—	—	—
Thurcroft Modern School ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Thrybergh Poplar Avenue ...	—	Thurs. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Whiston Church Institute, School Hill ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

In addition to the above there are 116 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.

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 1954 on the School Health Service, being the 47th Annual Report of the Principal School Medical Officer.)*

#### Introduction

During the year 1954, the trend noted in my last Annual Report for the character of the School Health Service to place the emphasis on the health of the school child has steadily increased. The need to deal with the whole child in such a way as to fit him to benefit from the education provided for him is becoming increasingly recognised by all who deal with children.

The work of the School Medical Officer carried out as it is so much away from the lime-light leads to a tendency on the part of many to decry its value. But there is evidence that amongst the specialist services the true value of the School Medical Officer in the community is gradually coming to be realised.

The great increase in the work of the School Medical Officers due to ascertaining the various categories of handicapped children has maintained the steady progress noted in the Report for 1953. The anxiety of the Education Committee to do their utmost for all handicapped pupils is evidenced by the opening as day special schools for junior educationally sub-normal children of the former day Open Air Schools at Wombwell and Shipley. These schools will eventually accommodate respectively 55 and 60 children of an age range of 7 to 12. The special schools already in existence have been functioning to capacity and doing excellent work.

The chief difficulty as in previous years lies in the placing of the educationally sub-normal and the spastic child. The younger age group of educationally sub-normal child now presents less difficulty, and this is applicable to the older educationally sub-normal boy, but some older educationally sub-normal girls are difficult to place in a special school. The higher grade of educationally sub-normal child requires to be dealt with in a special class in the ordinary school and the Committee are endeavouring to meet this need in so far as it is possible with the existing school accommodation. A considerable amount of difficulty is still being experienced in placing the spastic child.

The Child Guidance Service is still functioning without a psychiatrist and psychiatric social workers, and this is throwing a very heavy burden of work on to Dr. MacTaggart, the Child Guidance Psychologist. As in my previous report, I deplore the lack of a full tripartite team which is absolutely essential for this particular field of School Health. No single member of this team, no matter how enthusiastic or willing, can possibly carry out the many needs of this service, which requires expert medical opinion in addition to educational psychology and the equally valuable home background histories which should be supplied by the psychiatric social workers. As in previous years, our School Medical Officers continue to give valuable help to many anxious parents on the handling of difficult children.

During the year, the School Medical Officers have attended meetings which, in the majority of cases, have taken the form of a clinical talk given by a consultant. One such meeting arranged by Professor Craig of the Leeds University Department of Child Health took the form of a clinical demonstration given by Professor Craig's Senior Paediatric Registrars at St. James's Hospital, where approximately half the staff attended, the other half attending Seacroft Hospital. These meetings are very well attended by the School Medical Officers as not only do they afford an opportunity of keeping abreast of the times, but also a much valued opportunity of meeting colleagues and discussing difficulties and points of interest.

The position regarding staff has remained fairly stable. It was necessary during the year to review the establishment of School Medical Officers which in 1945 was fixed at 65. Since 1945 there have been many additional duties placed upon the School Medical Officers such as the medical examination of staff for the purposes of superannuation; the examination of school canteen employees; immunisation against whooping cough; the medical examination of entrants to Training Colleges; the introduction of the fourth routine school medical inspection under the School Health and Handicapped Pupils Regulations, 1953; and the new scheme for the B.C.G. vaccination against tuberculosis of the older school child. After reviewing the work of the medical staff it was decided towards the end of the year to submit proposals to the County Council for an increase in the establishment of whole-time School Medical Officers from 65 to 73.

I am pleased to report that the vacant post of Senior Medical Officer for the School Health Service has been filled by the appointment of Dr. Annabella Marshall, who commenced duties in her new post on the 1st January, 1955.

The report includes a detailed account of an extensive outbreak amongst school children of Virus B Influenza which affected large areas of the County.



In conclusion, I wish once again to record my deep appreciation of the never-failing co-operation and help given to me by my colleagues in the Education Department, and to all the teachers throughout the County for their continued interest in the health and well-being of the children. This co-operation is due in no small measure to the interest and enthusiasm of the School Medical Officers whose work in the field is of such vital importance to the School Health Service. I feel it is true to state that co-operation between the teachers and school doctors is becoming a much more accepted fact and is leading to ever increasing understanding between the two professions.

### The Medical Inspection of School Children

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

	Boys	Girls	Total
Nursery .....	284	286	570
Primary (County) .....	69,020	65,528	134,548
Primary (Voluntary) .....	23,928	22,840	46,768
Secondary Modern (County) .....	23,307	22,092	45,399
Secondary Modern (Voluntary) .....	649	894	1,543
Secondary Grammar .....	11,381	11,808	23,189
Secondary Technical .....	1,180	938	2,118
Comprehensive .....	411	388	799
	<hr/> 130,160	<hr/> 124,774	<hr/> 254,934

The total of 254,934 is an increase of 5,689 on the corresponding figure for the previous year.

79,553 periodic medical inspections and 33,956 special inspections and re-examinations were made during the year compared with 77,803 and 34,509 for the year 1953.

As from the commencement of the school year in September, 1953, and following the issue of the School Health Service and Handicapped Pupils Regulations, 1953, it was decided to examine children attending maintained schools as follows:—

- on or as soon as possible after entry for the first time to a maintained school,
- during the year the age of 8 years is attained,
- as soon as possible after entry to a secondary school, and
- during the last year of attendance at a secondary school.

The periodic examination at 8 years of age is additional to the three examinations which were formerly required under the 1945 Regulations and during the year 11,002 children in this age group were inspected. This figure represents only approximately half the total of children of 8 years of age in the schools, but due to other commitments it was not found possible in many areas for the school medical officers to undertake any inspections of children in this age group. With the increased staff referred to in the Introduction to this Report it should prove possible to undertake the inspection of all children in the schools in the four age groups mentioned above.

Of the 28,201 children examined as entrants to the primary schools, 4,329 (15.4%) were found to have defects requiring treatment. This compares with a figure of 30% a quarter of a century ago and serves to show the improvement which has taken place over the years in the general health of children. There are numerous factors to account for this, including a noticeable raising of the standard of general child management no doubt directly resulting from the teaching given at infant welfare centres, improved housing conditions leading to less overcrowding, and better and wiser feeding. Some children are, however, still entering school with defects which could have been treated and resolved during their pre-school years. This is particularly true in the case of ear, nose and throat defects which have reached a chronic stage in many cases by the time the child is 5 or 6 years of age.

The nature of the everyday work carried out at routine medical inspections prevents many people from realising how valuable a part this is of the School Health Service. The mere fact that a School Medical Officer examines so many healthy or near healthy children makes it inevitable that minor deviations from the normal and incipient illnesses are noted and dealt with by doctors whose interest lies mainly in the preventive aspect of medicine. School doctors are all medical officers who have already gained experience in the treatment side of medicine but who have chosen the preventive aspect of their own volition. Therefore, any deviation from the normal, no matter how slight it might appear to anyone else, is at once a challenge to be met and dealt with, whether in the field of physical or psychiatric medicine, and not least of the values of routine medical inspection lies in the opportunity afforded for joint consultation by all the parties interested in the health and well-being of the child—the parent, the teacher, the school medical officer, and the nurse.

It is again necessary to comment on the unsatisfactory conditions which exist in many schools for the conduct of medical examinations. A suitable room, free from noise, should be available



in every school where the medical examination can be carried out thoroughly and efficiently and where there can be proper consultation between the parent, doctor and teacher. Due to the continuing overcrowded conditions in many of the schools as a result of the higher birth rate in the immediate post-war years and the raising of the school leaving age, it is becoming more and more necessary to hire premises locally, in some places distant from the school, in which to conduct the examination. This can only be regarded as unsatisfactory as it means that the teacher is unable to be present at the time of examination.

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 .....	28,201
7 to 8 year group .....	11,002
Last year primary .....	18,030
First year secondary .....	4,308
Last year secondary .....	17,280
<b>Total .....</b>	<b>78,821</b>

Number of other Periodic Inspections .....

732

**Grand Total .....** **79,553**

**B. OTHER INSPECTIONS**

Number of Special Inspections .....

22,838

Number of Re-Inspections .....

11,118

**Total .....** **33,956**

**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 .....	486	4,051	4,329
7 to 8 year group .....	507	1,185	1,608
Last year primary .....	1,078	1,929	2,891
First year secondary .....	304	377	637
Last year secondary .....	1,117	1,636	2,616
<b>Total (prescribed groups) .....</b>	<b>3,492</b>	<b>9,178</b>	<b>12,081</b>
<b>Other Periodic Inspections .....</b>	<b>18</b>	<b>172</b>	<b>179</b>
<b>Grand Total .....</b>	<b>3,510</b>	<b>9,350</b>	<b>12,260</b>

Table II

## A. DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31st DECEMBER, 1954.

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 (1)	Periodic Inspections		Special Inspections	
	No. of Defects		No. of Defects	
	Requiring treatment (2)	Requiring to be kept under observation but not requiring treatment (3)	Requiring treatment (4)	Requiring to be kept under observation but not requiring treatment (5)
Skin .....	1,353	727	842	171
Eyes— <i>a.</i> Vision .....	3,510	4,899	1,130	2,151
<i>b.</i> Squint .....	536	889	150	276
<i>c.</i> Other .....	316	269	227	65
Ears— <i>a.</i> Hearing .....	193	600	94	131
<i>b.</i> Otitis Media .....	258	515	159	143
<i>c.</i> Other .....	303	157	130	82
Nose or Throat .....	2,061	4,288	714	1,326
Speech .....	328	511	216	233
Cervical Glands .....	153	1,362	91	443
Heart and Circulation .....	168	946	57	377
Lungs .....	525	1,388	255	471
Developmental— <i>a.</i> Hernia .....	128	183	26	47
<i>b.</i> Other .....	120	723	33	150
Orthopaedic— <i>a.</i> Posture .....	421	546	69	139
<i>b.</i> Flat Foot .....	807	761	226	237
<i>c.</i> Other .....	665	1,650	244	409
Nervous System— <i>a.</i> Epilepsy .....	62	103	30	55
<i>b.</i> Other .....	176	293	117	137
Psychological— <i>a.</i> Development .....	73	486	167	265
<i>b.</i> Stability .....	109	397	73	123
Other .....	1,499	834	1,472	533

## B. CLASSIFICATION OF THE GENERAL CONDITION OF PUPILS INSPECTED DURING THE YEAR

Age Groups (1)	Number of Pupils Inspected (2)	A. (Good)		B. (Fair)		C. (Poor)	
		No. (3)	% of Col. 2 (4)	No. (5)	% of Col. 2 (6)	No. (7)	% of Col. 2 (8)
Entrants	28,201	14,155	50.19	13,707	48.60	339	1.20
7 to 8 year group	11,002	5,805	52.76	5,047	45.87	150	1.36
Last year primary	18,030	9,100	50.47	8,753	48.55	177	0.98
First year secondary	4,308	2,007	46.59	2,232	51.81	69	1.60
Last year secondary	17,280	9,012	52.15	8,124	47.01	144	0.83
Other Periodic Inspections	732	236	32.24	481	65.71	15	2.05
Total	79,553	40,315	50.68	38,344	48.20	894	1.12

Table III

## Infestation with Vermin

- |   |         |
|---|---------|
| (i) Total number of examinations in the schools by the school nurses or other authorised persons .....                        | 549,961 |
| (ii) Total number of <i>individual</i> pupils found to be infested .....  | 13,619  |
| (iii) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944) ..... | 1,162   |
| (iv) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944) .....   | 42      |



**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	
	<i>By the Authority.</i>	<i>Otherwise.</i>
Ringworm—(i) Scalp .....	32	3
(ii) Body .....	76	7
Scabies .....	85	1
Impetigo .....	2,004	101
Other Skin Diseases .....	4,094	183
<b>Total</b> .....	<b>6,291</b>	<b>295</b>

## GROUP 2—EYE DISEASES, DEFECTIVE VISION AND SQUINT.

	Number of cases dealt with	
	<i>By the Authority.</i>	<i>Otherwise.</i>
External and other (excluding errors of refraction and squint) .....	1,812	274
Errors of refraction (including squint) .....	4	17,691
<b>Total</b> .....	<b>1,816</b>	<b>17,965</b>

## Number of pupils for whom spectacles were—

(a) Prescribed .....	nil.	9,240
(b) Obtained .....	not known	not known

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

	Number of cases treated	
	<i>By the Authority.</i>	<i>Otherwise.</i>
Received operative treatment—		
(a) for diseases of the ear .....	—	60
(b) for adenoids and chronic tonsillitis .....	—	1,977
(c) for other nose and throat conditions .....	—	121
Received other forms of treatment .....	2,252	246
<b>Total</b> .....	<b>2,252</b>	<b>2,404</b>

## GROUP 4—ORTHOPAEDIC AND POSTURAL DEFECTS.

(a) Number treated as in-patients in hospitals .....	286	
	<i>By the Authority.</i>	<i>Otherwise.</i>
(b) Number treated otherwise, e.g., in clinics or out-patient departments .....	1,390	544

## GROUP 5—CHILD GUIDANCE TREATMENT.

	Number of cases treated	
	<i>In the Authority's Child Guidance Clinics.</i>	<i>Elsewhere.</i>
Number of pupils treated at Child Guidance Clinics .....	563	4

## GROUP 6—SPEECH THERAPY.

	Number of cases treated	
	<i>By the Authority.</i>	<i>Otherwise.</i>
Number of pupils treated by Speech Therapists .....	2,118	10

## GROUP 7—OTHER TREATMENT GIVEN.

	Number of cases treated	
	<i>By the Authority.</i>	<i>Otherwise.</i>
(a) Miscellaneous minor ailments .....	40,474	482
(b) Other—		
1. Ultra Violet Light treatment .....	3,838	7
2. Chiropody .....	634	—
<b>Total</b> .....	<b>44,946</b>	<b>489</b>

Table V

## Dental Inspection and Treatment

1. Number of pupils inspected by the Authority's Dental Officers—		
(a) Periodic age groups		93,413
(b) Specials		8,419
	Total (1)	101,832
2. Number found to require treatment		74,063
3. Number referred for treatment		62,951
4. Number actually treated		53,998
5. Attendances made by pupils for treatment		116,815
6. Half-days devoted to: Inspection		922
	Treatment	15,602
	Total (6)	16,524
7. Fillings: Permanent teeth		61,118
	Temporary teeth	4,848
	Total (7)	65,966
8. Number of teeth filled: Permanent teeth		55,040
	Temporary teeth	4,642
	Total (8)	59,682
9. Extractions: Permanent teeth		15,369
	Temporary teeth	87,597
	Total (9)	102,966
10. Administration of General Anaesthetics for extraction		21,100
11. Other Operations: Permanent teeth		28,891
	Temporary teeth	4,200
	Total (11)	33,091

## The Care of the Handicapped Child

Section 34 of the Education Act, 1944, 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. In 1953 the School Health Service and Handicapped Pupils Regulations reduced the list of handicapped pupils from 11 to 10, the category of diabetic being included in the category of delicate, so that at present the children requiring special educational treatment fall into one of the following categories:—the blind, the partially-sighted, the deaf, the partially deaf, the delicate (including diabetic), the educationally sub-normal, the epileptic, the maladjusted, the physically handicapped, and the children with speech defects.

Between 1946 and 1953 there have been established in the West Riding two boarding special schools for the delicate, three for the educationally sub-normal, one for the deaf plus additional handicap, and two hostels for maladjusted children. The school already mentioned for deaf plus additional handicap is now one of two such schools serving the whole of England. During the past year another boarding school for junior educationally sub-normal boys and girls has been opened at Whinburn, Keighley, to accommodate 40 pupils, and two day special schools for junior educationally sub-normal boys and girls at Shipley and Wombwell. The Committee are also planning to build a further two day special schools for the educationally sub-normal and, with the emphasis now being placed more on day accommodation than boarding, this will greatly meet the needs of the service. In spite of the trend to make day accommodation for handicapped children preferable to boarding, there will always remain a percentage of children who will derive more benefit from being removed from the over-protective attitude of some parents which hampers the normal development so much of any child, but to a much greater extent of the handicapped child. The over-protection is a natural manifestation of a parental concern with any handicapped child, but it is sometimes difficult to get a parent to realise that this hampers the development and in the end is really an unkindness to the child. This point was well brought out in a visit to a well-known special school where one of our spastic boys almost failed to be retained because of his dependence on others.

It will thus be seen that this increased awareness of the need to provide for the handicapped child has added considerably to the work of the School Medical Officer. Ascertainment of any one handicap may involve not one but several examinations, and makes it essential that our School Medical Officers are familiar with the latest advances in medicine.



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

Category.	No. of Examinations.
Educationally sub-normal	902
Physically handicapped	343
Delicate	304
Deaf	53
Partially deaf	27
Epileptic	28
Speech (Requiring special school)	2
Maladjusted (Requiring hostel or special school)	51
Blind	10
Partially sighted	10
Double defect	20
Total	1,750

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 Ascertain-ments	New placings in Special Schools	Total No. attending Special Schools		No. Boarded in Homes or Hostels	Number Attending Independent Schools	No. awaiting placement in Special Schools	No. receiving Home Tuition
			Day	Boarding				
Blind	9	10	—	52	—	1	11	—
Partially Sighted	8	16	11	56	—	—	9	—
Deaf	34	23	24	152	—	2	29	—
Partially Deaf	11	8	3	23	—	—	8	—
Delicate	196	173	218	117	1	—	75	2
Physically Handicapped	39	34	3	97	—	4	46	41
Educationally Sub-normal	293	233	141	301	—	3	578	1
Maladjusted	44	39	—	4	45	1	47	—
Epileptic	8	8	—	26	—	—	4	—
Totals	642	544	400	828	46	11	807	44

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

**The Physically Handicapped Child.**—This is a very wide category as it includes diseases of the central nervous system, heart diseases, blood diseases, diseases of muscles, rare congenital diseases, and children crippled as a result of illness or accident.

The three largest groups in this category used to be those of cerebral palsy, post-poliomyelitis, and cases of heart disease, but the last named continues to show a numerical decrease in those recommended for special educational treatment due to increased clinical knowledge. As a result, the physically handicapped group consists largely of cases of cerebral palsy and post-poliomyelitis. It is true that very many of the latter require special educational treatment in special schools for the physically handicapped, if not in Hospital Special Schools, but those who have recovered even partial use of their limbs can be educated in ordinary schools with the sympathetic co-operation of the teachers concerned.

This leaves the cases of cerebral palsy as the largest single group of the physically handicapped. This is a problem which is world-wide in its aspect and as it is a group of conditions it is always better to talk of the cerebral palsies. There are four aims in dealing with cases of cerebral palsy; to establish speech; to establish use of arms; to establish proper use of legs; and to further educational development.

According to Dr. Phelps, the world famous American expert, not all the causes have been found as yet, but so far he is aware of 50 causes (pre-natal or natal) of these conditions. The effect of any one of these causes is damage to the child's brain, as a result of which there is difficulty in moving arms or legs or both, and in addition sight, speech, or hearing may be influenced. The limbs, one or more, may be in a state of spasm in which case the word spastic is used. Again there may be many involuntary movements present, when the case is classified as athetoid. In the athetoid class of case, Dr. Phelps lists 12 different types of involuntary movement, all of which may overlap. The athetoid has little intellectual impairment, so more can be done physically as well as educationally with him, but the spastic has a variable degree of intellectual disturbance. This brief outline serves to show how very difficult cases of cerebral palsy are, not only to diagnose, but to classify and make the appropriate recommendations.

In addition to the physical disabilities in these cases, there may be blindness, deafness (partial or complete), and loss of speech. The degree of physical handicap bears no direct relationship to the intellectual status of the child.

Some authorities, notably the Americans who have done most work on these cases, maintain that 75 per cent. of the cases of cerebral palsy are ineducable. Undoubtedly a large proportion of children suffering from cerebral palsy are educationally sub-normal and to estimate the level of intelligence of these children is an exceedingly difficult task. No case of cerebral palsy should ever be said to be ineducable as the result of one examination alone.



The incidence of cerebral palsy is not accurately known and this is not surprising when one remembers the number of causes. An American survey indicates that 7 cases are born per 100,000 of the population each year.

It will be understood from the foregoing that early diagnosis is essential. The West Riding are fortunate in that so many of their School Medical Officers also attend the Child Welfare Clinics and, with their knowledge of handicapped children and the provisions for such, are in a unique position to recognise and advise on this problem. This is essentially a medical problem and one with which experienced School Medical Officers are well able to deal.

The establishment of pre-school clinics or even the extension of toddler clinics would do much to help in ascertaining such cases early in life.

The Special Schools for Spastics already in existence naturally demand that children admitted to them should be of average or above average intelligence. It will be understood that the education of the spastic, who is also educationally sub-normal, is a most difficult problem. An increasing number of schools for physically handicapped are now admitting a number of cases of cerebral palsy, and this appears to indicate that cerebral palsy should not be considered as an entity, but rather as a part of the very much larger problem of the physically handicapped.

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		
220	80*	76	38	10	16

\*Accommodated as follows:—

Victoria Home Special School, Bournemouth	1
Brighouse Open Air School	5
St. Margaret's School, Croydon	1
St. Chad's School, Prestatyn	1
Heritage Craft Schools, Chailey	6
Welburn Hall, Kirbymoorside	4
Pinderfields Hospital, Wakefield	4
Halliwick Cripples Home, Edmonton	2
Chipping Norton Children's Home	3
Ian Tetley Memorial Home, Hampsthwaite	1
Hesley Hall, Tickhill	6
Bradstock Lockett Hospital School, Southport	4
Adela Shaw Orthopaedic Hospital, Kirbymoorside	2
Exhall Grange, Coventry	4
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	2
Whitiness Manor, Broadstairs	1
Leasowe Children's Hospital	1
Springfield School for Educationally Sub-normal Children	1
Etton Pasture School for Educationally Sub-normal Children	1
Baliol School for Educationally Sub-normal Children	2
Larchfield Special School, Harrogate	1
Rob Roy Special School, Oakham	2
Holly Bank Special School, Huddersfield	12
Braithwaite Open Air School, Keighley	1
Shipley Day Special School for Educationally Sub-normal children	1
Nortonthorpe Hall Hostel for Maladjusted Pupils, Scissett	1
Hoover House Hostel for Maladjusted Pupils, Wentworth	1
Town Hill Park Special School, West End, Southampton	1
Warlies Special School, Waltham Abbey	1
Sheiling Curative School, Thornbury Park, Bristol	1
Hattondale Special School, Wellingborough	1

**The Delicate Child.**—This category consists very largely of the asthmatic and bronchitic children. It also includes the debilitated child whose condition may be due to bad housing, poor feeding, lack of sleep, or overcrowding, but these cases appear to be decreasing. Open air schools for delicate children have been in existence for many years, but with the gradual improvement which has been effected in the health of the school child the need to provide either day or residential open-air special schools is diminishing. The emphasis is gradually being laid on the advisability of attempting to keep the child at home, ensuring that it has adequate treatment there and attends the ordinary school. In some cases a stay of a few weeks at a convalescent home with adequate rest and good food quickly restores a child to normal health. During the year, 117 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 School has accommodation for 40 senior boys, and it has been open throughout the year apart from the Christmas and Summer holidays. Originally it was thought that a majority would benefit more by remaining at school throughout the summer rather than return to what, in some cases, might be described as unsatisfactory homes. But it is to these homes the boys must eventually return, and it seemed psychologically unsound to isolate them for long periods from conditions which they must at some time accept, and to which they must adjust themselves. This is particularly important for the asthmatics, and a definite summer holiday has now been instituted. Other links with home are encouraged, for these are equally important.

The School has now been open for three years, and a pattern of life and treatment has evolved. Furthermore, the place of the School in the educational field now seems to be well recognised, and as a result, the recent admissions are mainly boys whom we feel should be at Netherside; cases who cannot, or have not been successfully dealt with by other forms of treatment, and whom we are glad to see.

Our major concern is still the care of the asthmatics, and we have met with a varying degree of success. Some have done extremely well, but even those still subject to attacks have been able to continue their education with very little or no interruption. The classes are small, and no effort is spared to make up the schooling which so many of the boys have lost before admission. Contrary to general belief, asthmatic children are not on average more intelligent than their colleagues, but intellectual success may be an important factor in lessening attacks. Furthermore, they will usually be recommended for the less arduous forms of employment on leaving, and their education is, therefore, of great importance.

Asthma is a strange disease, being a reaction to various stimuli which may be infective, allergic, psychic or climatic in origin. Its treatment demands team work by physician, radiologist, pathologist, psychiatrist, ear, nose and throat specialist, dentist, dermatologist, physiotherapist—and of course the school teachers. Netherside has a beautiful situation, but unfortunately, it is isolated, and to obtain specialist opinion and treatment means much travelling and inconvenience. However, this disadvantage is now accepted without remark; and it may be that some boys enjoy their bus journeys to Skipton to see the various doctors and the speech therapist, from whom we have had much valued opinion and treatment.

Boys admitted for other conditions, bronchitis, bronchiectasis, rheumatism, non-infective tuberculosis, and a variety of less severe conditions, have all made progress, and in general the duration of their stay is much less than that of the asthmatics, for the latter often have eczema and nasal disorders as accompaniments. The general health of the boys has been good, a streptococcal throat infection which occurred in the autumn being the only common condition.

For the major part of the year, the School has been without a trained nurse. This is a matter of regret, for there are always a few boys requiring special attention. But as there is insufficient work to occupy fully the time of a nurse, it is a difficult position to fill when many hospitals are short of trained staff.

In the Annual Report for 1953, Dr. Harvey, Paediatrician, asked what happened to the hard core of resistant asthma in senior school children. So far as my enquiries go, there is little information available on this point, for asthma has never received the attention which its frequency and often crippling effects deserve. I hope that we shall soon be able to organise a follow-up scheme for the boys who have been at Netherside, and although this will not be easy in an area as large as the West Riding, when the former pupils have taken up employment, I think some interesting information may be obtainable through the Divisional Health Service."

**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.**—In Pamphlet No. 5 of the Ministry of Education "Special Educational Treatment" the estimate of the number of deaf pupils requiring special educational treatment is given as 0.7 to 1.0 per 1,000 registered pupils. At the end of the year there were 207 deaf pupils on the register, 178 accommodated in day or boarding special schools, the remaining 29 awaiting placement. It can, therefore, be assumed that the ascertainment of deaf pupils is reasonably complete.

The earliest ascertainment of both deaf and partially deaf children is essential and here again toddler clinics could be of great value. In the case of the totally deaf child, it is important that ascertainment should take place as soon after two years of age as possible, to enable placement in a special school to be effected by three years of age. As children under five years are not subject to the close and frequent medical observation applied to school children, it may be that some deaf children are not ascertained as early as they could be.



The ascertainment of the pre-school deaf and partially deaf child is largely dependent on many people, the parents, health visitor, family doctor, infant welfare clinic medical officer, and the ear, nose and throat consultant. It has been found that an intelligent parent should be able to assess whether a baby is hard of hearing by the time the child is six months old. If it is suspected that any such baby is hard of hearing the mother can be helped to stimulate the child's hearing acuity by repeated talking to the child at a suitable distance from its ear, if necessary directly into the outer ear. It is believed that by doing this the area of the brain which deals with auditory perception is stimulated. Then at eighteen months old the hearing can be more accurately assessed by an ear, nose and throat consultant and, if necessary, a hearing aid supplied which is strapped to the child's back. This further stimulates the hearing perception area of the brain which develops in the first three years of life, and parallel with this, speech can be developed so that in effect a hard of hearing child in the future should be able to have normal or nearly normal speech. A great deal of work on this important subject has been done by one of the London consultants and it is hoped to get her to address a course to be organised for the School Medical Officers early next year. The University of Manchester is intending to organise short courses of a similar nature for health visitors and school nurses which should prove of great value.

It is likely that there is a number of partially deaf pupils in our schools who remain unascertained and in some cases may be thought to be educationally sub-normal. These are children suffering from a specific type of hearing defect not readily revealed by normal tests. The use of gramophone audiometers for group testing in schools is an invaluable aid in ascertaining the partially deaf and it is disappointing that greater use has not been made of the two audiometers which we have. This is entirely due to the lack of staff to undertake the work, as surveys can only be made by releasing school nurses from other important duties. Surveys are at present being undertaken in the schools in two Divisional areas and the results will be published in the Report for 1955.

**The Epileptic Child.**—There is evidence that more epileptic children are now being retained in the ordinary schools following advances made in recent years in drug therapy for the control of attacks. This is to be welcomed as, with an understanding and sympathetic teaching staff, wise handling by the parent, and reasonable sedation to control attacks, there is no valid reason why the epileptic child should be taken from his home and placed in an epileptic colony. With improved methods of treatment, pressure on places in boarding special schools has lessened and it is not nearly so difficult to place a child within a reasonable period of time as it was a few years ago. Even the educationally sub-normal epileptic has a reasonable chance of being admitted to a boarding special school when the need arises.

I think it wise to note here that a recent article in a medical journal raises the question of epilepsy manifesting itself, not as the classic convulsion and/or unconsciousness, but as vague pains referred to head, body, or limbs, or temporary changes in personality leading to manifestations of aggression, or vomiting which may be described as cyclical or even to a rise in temperature for which no specific cause can be found. The diagnosis of these cases can be confirmed by the taking of an electro-encephalogram and such cases respond to simple sedation.

There is also the fortunate rare case of Salaam Epilepsy with its normal history up to 7, 8, or 9 months of age and its inevitable gross mental deterioration.

**The Educationally Sub-normal Child.**—At the end of the year there were 1,392 educationally sub-normal children on the Register, of whom 445 were in day or boarding special schools, one was receiving home tuition, and 368 had been recommended for special educational treatment in the ordinary school, or in special classes in the ordinary school, leaving 578 on the waiting list for admission to day or boarding special schools. The 1,392 children ascertained mainly represent the more severely retarded children and it is likely that there may be in the schools some thousands of children who could be classed as educationally sub-normal to a minor degree — children just short of being of average intelligence, those with certain specific educational disabilities, and those who are retarded due to frequent absences from school resulting from illness or other reasons.

It is of some significance that an appreciable number of severely retarded children are first brought to the notice of the medical staff at the age of eleven when they enter the secondary modern schools which would appear to indicate that they do not present such a difficult problem in the primary schools. Late ascertainment does, however, put an undue pressure on the senior schools for the educationally sub-normal and many children cannot be placed. It is much more in the child's interests to ascertain at an earlier age when 2 or 3 years in a special school for pupils of junior school age can effect such an improvement that the child is able to return to a 'C' stream of a secondary modern school and hold his own at the age of 11 or 12.

It is hoped that the introduction of the additional routine medical inspection at the age of 8 will help to discover those educationally sub-normal pupils who should be benefiting from education in day or boarding special schools. For example, the child who at this age is unable to read letters in a visual acuity test would immediately be suspect. Much can also be done by discussion between the school medical officer and the teacher at the time of the examination.

With the increased day special school provision at Wombwell and Shipley and as a result of increased provision by other Local Education Authorities it is pleasing to note that the number of children requiring education in a special school fell from 681 at the end of 1953 to 578 at the end of 1954. The figures are still formidable, however, and serve to indicate how much yet remains to be done in this field.



During the year 132 children were reported to the Local Health Authority under Section 57(3) of the Education Act, 1944, as being ineducable and 120 under Section 57(5) as requiring supervision after leaving school. It cannot be too strongly emphasised how much care and serious thought is given to all such cases by the examining medical officer, as indeed to all the ascertainment of handicapped children. This is particularly true of the very young mentally handicapped child, and makes it essential that the ascertainment is done by an experienced School Medical Officer. The examination entails so much more than a mere assessment of intelligence, comprising as it does a most comprehensive history which includes the ante-natal history; any unusual feature at birth or in the neonatal period such as a period of anoxia; any delay in the milestones of development; or any physical condition which may contribute to the delay in the normal development of the child.

**The Maladjusted Child.**—I regret very much to have to report once again that neither a psychiatrist nor psychiatric social workers have been appointed. A child guidance service without the three essential components of psychiatrist, psychologist, and psychiatric social worker is a mutilated affair, quite incapable of giving efficient service in this important aspect of School Health in spite of all the work so willingly undertaken by the psychologist, Dr. MacTaggart. In such a large area as the West Riding, with its 250,000 school children, it is absolutely essential that there should be a psychiatrist on the staff who can organise and administer 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 with his wide knowledge of both general and psychiatric medicine he would be in a position to assess the needs of the service and advise on future development.

I am again grateful to Dr. MacTaggart for the immense amount of work she has done single-handed in the child guidance centres, and for the interest she has shown in the two hostels for maladjusted children. Her centres at Wakefield, Rawmarsh, Shipley, Mirfield, and Skipton have been working to capacity as the following table shows:—

	Boys	Girls	Total
1. No. of new cases seen during year	144	83	227
2. No. of cases continuing attendance from previous year	220	116	336
3. Total number of cases seen during year	364	199	563
4. Total number of attendances made during the year	1,330	757	2,087
5. No. of cases recommended for residential treatment in a Hostel for Maladjusted children	33	24	57
6. No. of cases referred for psychiatric opinion—	8	5	13
7. No. of cases examined at the particular request of the Magistrates	12	2	14
8. Types of problem for which cases were referred to Child Guidance Clinic—			
(a) Behaviour	174	84	258
(b) Delinquency	29	7	36
(c) Nervous problems	83	75	158
(d) Enuresis	32	20	52
(e) Educationally sub-normal	19	6	25
(f) Intelligence quotient assessment only	6	4	10
(g) Advice on education	7	—	7
(h) Advice on employment	1	—	1
(i) Other	13	3	16

**Children with Speech Defects.**—By the training of selected students after the War the Authority's staff was gradually built up until by 1952 there was a speech therapy service available throughout the County with the full establishment of ten speech therapists employed. In 1953 the establishment was increased to eleven to provide a service in the junior boarding schools for the educationally sub-normal. Early in 1954 it was felt that the service had been in uninterrupted operation sufficiently long to undertake a review of the establishment. With an establishment of ten, the number of school children per speech therapist varied between 18,000 in some of the scattered rural areas to as many as 30,000 in the smaller heavily populated areas. In reviewing the service regard was had to the existing waiting lists of children requiring treatment, the need for the speech therapists to devote sufficient time to visiting schools and the children's homes, and the average length of time considered necessary to treat different types of speech disorders. The County Council agreed to the proposals submitted to increase the establishment from 11 to 13 and in the revised areas the number of children per speech therapist varies between 14,000 and 21,000.

Having built up a reasonably adequate service during the past few years and made arrangements to improve and expand it in the future, it is disappointing to record that during 1954 we were unfortunate in losing the services of no less than five of our speech therapists and have been able to replace only two of these with students trained by the Authority. The staff left either because they were marrying and removing out of the County or were married and starting families. The next student being trained under the County scheme will not be available until September, 1956. It would appear that the wastage is higher than was considered at one time and arrangements have been made through the grammar schools to advertise the attractions of speech therapy as a career and of the County Council's Training Awards in an attempt to induce more girls to train for this type of work.



At the end of the year there were 45 speech therapy clinics in operation and the following table gives details of the work undertaken during the year:—

1. No. of sessions held during the year			4,082
	<i>Stammers</i>	<i>Speech Defects</i>	<i>Total</i>
2. No. of new cases admitted for treatment during the year	185	734	919
3. No. of cases continuing treatment from previous year	336	806	1,142
4. Total No. of cases treated during year	521	1,540	2,061
5. No. of cases discharged during year:—			
(a) Speech normal	140	571	711
(b) Unsuitable for treatment	27	96	123
(c) Left school	32	36	68
(d) By reason of non-attendance	42	123	165
(e) Other reasons	6	36	42
6. No. of cases awaiting treatment at end of year	611	84	695
7. No. of visits made to schools	320	14	334
8. No. of home visits	69	4	73

### The School Ophthalmic Service

The number of children dealt with through the School Ophthalmic Clinics shows a further slight increase on the number for 1953. This is particularly pleasing when one considers the situation of many of the clinics in the rural areas which in some cases are not particularly well-equipped and which may involve parents in some inconvenience in attending from a distance.

It is interesting to note from the statistics on the findings at school medical inspections the few number of entrants with defective vision (486 out of 28,201 in 1954), compared with the number when the children are examined in the last year at a primary school (1,078 out of 18,030). Although the school nurses visit the schools regularly in most areas to make visual acuity tests and select children for referral to the eye clinic, it does seem advisable that the school medical officer should be brought into the procedure at some intermediate stage during a child's primary school years. The additional routine inspection at or about 8 years should prove most useful in this respect as this is an age when many progressive eye defects begin to occur.

In the Report for 1953 reference was made to the statement in the Report of the Chief Medical Officer on the Health of the School Child for the years 1950 and 1951 to the effect that it was disturbing to find that the number of children with squint found at periodic medical inspection had increased sharply between 1949 and 1951. This did not appear to be the case so far as the West Riding was concerned where the percentage of children with squint of the total number inspected had fallen from 1.7 in 1947 to 0.8 in 1953. In 1954 this percentage fell further to 0.7.

The following figures show the number of children examined at the ophthalmic clinics during each of the years 1948 to 1954 and the number for whom glasses were prescribed:—

<i>Year</i>	<i>No. of children examined (including re-examinations)</i>	<i>No. prescribed glasses</i>
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
1954	17,691	9,240

### 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, 1954:—

Type of Clinic	Number	
	Provided directly by the Authority	Under arrangements with Regional Hospital Boards
Minor Ailment	212	—
Dental	32	—
Ophthalmic	—	66
Speech Therapy	45	—
Orthopaedic Treatment Centres	16	—
Ultra Violet Light	49	—
Paediatric	5	12
Chiropody	3	—
Consultant E.N.T.	—	19
Consultant Orthopaedic	—	17
Consultant Dermatology	—	1
Consultant Cardiac	—	2

A detailed list of the various clinics showing the days and times open is given in the section of the Report dealing with Child Welfare.



## Consultant E.N.T. Service

## CONSULTANT CLINICS.

1. No. of sessions held during the year	204		
	<i>Pre-school Children.</i>	<i>School Children.</i>	<i>Total.</i>
2. No. of individual children seen by consultant, including those continuing attendance from previous year	128	1,937	2,065
3. No. of (2) above referred for operative treatment	75	1,105	1,180
4. No. of children—			
(a) who obtained operative treatment during the year	74	1,016	1,090
(b) treated at school clinics	2	176	178

## Consultant Orthopaedic Service

## A. CONSULTANT CLINICS.

1. No. of sessions held during the year	220		
2. No. of individual patients seen by consultant, including those continuing attendance from previous year	408	1,166	1,574
3. No. of (2) above—			
(a) referred for operative treatment as short-stay cases only	8	66	74
(b) recommended long-stay hospital school	1	6	7
(c) recommended treatment by orthopaedic nurse or physiotherapist—			
(i) at treatment centres	45	200	245
(ii) domiciliary	21	10	31
4. No. of children who obtained operative treatment during the year	10	74	84
5. Total number of attendances at consultant clinic	557	1,623	2,180

## B. TREATMENT CENTRES.

1. No. of sessions held during the year	1,121		
2. Total No. of patients treated (including cases continuing treatment from previous year)	173	850	1,023
3. Total number of attendances	1,726	8,474	10,200

## C. DOMICILIARY TREATMENT.

1. Total number treated	—	1	1
2. Total number of visits to patients' homes	301	604	905

## D. APPLIANCES.

No. of appliances—			
(a) recommended	52	160	212
(b) obtained	45	148	193

## Paediatric Service

## CONSULTANT CLINICS.

1. No. of sessions held during the year	206		
2. No. of individual patients seen			
(a) New cases	106	391	497
(b) Cases attending from previous year	92	431	523
3. Total number of attendances at clinics	295	1,093	1,388

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

<i>Defect or Disease.</i>	<i>Pre-school Children.</i>	<i>School Children.</i>	<i>Total.</i>
Central Nervous System	10	46	56
Heart and Circulatory System	14	188	202
Respiratory System including E.N.T. Defects	25	146	171
Speech	7	6	13
Orthopaedic	5	6	11
Skin	4	7	11
Psychological	23	37	60
Mental Defect, including educational sub-normality	25	20	45
Congenital Deformities	13	12	25
Gastro-intestinal System	13	17	30
Epilepsy	5	43	48
Genito-urinary System	1	7	8
Glands	1	6	7
Nutritional	6	58	64
Developmental	20	22	42
Habit Spasms	1	10	11
Incontinence	9	117	126
Migraine	—	30	30
Unclassified	16	44	60
	198	822	1,020



### Minor Ailment Clinics and Other Non-specialised Clinics

As the treatment of minor ailments remains a function of the School Health Service, the clinics held in various parts of the County for this purpose continue to fulfil a very useful function. In the populous urban areas, the clinics for minor ailments and other non-specialised conditions have large numbers in attendance and a school medical officer is necessary as well as a school nurse. In the majority of these busy clinics there is excellent liaison between the general practitioners and the staff of the School Health Service; in many cases the general practitioners themselves advise children to attend the clinic.

These busy minor ailment clinics resemble an out-patient department of a hospital without the hospital atmosphere. The case load shows a bewildering variety of clinical material, referred to the School Medical Officer by the parents themselves, by teachers, or as already mentioned by general practitioners. In the majority of cases, the School Medical Officer deals with the many and varied complaints and when specialist opinion is desired this is obtained after consultation with the general practitioner concerned.

In some rural areas there are insufficient numbers to justify a fixed clinic with the attendance of either a School Medical Officer or school nurse. Where this state of affairs exists, the school nurse attends at regular intervals certain schools in her area and holds a minor ailment clinic there in addition to carrying out her other duties in the school such as cleanliness inspections. This regular attendance of school nurses helps to achieve the closer co-operation between the education and health services which is the goal of all members of the School Health Service.

### 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
1954	549,961	13,619	5.3

It is pleasing to note the gradual improvement over the past few years in the incidence of infestation and particularly the substantial reduction in the number of cases occurring in 1954. It would appear that the persistence and hard work of the school nurses is at last producing worthwhile results. The figure of 5.3% of school population found to be infested in 1954 is still large and there are no grounds for complacency. Infestation is a condition which can be remedied quickly with the range of insecticides which are available today and it remains a question of educating the parents to the belief that cleanliness is worth-while.

### Nutrition

Figures of the general physical condition of children examined at periodic medical inspections are given below for 1954 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 and is now little more than one per cent. of those examined. 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
1954	79,553	40,315	50.7	38,344	48.2	894	1.1



The number of meals provided to school children according to a check made in October, 1954, was 117,910 compared with 112,436 in October, 1953.

### Medical Examination of Entrants to Training Colleges

In connection with their applications for entry to Training Colleges, 886 students were medically examined during the year by the School Medical Officers, compared with 766 for the previous year.

### Protection of School Children against Tuberculosis

**Tuberculin Testing of Entrants.**—Few of the Divisions introduced the scheme for the routine tuberculin jelly testing of entrants during the year. The purpose of tuberculin testing is that in the case of positive results it will 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 medical supervision until the risks following primary infection are eliminated. Negative results are also of value in the diagnosis of obscure illnesses in childhood by removing suspicions of various forms of tuberculosis and directing diagnosis to other alternatives.

The following are details of some of the surveys undertaken in the County during the year:—

**Settle (No. 2) Division.** The parents of 379 children consented to the test (17 only refused). Of the children tested, 360 were found to be negative and 19 positive. The latter were followed-up but no adult case of tuberculosis was discovered. It was thought that the infection may have been milk borne.

**Wath upon Dearne (No. 26) Division.** 386 children were tested. Of these 381 were found to be negative. The remaining 5 positive cases were referred through the family doctor to the Chest Physician for follow-up.

**Doncaster (No. 28) Division.** 597 children were tested. Of these 574 were negative. The 23 positive cases were referred to the Chest Physician for follow-up. Nine of these cases were kept under observation at the Chest Clinic. In no instance was a previously unknown adult case of tuberculosis found.

**Barnsley (No. 25) Division.** The following report is submitted by Dr. R. S. Hynd, Divisional Medical Officer:—

"A routine survey of school entrants with a tuberculin jelly test was commenced in the Wombwell, Worsborough, Darfield, and Dodworth Districts in September, 1954. It will be appreciated that this was not completed in one school term and this report, therefore, only covers part of the survey and that the remainder will be included in next year's report. I give below details of testing:—

School	No. of children offered Tuberculin	No. of parents accepting	Positive results	% of acceptances	% Positive	Remarks
Worsboro' Ward Green.	53	43	2	81	4.6	One child referred to Chest Physician by us and the other by own Doctor.
Worsboro' Dale Council Inf.	121	98	—	81	—	
Wombwell Barnsley Road Infants.	58	50	—	86	—	
Wombwell Kings Road Infants.	78	69	5	88	9.3	3 referred to Chest Physician, the remainder already under supervision by him.
Wombwell Jump Council Infants.	59	36	1	61	2.8	Referred to Chest Physician.
Wombwell Hemingfield Ellis.	39	38	—	98	—	
Darfield (2 schools)	157	119	4	76	3.4	3 cases referred to Chest Physician and the other was already under observation by him.
TOTALS	565	453	12	80	2.6	

The procedure adopted was to ask the parent of each child who was found to be tuberculin positive to attend the clinic, together with any other children of school age in the family. A careful history was taken and a patch test applied to each of the other children. The details were then communicated to the Chest Physician who investigated the whole family. No active tuberculosis was discovered as the result of this survey but it was strongly suspected that one mother was active eighteen months ago and she is being kept under observation by the Chest Physician. One father was discovered to have early pneumoconiosis. The results of clinical and X-ray findings were communicated to the General Practitioners concerned and good co-operation was established with the Chest Physician and the General Practitioners, but I do not feel this scheme would have worked as smoothly if it had not been for the patient work of the Tuberculosis Health Visitors in securing the attendance of the families at the chest clinic."



**B.C.G. Vaccination of Older School Children.**—Particulars of the Authority's scheme for the B.C.G. vaccination of thirteen-year-old children and of the number of children dealt with during 1954 will be found in the section of the Report on Epidemiology.

### Outbreak of Influenza 'B' in School Children

During early November, 1954, an outbreak of influenza 'B' amongst school children occurred in the Harrogate Division of the County. This followed reports of earlier outbreaks of a similar nature in other parts of the country, notably Sunderland. The infection spread rapidly and by the last week in November and first week in December a large area of the County was affected. The pattern and symptoms of the disease were typical of influenza type B and bacteriological examination of specimens taken in some of the affected areas confirmed this. Urban and rural areas alike were affected, some more than others. The area of the County where the epidemic was heaviest was in the area surrounding the Barnsley County Borough, where on the 26th November, 5,752 children were absent from school out of a total of 13,143. In some of the schools in this area the attendance rates were as low as between 40% and 50%. By the end of the first week in December the peak of the epidemic was past and attendance rates at the schools improved to the normal 80% to 90% for the time of year.

The following is an extract from a report by Dr. D. D. Payne, Divisional Medical Officer, on the outbreak in the Harrogate Division:—

"On November 10th I was notified that at Ashville College, a private school which takes 250 boarders and approximately 80 day boys, there was a sudden epidemic, 40 of the boys had developed influenzal symptoms. There was a raised temperature, in some cases as high as 104° and 105°, headache and pain behind the eyes, tracheitis and in a number of cases vertigo. In one or two instances vertigo was severe, causing the boy to fall over if he endeavoured to stand. In a few cases also there was epistaxis.

The day boys were excluded from school but the boarders were kept at the school and in the next few days 140 of the boys were affected and 10 members of the staff of this school.

On November 18th it was decided to send the remaining boarders to their homes and it is intended to re-open the school on November 25th.

This epidemic in the school appeared to be typical of influenza, specimens were taken by the Public Health Laboratory Service but the results of this investigation are not yet available.

On November 11th I was informed by the Headmaster of Grove Road Primary and Infant school that in his school, which numbers 660, there were 109 absent with influenza-like symptoms. This number rose during the following week to a total of 306 children absent from this school by the following Friday. This number has shown a slight decrease today when the number absent totals 270.

On November 15th a further outbreak of this influenza like epidemic affected a second school, Western Primary School, 128 children being absent, this number rose to 159 and today numbers 158. Other schools such as Bilton Grange Primary and Bilton Endowed School have also a number of cases. In the remaining schools there are comparatively few children absent with this condition.

The present epidemic has spread to Ripon and Pateley Bridge where in some schools 50% of the pupils are affected and I have learnt today there is an outbreak in Scarborough.

Whilst only comparatively few adults have been so far affected in this second outbreak, there is a higher percentage affected than in the previous epidemic originating in Knaresborough."

The following report by Dr. D. P. Lambert, Divisional Medical Officer, on the outbreak in the sparsely populated rural areas of Bowland, Sedbergh, and Settle is of particular interest, particularly Dr. Lambert's observations on the changing pattern of rural epidemiology as a result of the post-war introduction of the Secondary Modern School, drawing its pupils from a wide area:—

"The pattern of the influenza outbreak is now clearer.

It began in Bentham (private) Grammar School on the 29th October, 1954. How it reached there is a mystery. On the 5th November, 1954, this school broke up for the half term holiday, and several sick children were sent home with the others. The School reassembled on the 10th November, 1954, and suffered a sharp epidemic, which the closing of the school for five days apparently did nothing to check.

From Bentham Grammar School infection was carried to Gisburn Junior School, and to Burton-in-Lonsdale and to Ingleton Secondary Modern School. The three junior schools in Bentham and the Junior School in Austwick might also have been infected from Bentham Grammar School directly, but they had contacts with Ingleton Secondary Modern School as well, and, I think, were more likely to have been infected from there. If it had been directly from the Grammar School they would have gone down sooner.

From Ingleton Secondary School the infection spread to Ingleton Primary, Langcliffe, Stainforth, Horton-in-Ribblesdale, Clapham, and Chapel-le-Dale Primary Schools.

From Gisburn Primary School the infection reached Riversmead (Grindleton) Secondary Modern School, and spread thence to Grindleton C. of E., Waddington and West Bradford, Bashall Eaves, Slaidburn and Paythorne Primary Schools. In the case of Paythorne the infection may have come direct from Gisburn, which is nearby.

An independent source of infection exists in Kirkby Lonsdale, Westmorland, and from schools there has been carried to Sedbergh and Newby Primary Schools, and from Sedbergh to Garsdale School.

I can see nothing to stop the infection from spreading farther, and am rather surprised that some places have been spared than that so many have been attacked, seeing that Secondary Modern Schools have been infected. The coming of these schools changed the pattern of rural epidemiology. Whereas infections like measles and influenza used to be small and confined to one village or to one Dale, they now spread quickly to all parts of the District and places widely apart are attacked simultaneously, at least they are if the Secondary Modern Schools are affected, if not the old pattern is still followed.



Clinically this outbreak is moderately severe. It is worst in the Junior Schools, less severe in Infant and in Senior Schools. Adults are being attacked too, notably but not exclusively teachers. In Bentham particularly the largest employers of labour notice an increase in sick-absence. The onset of the disease is with prostration, fever up to 102°—103°, though sometimes higher, headache, other vague pains, and nasopharyngitis. Epistaxis has been noted in about 5—10% of cases. The acute illness lasts 3—4 days, and in about 15—20% of cases there have been nausea and diarrhoea with unlocalised abdominal pain. Convalescence is attended by weakness, depression, and lassitude, and in a proportion of cases bronchitis and broncho-pneumonia have supervened. Children who get up too soon have often been forced to go back to bed with a chest complaint."

The following is an extract from Dr. Lambert's final report when the epidemic was on the wane:—

"In the five weeks of its life the clinical pattern of the influenza outbreak has changed. When it began epistaxis and gastro-intestinal symptoms were spontaneously complained of and were common; later these symptoms occurred occasionally but were not spontaneously mentioned; now no cases of nose bleeding and very few of gastro-intestinal upset are recorded. The most constant feature has been circum-pharyngeal inflammation, most intense on the soft palate; not a tonsillitis, as more than one family doctor has emphasised. Where temperature charts have been kept the temperature has been characteristically saddle-shaped, like sand fly fever, or (on a different scale) smallpox. In the later outbreaks convalescence is prompter, and is not marked by the same lassitude as at first, but chest complications seem to be as common.

Parallel with this change in clinical picture has been a reduction in infectiousness. Cases have occurred in Settle Girls' High School, and in Settle Junior School but there has been no explosive outbreak. In Sedburgh, where the infection came rather later from Kirkby Lonsdale to the Church of England Primary School and also to the Primary School in Garsdale, there was an outbreak. Contacts of cases from the Sedburgh Church School have taken the infection to Sedburgh Secondary Modern School and to the other Junior School in Sedburgh, but the infection has only spread sporadically in those schools, and not from them anywhere else.

In Settle itself, there seems to have been a degree of resistance to the infection, because although there were early infecting contacts, there was no epidemic spread. Certain other schools that escaped seem to have escaped by reason of small size, remoteness, and absence of infecting contacts; but that does not apply in Settle. Similarly the Hellifield area did not suffer, because their infecting contacts were few and late.

The impression I have is of a decline in the virus, rather like that from a smooth to a rough strain of *Salmonella typhi*, or of other bacteria in passage through animals, but that is pure speculation. What I do know is that a month ago we had an acute epidemic influenza and now we are getting back to the usual winter coughs and colds."

## 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:—

It is now clear that Child Health includes children's mental health, so the circle of our interest and influence spreads widely. "The world is our parish", and we come to rub shoulders and tread toes with educationalists, employers and other remote unknowns. The mental health of school leavers requires secure prospects for a career. But what if teachers are choosy, and appear to lose interest in the vocation of girls who don't intend to be teachers themselves? I hear this story too often to discount it entirely. And what will be the effect on our Infant Mortality Rate of the attitude of the Headmistress of a leading Grammar School, who last year told a fifth-former, "You needn't worry about the General Certificate of Education as you're only going to be a nurse." Will we still secure keen Health Visitor recruits?

I know that Divisional Medical Officers and Health Visitors often correspond directly with hospital almoners over cases, to their mutual advantage. What happens with hospitals which so far have no almoner? Are the Divisional Medical Officers and their Health Visitors at a loss for liaison, since visiting Health Visitors cannot be at the hospitals all the time? Paradoxically, in one area where there is good Health Visitor liaison, standing to gain most by enhanced contact on the hospital side, local sentiment still thinks the introduction of almoners would be the thin end of a white elephant.

## The Emotions of School Children

Perverse behaviour is often the child's reaction to starvation of affection. In one case the unavoidable circumstance was protracted illness and death of the mother, followed by an elderly rigid stepmother, leading to deranged bowel control, pilfering and untruths in a 7 year boy. In an 8 year girl, the tantrums occurred only at home and seemed secondary to mother's losing her grip with a "nervous breakdown" a year earlier. In other cases the "groan-ups" simply ask for trouble through concealing facts. There was the intelligent 8 year old only girl, independently finding herself a piano teacher, telling "deliberate lies", whose mother could not bear to divulge the fact of a first-born boy, killed on the road long ago. As soon as this girl could read tombstones her tantrums began: she knew she could not trust her parents for guidance. When she was taken honestly into confidence she responded normally at once.

## The Air Passages

Family doctors can help create a wholesome climate of opinion about respiratory ailments by resisting the public demand for awe-inspiring Greek names, which folk expect as much as their bottle of physic. If we were to speak of nose drip instead of "catarrh", cough instead of "bronchitis", sore throat instead of "tonsillitis", parents would be less scared and less disposed to press for needless second opinions or operations. The word "tonsillitis" naturally suggests that the child will never be right without an operation.



On the whole, I am happy about the position of the Tonsil Pendulum. In doubtful cases it could yet be stabilized by suggesting that children be not proposed to E.N.T. Consultations during the notorious Infant School period, when sore throats and colds will recur at frequent intervals anyhow. If children are still getting sore throats half a dozen times annually after entering the Junior School, there is a case for consultation. This does not apply to the more serious adenoid symptoms which are urgent at any age. Decision to carry out tonsil and adenoid operations is best made after a sufficiently long period of observation has excluded other causes for the complaints. A recent study claims that a person who has lost his tonsils is more susceptible to bulbar and bulbo-spinal forms of poliomyelitis, even though the tonsillectomy may have been done some years earlier. This suggests re-evaluation of the indications for operation. The prize story of 1954 in this section is of a 7 year old boy, whose parents kept him away from school for a whole fortnight, purely in order to contrive that he should not catch a cold which might prevent his keeping an appointment with the Consultant Throat Surgeon, with a view to getting on to the tonsil waiting list. This youngster had two or three sore throats a year and a snorting habit spasm of his palate.

#### **Asthma and Bronchitis**

For future study, I am wondering whether we could contrive a longitudinal survey of all children newly ascertained as handicapped with asthma and bronchitis. Such a survey might take account of family and environmental history, allergy, smoke pollution, family morale, domestic circumstances, sinusitis and E.N.T. complications, X-Ray appearances, loss of school time, experience at residential schools, physical growth and a follow-up of adaptation in employment and loss of working time after leaving school.

#### **Migraine in Childhood**

Migraine is numerically one of the commoner conditions referred by family doctors or School Medical Officers during the years of school life. The diagnosis seems, in many cases, to have caused much perplexity and often anxiety because parents have imagined that symptoms, which recur so frequently and cause so much upset, must surely be serious. The emotions of teachers, similarly, are vigorously stirred in the direction either of compassion or exasperation. They may have to send a child home from school repeatedly, and parents are reluctant to return the child to school lest another attack should follow. As recently as 1955, a broadcasting oracle spoke for 5 minutes about periodic stomachaches and headaches in childhood, without using the word 'migraine'. He cited Hector Cameron's "Nervous Child", mentioned acidosis, emotional stress, eye-strain and sight testing, without positively stating that all such considerations are secondary to straightforward periodic migraine.

#### **Epilepsy**

It is clear that we shall need to make much greater use of electro-encephalograms if we are to do the right thing for many youngsters with doubtful atypical symptoms. It is not adequate to adopt an attitude of indefinitely waiting to see what will emerge. In one recent instance of a 12 year boy in Local Authority care, who came from an extremely abnormal home, the E.E.G. put him in the clear as regards suspicion of malingering his fits and bad behaviour, as it showed very active temporal lobe discharges. In another fascinating case, an 8 year boy had begun having major fits, in which he saw a full fortification spectrum for 5 minutes before losing consciousness. His E.E.G. was characteristic of major epilepsy; presumably the cerebral vascular disturbance of migraine attacks was capable of setting off the discharges in his predisposed brain.

It has been a pleasure again to find that several supposedly epileptic toddlers were, in fact, displaying innocent breath-holding convulsions, the characteristic description of which had been missed in earlier clinical examination.

#### **Surgery of the Heart**

A moderately handicapped, moderately blue boy with Fallot's Tetralogy, whose football had hitherto been confined to the goalmouth, was elected by his friends to the centre forward position within four weeks of his operation at Sheffield.

### **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-fifth Annual Report on the work of the School Health Services of the Borough for the year 1954.

The most important development during the year was the introduction of a scheme providing for the routine medical inspection of all scholars on four separate occasions during their school life, thus superseding the old scheme of three routine medical inspections. There can be no doubt about the advantages of such a scheme and I am glad that the time has arrived when circumstances have made this possible.



During the year 148 school entrants were invited to submit to routine tuberculin jelly testing, of these 138 accepted and the results are set out in the body of this report. The response is encouraging, the clinical value of this measure is of the highest importance not only to the individual child but to the school community generally. I hope the co-operation of all parents will continue.

It is gratifying to note the very moderate incidence of infectious disease. Dysentery figured rather more prominently than usual but all cases were mild and with the co-operation of my colleagues in general practice was very soon brought under control.

The scheme whereby the Area Youth Employment Officers visit schools when the child is due to leave is finding general acceptance. Their advice, in co-operation with the School Medical Officer, as to suitability for employment or choice of career is much appreciated.

I have great satisfaction in acknowledging the excellent work of every member of my staff during the year, all have given of their best. Our relations with the Borough Education Officer and his staff continue in the most cordial atmosphere.

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 Hall at Oxenhope C. of E. and in the Domestic Subjects room of St. Annes R.C. Schools. New floors have also been installed in seven classrooms at Highfield Secondary Modern School. The Worth Village Nursery Hut floor has been tiled. Playgrounds have been re-surfaced at various schools. St. Annes R.C. School has been re-wired. Washbasins have been replaced at Haworth Secondary Modern School. 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 four 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 year in which the age of 8 years is attained;
- (c) every pupil attending a maintained secondary school shall be inspected as soon as possible after admission to such a school;
- (d) every pupil attending a maintained secondary school shall be inspected during the last year of attendance at such a school.

In addition children attending Nursery Schools are examined at least once each year until reaching compulsory school age.

Having regard to the Authority's Youth Employment Service particular attention has been given to the medical examination at paragraph (d) 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 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 5,841, Secondary Modern 1,338, Secondary Grammar 1,228, 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) = 7 to 8 year group, (c) = First year secondary, (d) = Last year secondary.



TABLE I

## A. PERIODIC MEDICAL INSPECTIONS

Number of Inspections in the prescribed Groups.

Entrants .....	1,013
7 to 8 year group .....	875
First year secondary .....	295
Last year secondary .....	502
Other periodic .....	91
<b>Total</b> .....	<b>2,776</b>

## B. OTHER INSPECTIONS

Number of Special Inspections .....	918
Number of Re-inspections .....	1,100
<b>Total</b> .....	<b>2,018</b>

## Findings of Medical Inspection

## (a) CLASSIFICATION OF GENERAL CONDITION OF PUPILS.

Detailed figures regarding the general condition of pupils 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	1,013	610	60.2	392	38.7	11	1.1
7 to 8 year group	875	581	66.4	289	33.0	5	0.6
First year secondary	295	197	66.8	98	33.2	—	—
Last year secondary	502	357	77.1	144	28.7	1	0.2
Other Periodic Inspections	91	6	6.6	73	80.2	12	13.2
<b>Total</b>	<b>2,776</b>	<b>1,751</b>	<b>63.1</b>	<b>996</b>	<b>35.8</b>	<b>29</b>	<b>1.1</b>

All cases of poor nutrition are investigated and severe cases are referred to the Open Air School. The provision of free milk and mid-day meals at school has done much to improve the general condition of children. 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.
30.6.54	304	3,015	(Figure unavailable)
30.10.54	314	3,421	6,360

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 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 .....	35
Adexolin .....	280
Vitamin C. ....	1,003
Minadex .....	147
Vitamin B. ....	166
Fersolate .....	552

## (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 .....	6	173	174
7 to 8 year group .....	33	117	142
First year secondary .....	22	27	47
Last year secondary .....	42	31	70
Other Periodic Inspections .....	2	100	91
<b>Total</b> .....	<b>105</b>	<b>448</b>	<b>524</b>



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 .....	57	55	102	8
Eyes— <i>a.</i> Vision .....	105	112	65	37
<i>b.</i> Squint .....	36	26	21	6
<i>c.</i> Other .....	36	10	43	2
Ears— <i>a.</i> Hearing .....	4	12	11	4
<i>b.</i> Otitis Media .....	15	23	23	1
<i>c.</i> Other .....	5	5	8	2
Nose or Throat .....	59	191	39	15
Speech .....	22	17	42	3
Cervical Glands .....	5	67	5	4
Heart and Circulation .....	14	40	15	12
Lungs .....	41	68	40	7
Developmental— <i>a.</i> Hernia .....	5	8	3	—
<i>b.</i> Other .....	2	44	1	1
Orthopaedic— <i>a.</i> Posture .....	40	5	16	2
<i>b.</i> Flat Foot .....	22	9	12	4
<i>c.</i> Other .....	24	32	4	8
Nervous System— <i>a.</i> Epilepsy .....	2	2	6	—
<i>b.</i> Other .....	12	17	11	4
Psychological— <i>a.</i> Development .....	7	13	29	7
<i>b.</i> Stability .....	4	10	2	2
Other .....	36	68	413	10

## 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 .....	2	—
(2) Body .....	19	—
Scabies .....	—	—
Impetigo .....	48	—
Other skin diseases .....	107	—
Total .....	176	—

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. The number of cases of scabies among school children has fallen considerably as indicated by the figures for the past five years.

1950—3 School children were treated.

1951—Nil.

1952—1 School child was treated.

1953—Nil.

1954—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 .....	43	—
Errors of refraction (including squint) .....	—	222
Total .....	43	222
Number of pupils for whom spectacles were prescribed .....	—	172

During the year 170 cases of defective vision and 52 cases of squint were examined by the Visiting Ophthalmic Surgeon, 16 cases of Blepharitis, 19 of Conjunctivitis, and 8 of other eye conditions were treated at the minor ailments clinic.

The number of repairs to spectacles and replacements amounted to 170. After testing there were 25 cases in which spectacles were not prescribed and 6 cases where existing spectacles were found to be satisfactory. 14 cases were also referred to the Bradford Eye and Ear Hospital.

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

Received operative treatment:—		Number of cases dealt with:—	
		By the Authority.	Otherwise.
(a) For diseases of the ear	—	—	478
(b) For adenoids and chronic tonsillitis	—		
(c) For other nose and throat conditions	—		

### GROUP 4. ORTHOPAEDIC AND POSTURAL DEFECTS

No. treated as in-patients in hospitals		Number of cases treated:—	
		By the Authority.	Otherwise.
No. treated otherwise, e.g., in clinics or out-patient departments	—	353	216

The following table shows details of the work undertaken by the Authority's Physio-therapist during the year.

TABLE V

School Children						Number of cases treated	Attendances
Asthma	.....	.....	.....	.....	.....	30	337
Bronchitis	.....	.....	.....	.....	.....	35	176
Breathing	.....	.....	.....	.....	.....	54	276
Bronchiectasis	.....	.....	.....	.....	.....	2	23
Poor chest development	.....	.....	.....	.....	.....	8	68
Postural drainage	.....	.....	.....	.....	.....	2	57
Flat feet	.....	.....	.....	.....	.....	70	528
Talipes	.....	.....	.....	.....	.....	2	39
Knock knees	.....	.....	.....	.....	.....	3	9
Hallux rigidus	.....	.....	.....	.....	.....	2	49
Claw foot	.....	.....	.....	.....	.....	9	98
Posture	.....	.....	.....	.....	.....	94	537
Kyphosis	.....	.....	.....	.....	.....	4	48
Scoliosis	.....	.....	.....	.....	.....	10	121
Central nervous system	.....	.....	.....	.....	.....	2	52
Anterior Poliomyelitis	.....	.....	.....	.....	.....	3	76
Monoplegia	.....	.....	.....	.....	.....	1	3
Rheumatism	.....	.....	.....	.....	.....	6	101
Hemiplegia	.....	.....	.....	.....	.....	4	105
Recent injury	.....	.....	.....	.....	.....	3	9
Cerebral palsy	.....	.....	.....	.....	.....	4	107
Psoriasis	.....	.....	.....	.....	.....	2	9
Friedrich's ataxia	.....	.....	.....	.....	.....	1	14
Graduated exercises	.....	.....	.....	.....	.....	1	14
Poor balance	.....	.....	.....	.....	.....	1	7
Total						353	2,863
Pre-school Children							
Flat feet	.....	.....	.....	.....	.....	8	43
Knock knees	.....	.....	.....	.....	.....	2	87
Claw feet	.....	.....	.....	.....	.....	2	12
Total						12	142

Attendances at the Orthopaedic Swimming Class ..... 441.

The Swimming Bath closed on the 30th November, 1954.

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	Elsewhere
No. of pupils treated at Child Guidance Clinics	.....	4	—

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. Details of the work carried out during the year is provided in the following table.



TABLE VI

	Boys	Girls	Total
1. No. of new cases seen during year	1	—	1
2. No. of cases continuing attendance from previous year	2	1	3
3. Total number of cases seen during year	3	1	4
4. Total number of attendances made during the year for:—			
(a) Individual interview	4	11	15
(b) Group Therapy	11	—	11
5. No. of cases recommended for residential treatment in:—			
(a) Hostel for Maladjusted Children	—	—	—
(b) E.S.N. Special School	—	—	—
(c) Other	—	—	—
6. No. of cases referred for psychiatric opinion	—	1	1
7. No. of cases examined at the particular request of the magistrates	—	—	—
8. Types of problem for which cases were referred to the Clinic:—			
(a) Behaviour	1	—	1
(b) Delinquency	—	—	—
(c) Nervous problems	1	1	2
(d) Enuresis	—	—	—
(e) Other—			
(Partially Sighted—I.Q. testing only)	1	—	1

## GROUP 6. SPEECH THERAPY

Number of cases treated:—

By the Authority.      Otherwise.

Number of pupils treated by Speech Therapist      66      —

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

TABLE VII

Total No. of sessions held during the year	172
	Stammers      Speech Defects
No. of new cases admitted for treatment during year	8      21
No. of cases already attending for treatment from previous year	16      21
Total number of cases treated	24      42
No. of cases discharged during year:—	
(a) Speech normal	5      10
(b) Unsuitable for treatment	2      —
(c) Left school	3      —
(d) By reason of non-attendance	—      4
(e) Other reasons	2      3
No. of cases awaiting treatment at end of year	24
No. of visits made to schools	—
No. of home visits	—

## GROUP 7. OTHER TREATMENT GIVEN

Number of cases treated

By the Authority      Otherwise

Miscellaneous Minor Ailments	752	—
Ultra Violet Light Treatment	75	—
	827	—

In addition to the 752 children who received treatment at the Clinic for miscellaneous minor ailments a further 68 cases were kept under observation, all cases being initially examined by the School Medical Officers. Of the 75 school children who received ultra violet light treatment at the School Clinic 18 were still under treatment at the end of the year.

Through the interavailability of Clinics 44 pre-school children received ultra violet light treatment, of these 3 were cured, 20 improved and 21 were still under treatment at the end of the year.

#### Follow-up of Medical Inspections

The following domiciliary visits were paid by nursing staff during the year:— 53 Infectious diseases, 13 Handicapped pupils, 41 Neglected and verminous, 35 Routine medical inspection follow-up, 26 Other visits.

#### 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 .....	12,487
Total number of individual pupils found to be infested .....	509
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 Officers at the routine inspections and at 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 a School Medical Officer at least once each year and the parents are invited to be present at these examinations to discuss their child's health and progress.

The relevant figures for 1954 are given below:—

Number of admissions .....	41
Number of re-admissions .....	3
Number of children discharged as physically fit to attend ordinary school .....	29
Number removed to Secondary Technical School .....	1
Number removed to Boys' Grammar School .....	1
Number removed to Special Schools .....	1
Number removed to Sanatorium .....	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	2	—	—	—
Partially Sighted	4	1	—	1
Deaf	6	—	—	—
Partially Deaf	2	5	—	5
Educationally Sub-normal	6	12	—	12
Epileptic	2	3	1	4
Maladjusted	2	7	—	7
Physically Handicapped	2	8	1	9
Speech Defect	—	—	—	—
Delicate	92	29	—	29
Total	118	65	2	67



### Mentally Defective Children

There were three children notified during the year ended 31st December, 1954, under the provisions of Section 57(3) of the Education Act, 1944, and four were notified under Section 57(5) as requiring supervision after leaving school.

### 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 admission, and
- (b) Every pupil attending a maintained school or County College shall be inspected by a dental officer on such later occasions as may be practicable and necessary.

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	4,482
2. No. found to require treatment	2,719
3. No. offered treatment	2,473
4. No. treated	2,567
5. Attendances made by pupils for treatment	4,062
6. Extractions:—	
Temporary	4,626
Permanent	1,033
	<hr/>
Total	5,659
7. Administration of General Anaesthetics	1,074
8. Fillings:—	
Temporary	177
Permanent	2,850
	<hr/>
Total	3,027
9. No. of Other Treatments:—	
Temporary	100
Permanent	1,412
	<hr/>
Total	1,512

### Infectious Diseases

Six cases of tuberculosis were notified during the year as occurring amongst school children, two were pulmonary and four 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 1954 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	52	—	—
Pneumonia	4	—	—
Dysentery	28	—	—
Chicken Pox	3	—	—
Whooping Cough	17	—	—
Measles	3	—	—
Erysipelas	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	318
378	90	468	

(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
4	189	63	28	1

#### Tuberculin Jelly Testing of School Entrants

The following shows details of the work undertaken during the year under the provisions of the scheme for the routine tuberculin jelly testing of school entrants:—

<i>Invited</i>	<i>Accepted</i>	<i>Negative</i>	<i>Positive</i>	<i>Doubtful</i>	<i>Absentees</i>
148	138	85	20	5	28

#### Co-operation of Teachers, Welfare 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) *Welfare Officers.*

As usual the Welfare 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:—

The following figures, except for the month of December, 1954, relate to cases dealt with by Inspector Sullivan for the year 1954 (Keighley District).

Total new cases:— 59 — classified as follows:—

Neglect 33, Ill-treatment 8, Advice Sought 18.

Total number of children: 139 (68 boys, 71 girls)

0 — 2	2 — 5	5 — 15	15 and under 17	Illegitimate
33	38	57	5	6

Total supervision visits made on families:— 504

Total miscellaneous visits:— 729

There were no Prosecutions in the Keighley District during 1954.

(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 1954.

## Class Attendances

Boys 7,570  
Girls 7,902

## Attendances by individuals on 2d. tickets

Boys 8,575  
Girls 5,303

## Results of Instruction

Preliminary Certificate	—	—	—	199
Elementary Certificate	—	—	—	298

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

## 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.), D. Orth. R.C.S.:—

The problems associated with shortage of staff continue to be the main obstacles in the way of progress of Public Dental Service. These problems are nation-wide and until they are solved we are forced into the unhappy position of having to cut our coat according to our cloth and many cherished ideals of service have to be sacrificed.

We have, however, some reason for pride in the development of our programme for the establishment of clinics in the West Riding and it is interesting to remember that whereas in 1945 we had 4 equipped clinics, now we have 33. During the year under review we have opened 5, at Ilkley, Knaresborough, Honley, Slaithwaite and Uppermill. At Slaithwaite a floor of an old woollen mill has been adapted to make one of our most pleasant and effective clinics, comprising Waiting Room, 2 Surgeries, Recovery Room, Office, etc. This clinic is an excellent example of the ingenious and imaginative planning which we have come to expect from the Architect's Department.

It must be realised that the establishment, equipping and maintenance of such a large number of clinics calls for a lot of administrative work and responsibility and it is in this respect that I want to pay a very sincere tribute to my very small but most efficient clerical staff, in particular my Sectional Clerk, Mr. Marshall, who has given an enormous amount of thought and energy to the hundred and one problems which inevitably arise. These "back room boys" whose work is unspectacular and whose praises are rarely sung form a very solid and trustworthy backbone to all branches of Public Health Service. So far as the Dental Service is concerned their value is immeasurable and their conscientious reliability allows the professional officer to devote the maximum amount of his time and energy to the work for which he is trained.

The development of clinics has materially altered the character of the service which we provide. Perhaps one of the most marked examples of this is in the use of general anaesthetics. I have always frowned upon the use of general anaesthetics under the unsatisfactory conditions of the old travelling surgery which was in use before the establishment of clinics. In spite of the extreme safety of the anaesthetics we use, there is no doubt that the anaesthetist is taking the patient's life in his hands when he administers a general anaesthetic and every safeguard in the way of apparatus and conditions under which the work is carried out should be taken.

As these conditions have been fulfilled in the clinics, more and more work of this nature has been done and it is interesting to record that whereas in 1945 1,968 administrations of a general anaesthetic were made, in 1954 the figure reached the rather astonishing total of 21,100.

The establishment of clinics has also made it possible to increase very materially our work for expectant and nursing mothers and this increase is shown as follows:—

1948	—	58 cases treated.
1951	—	481 cases treated.
1954	—	1,100 cases treated.

The Orthodontic Service continues to increase in popularity and I have arranged for several dental officers to attend the Central Dental Clinic for experience and instruction in this branch of dentistry and so take the service out into the periphery of the County. During the year, 1,293 children have received orthodontic treatment making 12,486 attendances and 1,445 appliances for the correction of oro-facial abnormalities and malocclusion of the teeth have been made at the County Dental Laboratory, Wakefield.

Towards the end of the year we made an addition to the Establishment by the appointment of two Dental Hygienists. These girls are specially trained under the auspices of the Ministry of Health to scale and clean teeth of both children and adults and to give instruction on oral hygiene. It is felt that an extension of this service may do something to fill the gaps in the dental personnel and the encouragement that they can give to school children and expectant and nursing mothers to keep their teeth clean can do nothing but good.

**Dental Treatment of Expectant and Nursing Mothers.**—There has been no increase in the number of cases referred from ante-natal clinics or by General Medical Practitioners for dental examination. A far greater proportion of the cases have, however, been treated at County Dental Clinics. These figures for 1954 are more than double those for the previous year. 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	1,764	1,380	3,144
No. of cases examined	1,383	1,004	2,387
No. found to require treatment	1,331	1,001	2,332
No. treated	1,100	576	1,676
No. made dentally fit	997	520	1,517
No. of extractions	8,332	7,912	16,244
No. of teeth conserved	1,210	1,392	2,602
No. of crowns and inlays	5	—	5
No. of general anaesthetics	925	544	1,469
No. of scalings	331	366	697
No. of dentures — Complete	659	516	1,175
Partial	254	356	610

**Analysis of the Work carried out during the Year.**—The information concerning dental treatment provided for school children in Table V on Page 80 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 87,597 temporary teeth and 15,369 permanent teeth extracted does not represent, as might be thought, so many teeth which it has been found impossible to save. No less than 12,098 temporary teeth and 2,417 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 regular order. Approximately 1 tooth in 7 is extracted with the object of preventing irregularity and ensuring the satisfactory future of the dentition.

**FILLINGS**—4,642 temporary teeth were conserved by the following means:— 1,686 cement fillings, 1,081 amalgam fillings, 2,081 combined cement and amalgam fillings. 36,926 first permanent molars and 18,114 other teeth, a total of 55,040 permanent teeth were conserved by the following means:— 1,027 cement fillings, 13,558 amalgam fillings, 41,875 combined cement and amalgam fillings, 4,658 silicate (porcelain) fillings. Other treatments of a varied nature include 238 root fillings, 5,999 dressings, 202 crowns, inlays, etc., 4,948 scalings and gum treatments. Dentures were provided in 417 cases to replace teeth lost by accident or disease, 1,308 attendances being made for the necessary work incurred in the fitting of these dentures.

The very large figure of 33,091 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 12,486 attendances for orthodontic treatment, 1,308 attendances for prosthetic treatment, 4,948 scalings and gum treatments, 1,335 X-rays, 5,999 dressings, etc.



## PART VII

### CARE AND AFTER-CARE

#### Care and After-Care of the Hospital Patient

The link with the hospital service continues as previously reviewed. There is no pre-determined pattern, the method in each area being that most suitable and acceptable to the different organisations concerned. Experience confirms that the most effective co-operation can be demonstrated where the health visitor is used as a liaison officer between the Local Health Authority and the Hospital Service, with personal access to the hospital staff and wards. Where this system is not in operation, the co-operation is weaker, operating undoubtedly where there is obvious need for after-care facilities for a patient leaving hospital, but less certain with the many less obvious sociological factors affecting the patient throughout the course of hospital treatment. The first experimental use of health visitor liaison was undertaken at the Otley General Hospital and has operated most satisfactorily. The decision of the Hospital Management Committee to appoint an Almoner was, therefore, learned with some little misgiving. It is pleasing to report that a mutually satisfactory working arrangement has been established whereby all the health visitors now have direct contact with the Almoner, when there can be an interchange of information concerning patients to the ultimate benefit of the patients, the common objective of both services.

In those hospitals to which the health visitors have access, they made 1,145 sessional and 493 additional visits. Requests for background reports were received on behalf of 2,908 patients, 2,603 of which were completed and returned to the hospitals for the information of the medical staff. Out of 4,255 patients interviewed, 988 were found to be in need of some form of assistance; in 444 cases, this need had been satisfactorily met before discharge, and in 484 cases, the matter was being dealt with on discharge. In 2,297 cases, patients were referred to the Divisional Medical Officers for after-care upon discharge from hospital. An analysis of these cases shows after-care afforded by the midwife (626 cases), home nurse (259), health visitor (1,821), home nursing equipment provided (31), home help (242), rehabilitation arranged (100), referred to convalescent homes (15), transfers to hospitals or homes for chronic sick (330), transfers to other hospitals, including 1 re-admission, (106). Patients were referred to the Welfare Officer (61), National Assistance Board (21), nursing homes (6), Divisional Rehabilitation Officer (3), Housing Officer (3), Mental Health Social Worker (1), Children's Officer (1). There were 1,308 home visits by the liaison officer, 2,198 environmental investigations and 805 follow-up visits.

From the hospitals where health visitor liaison is not established, we had 316 requests for background reports on patients for the information of the medical staff. Nine hundred and eleven patients were referred to the Divisional Medical Officers for after-care. The midwives attended 836 patients discharged from hospital, the home nurses 339 and the health visitors provided assistance in 996 cases. Nursing equipment was loaned to 437 patients and home helps provided for 127. Rehabilitation was arranged for 3 cases, convalescence for 65. Twenty-eight patients were transferred to hospitals or homes for chronic sick and 45 to other hospitals. There were 135 environmental investigations and 65 follow-up visits. Much of the foregoing post-hospital work arose other than through direct liaison. Similarly, much of the liaison work arising from direct telephone communication between the hospital and the divisional staff remains unrecorded.

#### Tuberculosis

A major part of the preventive work must still be attributed to effective case finding. The follow up of contacts is of primary importance and from a sample of 2,833 cases notified during the past five years, 7,133 contacts were traced and referred for investigation, representing 2.5 contacts for each case.

The increased use of tuberculin testing of children is opening new approaches to the problems of case finding. Child contacts of known cases are being jelly tested with a view to follow up and to B.C.G. vaccination where necessary. The jelly test is being used in one area on children recommended for U.V.L. treatment. One child, with a positive re-action and subsequently notified, was found to have played with other children who were notified in 1953. Her parents and all other adults in the family were found to be free from the disease, but further enquiry revealed that there had been contact with the father of her playmates and he was an infectious adult case. Ten of the contact children had positive jelly tests and after X-ray, one was notified. In the introduction of B.C.G. vaccination (see page 36) at one secondary modern school, the tuberculin test revealed 83 per cent. positive re-actors, in consequence of which arrangements were being made for a special visit of the Mass Radiography Unit to this school and to the village from which the majority of the positive tuberculin children were drawn. In parts of the County area, it has been possible to arrange for the tuberculin jelly testing of school entrants, a report on which appears in the section 'School Health', and which shows that out of 1,815 children tested, 59 or 3.3 per cent. gave a positive re-actor requiring further investigation, an investigation which led in some cases to a revelation of an hitherto unknown infective case. The jelly test is also being used as a routine in the medical examination of handicapped school-children having any symptoms of respiratory disorder.

Of special interest has been a tuberculin test survey of infants born in Sowerby Bridge 1953-54. Dr. J. Lyons, Divisional Medical Officer reports—



<sup>3</sup>The survey is proceeding according to plan and will not be completed until September, 1956. The following summary outlines the result so far:—

Total live births Sowerby Bridge U.D. between October 1st, 1953, and September 30th, 1954		268
No. of infants whose parents consented to survey	223	(83.2%)
No. of infants whose parents refused survey	30	(11.2%)
No. of infants who have received (or are receiving) periodic tuberculin tests	213	(79.5%)
No. of infants eliminated from survey by reason of removal from district	15	(5.6%)
No. of infants eliminated by reason of death	6	(2.2%)
No. of infants eliminated by reason of B.C.G. vaccination as contacts	4	(1.4%)
No. of positive reactors discovered before January 1st, 1955	1	(0.4%)
Average age of infants in survey at January 1st, 1955	9 months (approx.)	

The results to date suggest that there is no appreciable risk of tuberculous infection from human or other sources in Sowerby Bridge during the first few months of life. This confirms the impression already gained from the M.M.R. survey of 1954 of a low incidence of unascertained active cases of respiratory tubercle in the area. The risks from bovine sources will probably not become apparent until all the infants are weaned.

The one positive reactor found showed no clinical evidence of disease after hospital investigation. X-ray examination of family contacts also revealed negative results."

Intensive surveys are undertaken when cases of tuberculosis occur in schools, more particularly where the case is that of a teacher or a child with the adult type of disease. In one area, two teachers were found to be suffering from tuberculosis; 260 child contacts were subjected to the tuberculin test, and 36 (13.8%) were found to have a positive re-action and were referred for further investigation. Again, two cases of tuberculous meningitis and one case of primary infection of the lungs, all occurring in children aged five years and attending the same primary school, led to an X-ray examination of the staff of the school. One member of the canteen staff had a suspicious history of cough but refused to be X-rayed and relinquished her appointment in the school service. At another school, a child was found to have adult type tuberculosis; 37 children and 12 teachers were X-rayed with negative results and the source of infection was proved to be outside the school.

The development of institutional care for children and for the aged presents its further problems in the limited facilities which exist for the segregation of the tuberculous patient for whom a hospital may not be available. Particular attention was drawn to this problem during the year when a man aged 71, a resident in one of the Authority's homes for the aged, was found to be suffering from respiratory tuberculosis with a positive sputum. The man was living an active life with no impairment, and in the opinion of the chest physician, there were no clinical grounds to warrant his admission to a sanatorium. Although the patient, the hostel staff and other residents were kept under close supervision, there remained some anxiety until the hospital authorities were eventually persuaded to take him into hospital. Had the man refused hospitalisation and general co-operation, a more critical situation would have arisen.

Mass radiography (see page 38) has made an invaluable contribution to case finding, although one Divisional Medical Officer reports, "The results of mass radiography have been disappointing and suggest that a law of diminishing returns is operating. Old cases come for examination again and again, along with other known cases of chronic non-tuberculous chest disease; but new subjects are slow to come forward and some whom one would like to screen, do not come at all."

The close co-operation between the chest clinic and the local health services continues with the tuberculosis visitor, be she wholly engaged on such work or a general purpose health visitor, as the liaison officer between the two services.

No report on a tuberculosis programme would be complete without reference to and an appreciation of the invaluable aid afforded by local district councils in re-housing the families of tuberculous patients when the existing home conditions are found to be unsatisfactory. Despite the pressure which has been exercised on these authorities in meeting the normal demands for housing, a pressure which is now easing in many areas, they have been most sympathetic in dealing with such cases. This aptly illustrates the advantage of the Divisional Medical Officer, in his capacity as Medical Officer of Health of the local district council, being able to make direct representation on special housing needs.

In the present era of full employment, the re-employment of the tuberculous patient presents little difficulty although the ease with which he can be re-employed is itself a problem if it is not to give rise to further infection. There is close co-operation with the many interested persons, authorities and bodies, but, although the overall position may be viewed with some satisfaction, individual cases arise from time to time to present their particular and peculiar difficulties. Foremost amongst these is the infectious patient who resumes his employment and refuses to have divulged to his employers, or to his workmates, the knowledge of his condition. For so long as the liberty of the individual has greater value than the risk to health of the community, this is a situation which can be met only by educative means. Similar means have been successfully employed in persuading patients to change from occupations involving the handling of food or close personal contact with other persons. Difficulty in finding re-employment occurs in the coal mining areas where there is little or no light industry; this causes delay before reasonably lighter employment can be found on surface work. There remain those who, from pressure of economic circumstances, seek and obtain employment unsuitable for their physical condition and the chronic infective case, usually of middle age or elderly, who will not accept placement in a village settlement; for these there must be continuous supervision.



This brief review ends with extracts from reports received from Divisional Medical Officers. Dr. Lambert of the No. 2 (Settle) Division writes—

"The principles of Tuberculosis control are still as Sir Robert Philip enunciated them nearly seventy years ago: to find, treat, segregate, and educate all cases or as many cases as possible. Treatment and segregation are now matters of hospital policy rather than of public health, but one may perhaps be allowed to comment that the success of modern treatments, by shortening the average stay in Sanatorium, has reduced the amount of education in the care of his own and of other people's health that used to be imparted to sanatorium patients in earlier days. There is a most dangerous ignorance of the fact that Tuberculosis is an infectious disease, and in especial an infection of families. A good deal of the time of all concerned is spent in combating this ignorance. In four instances cases of pulmonary tuberculosis have been found employed on milk producing farms, T.T. milk producing farms in three of them. They were segregated at once; but that such instances can occur at all reinforces the suggestion that even T.T. milk should be pasteurised. No other known cases are employed in jobs that create a special health risk for themselves or for other people. Two cases are irresponsible, and totally neglectful of their health, both are rapidly worsening, but neither is so employed as to be a danger to the public. If either of them were, it is doubtful whether effective action could be taken to control them. The Law and Public Opinion are not wholeheartedly behind the anti-tuberculosis campaign. We must educate our masters."

Dr. Lyons of the No. 19 (Todmorden) Division, writing on the Control of Infectious Cases in the Community, states—

"Admission of active infectious patients to sanatorium is no longer the main bulwark of defence against the spread of infection in the community. The periods of stay in hospital are now relatively short, patients being discharged as soon as the appropriate course of treatment and rest have rendered the patient reasonably fit for ordinary home care. Alternatively the patient may be discharged simply because no further special hospital treatment is indicated for the present. In either event a small proportion of patients will still be returned home in an infectious condition or in a condition of doubtful infection. The home-care, employment and rehabilitation of such patients becomes a difficult and serious problem, often placing the Medical Officer of Health in a dilemma. On the one hand the psychological and economic needs of the patient demand as full a return as possible to a normal place in society. On the other hand the family and the community must be protected against the risk of infection. These two objectives can be mutually antagonistic. A tactful personal approach by the Health Visitor or the Divisional Medical Officer (or both) can, where the patient is co-operative, often 'solve' the problem by a compromise, as a result of which it is piously hoped that the risks of infection at home and work will be minimised and that the patient will not feel that he is being unduly restricted or victimised. It is, of course, extremely important that these decisions are made by those with a knowledge, not only of the patient's home conditions, but also of the conditions in local mills, factories, offices and workshops. This important preventive work should therefore not in general be undertaken by hospital physicians and almoners unless there has been close consultation with the Health Department. Where the patient is unco-operative, anti-social, or hostile, the difficulties are multiplied enormously. The statutory powers of the Medical Officer of Health and local authority are restricted to certain well-defined sets of circumstances outlined in the Public Health Acts and elsewhere. Outside this limited field one has no powers of compulsion and there can be no doubt that an irresponsible patient may often 'cock a snook' at the Health Department and distribute his germs very nearly with impunity. Fortunately such patients are few and far-between."

The protracted negotiations with the Leeds Regional Hospital Board for the joint use of chest physicians were successfully concluded during the year. An agreement was reached whereby the County Council accepted financial responsibility for 12½ per cent. of the salary and expenses of chest physicians employed in the administrative area, the cost of those employed for an area of more than one Local Health Authority being apportioned between the authorities on a proportionate population basis. The chest physicians will devote this proportion of their time to the preventive, care and after-care duties of the Local Health Authority, in the county area working in close co-operation with the Divisional Medical Officer.

The activities of the Tuberculosis After-care Committees were again reviewed. Their latest accounts showed that County Council grants, totalling £435 had been supplemented by £128 from County Borough Councils and £1,069 had been raised from voluntary sources. Eight hundred and thirty-five pounds had been spent in direct grants to patients and administration costs were approximately £115. Of particular interest amongst the many activities of these Committees is the Rotherham Car Park Scheme. The Committee, which formerly included only the County Borough area, has extended its activities into the administrative county area and its Car Park Scheme provides employment for four attendants throughout the year. When the expenses, including full wages for the attendants, were offset against the receipts from motorists, the deficit remaining to be met by the Committee at the end of the year was little more than £50. Provision was made for the possibility of new Committees being formed in the Otley and Wakefield areas, subject to which the County Council authorised grants-in-aid totalling £745 for the financial year 1954-55.

#### W.R.C.C. Area Served

After-care Committee	Division	Population	Grant £
Brighouse	18	58,297	60
Castleford	11 (part)	42,580	45
Doncaster	26 (part)	215,250	215
	27, 28, 29, 30		
Goole	10 (part)	28,490	30
Harrogate	7 & 8	99,366	100
Morley	14	39,560	40
Normanton	11 (part)	18,830	20
Otley	6	34,469	35
Pontefract	12	54,848	55
Rotherham	26 (part), 31	98,590	100
Wakefield	13	41,669	45
		731,949	745



Nine thousand one hundred and eighty-seven grants of extra nourishment, comprising two pints of milk daily for a period not exceeding two months, were made to 2,370 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 six patients were admitted to and eight discharged from institutional training and resettlement centres leaving ten at such institutions at the end of the year; at Sherwood Village Settlement, Rainworth, Notts. (1); Enham Alamein Village Centre, Andover, Hants. (1); and Papworth Village Settlement, Cambridge (8).

### Recuperative Homes

Four hundred and eighty-three applications were received for admission to recuperative homes and one hundred and twenty-nine (27%) were cancelled. Six remained on the waiting list at the end of the year and the remaining 348, comprising 80 men, 262 women (including 18 with children) and 6 pre-school children, were admitted to Binswood Short Stay Rest Home, Manchester; Blackburn and District Convalescent Home, St. Annes-on-Sea; Boarbank Hall, Grange-over-Sands; Brentwood Recuperative Home, Marple, Cheshire; Children's Convalescent Home, Wirral, Cheshire; Ellen Goner Convalescent Home, Hoylake, Cheshire; Hunstanton Convalescent Home, Hunstanton, Norfolk; Men's Convalescent Home, Rhyl; N.E.C.F.S. Convalescent Home, Grange-over-Sands; Semon Convalescent Home, Ilkley; Shoreston Hall, Seahouses, Northumberland; Silver Jubilee Home, Heysham; Spofforth Hall, Spofforth; St. Joseph's Convalescent Home, Freshfield; Sydney House, Abergele, North Wales; Valda Convalescent and Rest Home, Bridlington; West Hill Convalescent Home, Southport.

### Health Visiting

An examination of the work of the health visitors indicates that selective visiting, owing to the improved standard of living and better housing conditions, can be carried still further. With more money coming into the house and a better house to live in, the mother can now listen to health education and aspire to a more healthy way of living, and there is strong evidence of this taking place. Individual problems in individual homes still exist and these take time and perseverance, but it is gratifying to the service that the health visitor is sought out and asked for advice and guidance. Group teaching at clinics has a place in the plan, but the home is still the only place where the heart-to-heart talk can take place. The father is more and more coming into the picture and is, in many cases, ready and willing to discuss with the health visitor the problems of the child. It may be a disadvantage that the health visitor must visit the homes when the father is out at work, and perhaps in the not too distant future, a shift duty would be desirable.

The door-to-door routine visit of the health visitor is past, but her work has not ended. While we are satisfied that the physical and nutritional state of our children has improved, there is still a wide field for the resourceful health visitor in mental health and in the rehabilitation of the sick. Much of the work done in connection with the aged by health visitors could be undertaken by voluntary assistance, and in some areas, the health visitors are taking advantage of this and encouraging voluntary effort. Many new "Darby and Joan" Clubs have been formed and are run entirely, not by people of leisure who are not numerous in these days, but by those who make time to take on extra work.

The extension of the Health Visitor's activities from the mother and child to all persons has emphasised the need for her to work in the closest co-operation with the local general practitioners and to be readily available for this purpose. The County Council, eager to foster this co-operation, authorised the provision of telephone facilities for all health visitors, and installations for 113 were completed by the end of the year.

The staffing position of trained health visitors deteriorated but there are hopes for improvement in 1955. There were 38 resignations and retirements with only 27 replacements, 18 of whom were recruited from our training scheme.

Thirty-one health visitors attended post-certificate refresher courses organised by the Women's Public Health Officers' Association, the Royal College of Nursing, the Central Council for Health Education, and the National Association for the Prevention of Tuberculosis, and held at Bangor, Bristol, Edinburgh, Liverpool, London and Oxford. Thirty-two health visitors attended a special week-end refresher course at the Grantley Hall Adult Training College to consider "Paediatrics and Prematurity", with lectures by Dr. F. J. W. Miller of the Children's Department of the Royal Victoria Infirmary, Newcastle, Miss F. Stephenson, Chief Nursing Officer, and Miss S. Emmerson, Health Visitor, both of the Newcastle Health Department, and by Dr. C. C. Harvey, County Paediatrician. Four conferences were also held at the County Hall, at three of which lectures were given, "Chest Surgery" by Mr. G. Wooler, F.R.C.S., of the Thoracic Surgery Department of the General Infirmary at Leeds, "Occupational Health" by Dr. J. Hughes, Lecturer of the Nuffield Department of Occupational Health, Manchester, and "Psychology of the Family" by Dr. W. Mary Burbury, Senior Lecturer of the Department of Psychiatry, Leeds.

**Supervisory Staff.**—The practical supervision of health visitors has been continued by Miss A. Carey and Miss O'Brien who paid 367 visits to health visitors and 306 visits to clinics. They have conferred with the respective Divisional Medical Officers on matters relating to the practical work of the health visitor and on the appointment of staffs.



Miss A. M. Clarke retired in August, 1954. She had acted as Tutor to the health visitor students at Leeds University since 1948. She has been replaced by Miss M. G. Edwards who holds the Tutor's Certificate and came from Bradford where she had been a health visitor tutor attached to the Health Department and Bradford Technical College.

### Home Nursing

The continued expansion of the Home Nursing Service has necessitated an approach being made to the Ministry of Health for authority to increase the establishment of 228 home nurses which was authorised in 1948. Approval of these proposals will do much to relieve the strain on existing staff, whose work has increased by one-third since the inception of the service, and to provide sufficient fluidity to meet any further expansion and the normal casualties of sickness and holidays.

There were 288 nurses on the staff in December; of these, 73 were home nurse/midwives. There were 36 resignations and 36 appointments of whole-time staff, the latter figure including 22 who were trained under the West Riding scheme.

The table below gives an arithmetical analysis of the work during the year and draws attention to the proportion of the service being devoted to the aged and chronic sick. The age group "Over 65" represents 45 per cent. of the cases and 57 per cent. of the visits, while the patients receiving more than 24 visits during the year represent 14 per cent. of the cases and 44 per cent. of the visits.

<i>Type of Case Attended</i>								<i>No. of cases attended</i>	<i>No. of visits by Home Nurses</i>
Medical	...	...	...	...	...	...	...	27,330	614,392
Surgical	...	...	...	...	...	...	...	10,615	184,542
Infectious Diseases	...	...	...	...	...	...	...	93	895
Tuberculosis	...	...	...	...	...	...	...	633	18,344
Maternal Complications	...	...	...	...	...	...	...	363	3,833
<b>TOTAL</b>	...	...	...	...	...	...	...	<b>39,034</b>	<b>822,006</b>
<i>Age Groups</i>									
0-5	...	...	...	...	...	...	...	2,874	23,145
5-65	...	...	...	...	...	...	...	20,339	332,702
Over 65	...	...	...	...	...	...	...	15,821	466,159
<b>TOTAL</b>	...	...	...	...	...	...	...	<b>39,034</b>	<b>822,006</b>
Patients included above who have had more than 24 visits during the year								5,340	358,348

The following comparison shows the growth of the service since 1948.

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	"
1954	...	...	...	...	...	...	...	822,006	" "	39,034	"

Home Nurses attended a post-certificate training course organised at the Grantley Hall Adult Training College. Three conferences were also held at the County Hall when visiting lecturers spoke—Dr. S. T. Anning, Leeds, on "Treatment of Skin Diseases", Dr. D. Laing, York, on "Treatment of Cerebral Conditions", and Dr. J. K. Rennie, Bradford, on "Recent Developments in Treatment of Rheumatism". The course and conferences were greatly appreciated and their benefits were adequately demonstrated in the improved standard of nursing technique.

### Nursing Equipment for the Homes

Under the provisions of Section 28 of the National Health Service Act, a Local Health Authority may provide, on loan, nursing equipment required for use in the home. The assets of the former District Nursing Associations, purchased by the County Council, included a variety of articles available for this purpose; many were of an obsolete pattern or rapidly became unserviceable, and there has been a continuous stream of replacements and additions. The equipment is dispersed strategically, with the smaller items being generally available from the local home nurse. The larger items, viz., beds, mattresses, wheel chairs, commodes, etc., are held divisionally, with the central office acting as a clearing house between divisions so as to obviate purchases when the desired article is surplus to requirements elsewhere. Some appreciation of the extent of this loan service may be gained from a perusal of the following details showing the disposal of the larger items as at the 31st December. The chairs shown as being available for issue include 7 at present under repair.



	<i>On loan</i>	<i>Available for issue</i>	<i>On loan</i>	<i>Available for issue</i>
<b>BEDSTEADS</b>				
Single	70	—		
Single, with self-lifting poles	62	—		
Cots, adult	1	—		
Cots, children's	2	—		
			135	—
<b>MATTRESSES</b>				
Dunlopillo	111	2		
Hair	73	1		
Biscuit	10	4		
Water, full and half length	4	10		
Air	5	1		
			203	18
<b>FRACTURE BOARDS</b>			8	—
<b>WHEEL CHAIRS</b>				
Bath	21	6		
Folding	131	16		
Self-propelled	9	2		
Spinal, adult	2	4		
Spinal, child	4	3		
Stairway, wheel	1	4		
Stairway, carry	—	2		
Miscellaneous	8	1		
			176	38
<b>COMMODOES</b>				
Chair	35	1		
Other	2	2		
			37	3
<b>CUSHIONS</b>				
Dunlopillo	23	5		
Air	5	—		
			28	5

### Home Helps

In February, the attention of the Committee was directed to the need for a further increase in the establishment of Home Helps. Starting in 1948 with 310 Home Helps, increases had been approved to 500 in 1950 and to 600 in 1952. (In each case, the establishment represents whole-time personnel or their equivalent in part-time workers). During this period, there had been an increase of 146 per cent. in the number of cases dealt with. With a staff expanded by only 90 per cent. this achievement had become possible by the practice of the most rigid economy and supervision of the service. Even so, it was becoming impossible to meet all legitimate demands on the service and each new aged person requiring help became an embarrassment in that there was not a similar rate of cases discontinued. To meet this situation, the Ministry of Health approved proposals for an increased establishment of 700 as from 1st April, representing an overall establishment of 675 for the year under review.

During the year, 9,195 cases received help through the service on which 1,392,105 home help hours were expended as against 8,348 cases and 1,272,556 hours for the year 1953. Again it will be seen that the chronic sick, including the aged and infirm, made the greatest demand on the service representing 67 per cent. of the cases and 77 per cent. of the total hours. The number of cases still in receipt of help on the 31st December was 4,516. The statistical details are as follows.

Number of Home Helps employed at 31st December.

(i) Whole-time by part-time workers	56
(ii) Part-time	1,479
<b>TOTAL</b>	<b>1,535</b>

Cases provided with Home Help during the year.

	<i>No. of cases</i>	<i>Hours employed</i>
(i) Maternity	1,739	138,174
(ii) Tuberculosis	148	26,752
(iii) Chronic sick, aged and infirm	6,196	1,075,321
(iv) Others	1,112	151,858
<b>TOTAL</b>	<b>9,195</b>	<b>1,392,105</b>

In February also, authority was obtained for the experimental use of home helps, without recovery of cost, in sub-standard homes, the experiment being restricted to not more than two households in each of two divisional areas. Three families were provided with help; in each case, the

standard of home care had deteriorated to such an extent as to bring them within the range of quasi-problem families. The home helps, with the housewife, cleaned the house and sought to teach the housewife, by example, the routine household duties of cleaning, washing, mending, cooking, etc. When the service was withdrawn, there was a marked improvement in the household conditions and in the housewife's general attitude. It is premature to suggest that a complete cure had been effected, but the results were encouraging and the experiment may be repeated where justified by the particular circumstances.



## PART VIII

### THE AMBULANCE SERVICE

This Service is under the control of Mr. V. Whitaker, O.B.E., County Ambulance Officer, who has supplied the following report:—

Statistical data for the Ambulance Service have this time been changed from a financial to a calendar year basis, to conform with other sections of the County Medical Officer's Report.

The numbers of patients carried in the year ended 31st December, 1954 again increased, being 6.17 per cent. above those of calendar year 1953:—

<i>Type of Case</i>	<i>Years ended 31st Dec.</i>		<i>Variation on 1953</i>	
	<i>1953</i>	<i>1954</i>	<i>Increase</i>	<i>Decrease</i>
Admissions	39,406	39,795	389	
Discharges	30,180	29,991		189
Transfers	8,161	8,442	281	
Out-patients	307,633	330,666	23,033	
Accident Patients	8,576	10,485	1,909	
Children to Occupation Centres	2,445	398		2,047
Total of Direct Service	396,401	419,777	23,376	
Total of Direct Agency and Car Pool Services	423,163	449,272	26,109	
Total Miles	3,010,275	3,207,046	196,771	

A regular annual statement in this report is that out-patient user, in common with other authorities, has continued to rise. This year must be added the warning that any subsequent increases may well mean a deterioration in service, particularly to out-patients, whose waiting time at hospitals for vehicles to return them home would be extended. The present increase could not have been handled had it not been for improvements in the operational running of vehicles and the use of radio in particular, which is now a vital part of Ambulance Service Management. There are, however, limits even to efficiency and the ultimate alternative can only be an increase in the fleet and manpower establishment of the Service should demand rise further.

With particular regard to recumbent patients and the policy stated in last year's report, that stretcher case admissions and discharges were to be conveyed individually, or limited to two stretcher cases of the same sex per vehicle, this has meant a considerable increase in miles run and is responsible for the major part of the mileage increase in the current year.

More patients have been conveyed by rail than in previous years and, where convenient, this is the most practical means of carrying out long distance work. Objections to this form of transportation are being gradually overcome, particularly when it is realised that the patient has ambulance privacy in the way of a reserved compartment, suffers less travel movement and has a more speedy journey. Furthermore, the practice releases vehicles for local duty, which would otherwise be occupied outside the County area.

Apart from the increased demand already referred to, the year has been progressive, particularly in the training of staff in connection with operational duties and also in First Aid.

Experiments have been undertaken in connection with the operation of a Diesel Ambulance. These experiments are of considerable importance in that if all vehicles of the Ambulance Fleet were powered by diesel engines the annual fuel cost of approximately £40,000 for petrol would be reduced by half. There is, however, one particular feature of the diesel engine connected with ambulance work about which the Authority will wish to be satisfied. This is the characteristic diesel knock which occurs when the engine is ticking over and which disappears as speed is increased. The important aspect of the test, therefore, is the effect on patients conveyed and it can now be stated that for general ambulance work the vehicle has, so far, given every satisfaction. Modifications resulting from experience are to be incorporated in additional diesel powered ambulances, with a view to eliminating all engine vibration. Data on this later development will not be available until next year.



## PART IX

### MENTAL HEALTH

**Administration.**—The detailed administration of the Mental Health Services of the County Council has been referred by the Local Health Authority to a Mental Health Sub-Committee consisting of 24 members which meets monthly.

The staff of the Mental Health Section of the County Health Department consists of:—

(a) *Medical.*

The County Medical Officer is responsible to the Mental Health Sub-Committee for the organisation and control of the Mental Health Services and he is responsible for the medical direction of the services.

The local medical administration of the Mental Health Services is undertaken by the whole-time Divisional Medical Officers in the 29 Divisions into which the County has been divided for the divisional administration of the preventive medical services. The Divisional Medical Officers and Assistant County Medical Officers approved for the purpose give certificates in accordance with the provisions of Sections 3 and 5 of the Mental Deficiency Act, 1913; undertake the statutory medical visitation of mentally defective persons under guardianship and complete Special Reports and Certificates in accordance with the requirements of Section 11(4)(b) of the 1913 Act.

(b) *Non-Medical.*

(i) Two Senior Clerks act as Petitioning Officers, one of whom holds the Diploma in Public Administration.

(ii) Twenty-four Duly Authorised Officers under the Lunacy and Mental Treatment Acts (who also perform welfare duties under the National Assistance Act), 2 of whom hold the Certificate of the former Poor Law Examinations Board and one the Lunacy and Mental Treatment part of that examination; 3 possess the Diploma in Public Administration; 6 have attended Extra-Mural Courses on Mental Health at Universities and most have had many years experience of the work. In addition certain members of the male staff of the Divisional Welfare Offices have been trained to act as Duly Authorised Officers in exceptional cases such as protracted absence of an Authorised Officer owing to sickness, holiday periods etc.

(iii) Sixteen Mental Health Social Workers, one of whom is a qualified Health Visitor and 2 are State Registered Nurses and have acted as Assistant Health Visitors; 1 holds the Diploma of the National Association for Mental Health; 7 have attended Extra-Mural Courses on Mental Health at Universities and all have had four to five months training organised by the County Council prior to being allocated to their duties in the respective Health Divisions.

(iv) Two Supervisors of Occupation Centres, one of whom holds the Diploma of the National Association for Mental Health and the other has had many years experience in School Departments of Hospitals; 2 Assistant Supervisors and 4 Nursery Assistants. An additional Assistant Supervisor is at present taking the course of training provided by the National Association for Mental Health.

(v) The County Council have an approved establishment for 24 Home Teachers. The present staff consists of sixteen whole-time Home Teachers and one part-time Home Teacher, of whom 4 are certificated teachers; 4 hold the Diploma of the National Association for Mental Health and 1 the Diploma of Occupational Therapy, whilst most of the others have had many years teaching experience in primary schools or evening institutes.

(vi) There is an establishment of six Psychiatric Social Workers but no applications have been received from qualified persons to fill these posts.

The Consultant Psychiatrists in Lunacy or Mental Deficiency employed by the Regional Hospital Boards are ever ready to give clinical opinions and advice on medication, either at Out-patient Clinics or at the appropriate Hospitals. The Medical Superintendents of the Mental Hospitals will, as a rule, arrange at the request of the Duly Authorised Officers domiciliary visits either by themselves or by members of the medical staffs and advise on the mental condition and action desirable.

Two of the Mental Health Social Workers attend Psychiatric Out-patient Clinics to assist the Psychiatrists by taking case histories of new patients, visits to patients' homes and relatives and act as liaison officers between the Psychiatrists and other Local Health Authorities, and the Duly Authorised Officers etc.

West Riding patients are admitted to 12 different Mental Hospitals some of which make use of the County Social Workers in obtaining background information relating to patients admitted to the Hospitals. This co-operation between the Mental Hospital and County Council extends to the supply, where after-care services are required, of information and case histories of patients discharged from the Hospitals and gives opportunities for discussions between the Hospital and Local Authority Staffs on patients about to be discharged, when the Social Workers are able to see patients in the Hospital and establish friendly relationships prior to discharge. This close co-operation is not the general rule although there is a gradual development of a closer liaison between the Mental Hospitals and Local Health Authority towards the goal of a completely integrated service for the benefit of the mentally ill.



**Training of Staff.**—The inability to obtain Psychiatric Social Workers is referred to above but every endeavour is made to fit the Mental Health Social Workers to carry out care and after-care of the mentally ill as well as the mentally defective. The training provided for all new appointments to the staff of Social Workers is as follows:—

One month at Oulton Hall (mental defectives) doing ward rounds with nurses, examining case papers and receiving lectures on mental deficiency, elementary psychology, etc. followed by one month at the Stanley Royd Hospital (mental) talking to patients, seeing and assisting with treatments, attendance at Out-patient Clinics and Occupational Therapy Department.

One month in the West Riding County Council's Child Guidance Section of the Health Department and Neurological Clinics and Child Guidance Clinics of the Regional Hospital Board. Training in the Mental Health Section of the County Health Department in the historical scope of the work; the statutory and voluntary Mental Health Services and visits to Occupation Centres and practical work with an experienced Social Worker.

The County Council are anxious that the scope of the training provided should be increased and with this in view discussions have been held with one of the Hospital Management Committees and the Department of Psychiatry of a University and it is hoped that the University will be able to provide an approved course of training.

The County Council have a scheme whereby the staffs of Occupation Centres and Home Teachers are recommended for the 12 months course of training provided by the National Association for Mental Health. Those accepted for the course are granted leave of absence for the period of the training and the County Council pay Students 60% of the salary of a qualified Home Teacher during the period of the course and also the course and examination fees.

There is close co-operation with all County Services to avoid overlapping, for example, where a mentally defective child is in the care of the Children's Department it is usual to arrange which Department shall undertake the major supervision and keep the other Department informed of the conditions and requirements. There is also very close co-operation with other statutory and voluntary services (Probation, Ministry of Labour and National Service, National Assistance Board, National Society for the Prevention of Cruelty to Children, the Women's Voluntary Service etc.)

In some Health Divisions frequent meetings are held at which all Social Welfare branches of the County Council are represented and all other statutory and voluntary Welfare Services are invited.

**Work undertaken in the Community.**—The general public are only gradually coming to the stage where they will accept that mental illness is another form of illness and not something to be talked about in whispers or carrying some disgrace. Acquaintances of mental health workers still tend to refer to the Social Workers' harassing and harrowing experiences rather than to their satisfaction at being members of a team able to relieve sickness and suffering.

During 1954, after-care was provided by the Mental Health Social Workers for 459 mentally ill persons discharged from Mental Hospitals, Out-patient Clinics or from the Armed Forces. In 37 cases only were care and guidance provided prior to admission to Mental Hospital or Out-patient Clinic, although to this number must be added those cases where services were rendered by the Duly Authorised Officers when they did not consider action under the Lunacy and Mental Treatment Acts to be necessary. This is a rather disappointing aspect of the work and there is need for closer co-operation with medical practitioners and relatives in this field of preventive medicine. The activities of the Mental Health Social Worker in dealing with this type of patient cover most of the normal human activities and emotions and the following are quoted as examples of the work:—

A middle-aged, divorced woman, was referred by the National Assistance Board in March 1953, as one of their problem cases, and the following information was given about her. She lived alone and had been receiving Out-relief (later National Assistance) for the past 15 years; she was regarded as a "hopeless" case by the Ministry of Labour who had ceased to consider her as employable. Her behaviour was reported to be eccentric and unpredictable, e.g. neighbours complained that she played the organ during the night and that she had been out in the street unclothed on one occasion. She would not attend enquiry boards of the National Assistance Board, nor would she attend interviews for employment. Because of these refusals her National Assistance Allowance was suspended on one occasion, but neighbours reported that the woman was slowly starving and the Board felt morally unable to withhold payment in these circumstances. Armed with these facts the Mental Health Social Worker visited the home. The woman showed marked symptoms of mental illness, but it was considered that she was not certifiable at that time. Her manner was vague, she was suspicious and withdrawn and she refused to consider voluntary treatment either as an In-patient or at an Out-patient Clinic. It seemed, in view of the past history, a hopeless task to try and attempt to rehabilitate this patient. However, regular visiting was arranged and gradually she began to accept these visits, became less suspicious and gained confidence in the Social Worker. Contact was established with her married daughter living in Gloucester who was able to give valuable information regarding her past history. It was possible to help the patient in many ways during 1953. She was given regular handicraft lessons by the Home Teacher and a great deal of advice, help and encouragement, especially in the matter of lodgings,



after having been evicted from her own home in August. Employment, of course, proved the biggest problem, but an offer of work was finally secured from a local textile mill and arrangements made for close contact between the Mental Health Social Worker and the Welfare Officer of the mill. By dint of constant supervision and encouragement it has been possible to keep this woman working during the whole of 1954, and she has been self-supporting, probably for the first time in her life. She now lives in accommodation owned by the mill where she works, and she is accepted by the community in which she lives and works. The woman still requires advice and help in dealing with her problems, but the improvement in both her physical and mental condition during the past two years is most marked.

Another more amusing case where benefit was derived from an unexpected source was a woman, aged 55 years, who had been a patient in a Mental Hospital. The family consisted of the woman and her husband and an adult son. There were also two married daughters living away from home. The family lived on a farm  $1\frac{1}{2}$  miles from the nearest hamlet. Before her admission to Hospital she did not take much interest in the life of the community but was not too withdrawn. Whilst in Hospital the farm was sold and a terrace house in a large village purchased. On her return home Mrs. 'Blank' refused to go out of the home or to join in any of the village activities. All avenues of interest were explored and she was urged to find some faith and interest in life. At one visit she startled the Social Worker by announcing she now had an interest as she had started to gamble. Each week she started with a 1/- each way on a horse and winnings were placed on a horse the following day etc. This required her to go out for a daily paper to follow her racing interests. This in turn led to friendly overtures from neighbours and she now does her own shopping and takes an interest in the village activities.

**Lunacy and Mental Treatment Acts.**—Action under the Lunacy and Mental Treatment Acts during 1954 was as follows, the figures for 1953 being given in brackets:—

Lunacy Act, 1890. Patients admitted under Section 16, 461(487); under Section 20, 206(177); under Section 21, 39(19); under Section 11, 6(6). Assistance was also given in respect of patients admitted under the Mental Treatment Act, 1930:—Section 1, 238(191); Section 5, 16(7). The Duly Authorised Officers were also consulted by general medical practitioners and relatives in 219 cases (243) where action under the Lunacy and Mental Treatment Acts was considered to be unnecessary.

The Psychiatric Out-patient Clinics and Specialist Services are proving very valuable in providing expert advice for the general medical practitioners in difficult and doubtful cases and also where the Duly Authorised Officers can obtain advice on the most appropriate action, particularly with regard to the elderly and old senile dementia patients. When a patient is recommended at an Out-patient Clinic there is little difficulty in arranging the appropriate admission. Additional Psychiatric Out-patient Clinics have been established during the year but there are still areas of the County where increased out-patient facilities would be appreciated.

Unfortunately accommodation is not always available for Section 20 cases in the Hospitals designated for this purpose and, in view of the undoubted advantages for the patients of Section 20 care, it is felt that additional accommodation should be designated for this purpose. Whilst there has been some improvement in the availability of accommodation for certified patients, occasionally Orders, although suspended, have lapsed before accommodation has become available.

It is pleasing to know that there has been a slight decline in the number of elderly people referred by general medical practitioners and members of families of these old people to the Duly Authorised Officers with a view to their admission to Mental Hospitals. Many of the cases (219) where no action was taken by the Duly Authorised Officers under the Lunacy and Mental Treatment Acts were elderly people living alone, some of whom were admitted to Chronic Sick Hospitals, others to Part III accommodation under the National Assistance Act and relatives were persuaded to provide the necessary care or to take an active interest in others. In some of these cases attendance at Psychiatric Out-patient Clinic was considered desirable and this was arranged.

**Mental Deficiency Acts.**—During 1954, 305 persons were reported to the Local Health Authority as alleged mentally defective persons, of whom 17 had not been confirmed as defective by the 31st December, 1954, and 7 were found not "subject to be dealt with"; the remaining 281 were reported as follows:—By the Local Education Authority under Section 57(3) of the Education Act, 1944, 126; under Section 57(5), 104; by Police or Courts, 5, and by other sources, 46. These 281 mentally defective persons were dealt with as follows:—Placed under Statutory Supervision, 261; admission to Hospitals, 20.

The total number of ascertained mentally defective persons in the Riding on the 31st December, 1954 was 4,254:—Under Statutory Supervision, 2,112; Under Guardianship, 73; in "Places of Safety", 3; Admitted to Hospitals, 1,655; Under Voluntary Supervision, 411.

On the 31st December, 1954 there were 247 mentally defective persons awaiting institutional care of whom 65 (including 24 cot or chair cases) were in urgent need.

Of the patients under community care 872 were considered to be suitable for some form of training as follows:—



		Under age 16 years		Aged 16 and over		Total
		M.	F.	M.	F.	
(i)	Occupation Centre	210	193	46	130	579
(ii)	Industrial Centre	4	1	89	19	113
(iii)	Home Training	11	9	27	78	125
(iv)	Group Training	5	6	8	36	55
		230	209	170	263	872

Of these 671 were receiving training as follows:—

(i)	In Occupation Centre	108	83	9	25	225
(ii)	In Industrial Centre	1	—	8	—	9
(iii)	At home	16	26	52	85	179
(iv)	In Group Training Classes	82	72	29	75	258
		207	181	98	185	671

Seven hundred and twenty-one of the remainder of the mentally defective persons under community care (506 males and 215 females) were in full time employment and 44 (36 males and 8 females) were in part-time employment. Of the others 389 (105 males and 284 females) were adequately occupied at home.

**Training.**—The County Council's Scheme under Section 51 of the National Health Service Act, 1946 provides for the establishment of 15 Occupation and/or Industry Centres in various parts of the Riding and Centres have been established at Castleford and Keighley, both with accommodation for 45 mentally defective persons. A new Centre at Hemsworth is nearing completion; a site has been acquired for a large Centre at Wath upon Dearne and plans of the proposed buildings have been submitted to the Ministry of Health for approval. It is proposed to adapt County property at Wombwell, Ossett, Brighouse and Yeadon for Centre purposes and sites for new Centres have been inspected at Adwick-le-Street and Maltby and proposals for the erection of Centres in these two areas have been approved.

The Scheme also provides for co-operation by the County Council with other Local Health Authorities in the establishment of joint Centres; for West Riding defectives to be admitted to Centres provided by other Authorities; for the provision of Home Teachers who visit mentally defective persons in their own homes and provide training for small groups in available clinic and other suitable premises and also for the provision by the Mental Health Social Workers of some training for defectives in isolated parts of the County.

West Riding defectives are admitted to Centres provided by the Leeds, Bradford, Barnsley, Burnley, Dewsbury, Doncaster, Huddersfield, Oldham and Wakefield County Borough Authorities. In addition arrangements have been made with the Hospital Management Committee for a few West Riding defectives to be admitted to the Westwood Hospital, Bradford, for daily training.

Although there is an approved establishment of 24 Home Teachers, difficulty has been experienced in obtaining suitable applicants for this onerous duty and the staff at present consists of 16 whole-time and one part-time Teacher. Of the 437 defectives (196 children and 241 adults) receiving training otherwise than in occupation or industry centres, 179 are visited in their own homes and 258 attend group classes.

**Short Stay Care** (Section 28, National Health Service Act, 1946).—During 1954 short stay care was provided on 105 occasions for defectives where there was an emergency in the family or the parents were in need of a rest from the strain of caring for a mentally defective child.

The accommodation obtained was in Hospitals in the area of the Leeds Regional Hospital Board on 75 occasions, in the Sheffield Regional area on 24 occasions and in the Manchester Region on one occasion whilst on five occasions the care was provided at the expense of the County Council in a Home provided by a voluntary Association.

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.)

This Centre continues to serve the needs of the mentally defective children from the Castleford, Rothwell, Pontefract and to a lesser extent the Wetherby Health Divisions. The activities carried on at the Centre are essentially of a practical nature, the aim being to teach the younger children the foundations of clean social habits and the older children those things which should be of beneficial use in the home. Most of the older girls are now able to engage in darning, mending and plain sewing and in one or two cases have reached quite a high standard. The work carried out by the boys is not so satisfactory as our premises are unsuitable for wood and craft work but considerable progress has been made in the art of making rugs, sea grass stools and cane work. The Supervisor and her staff must have put a considerable amount of time and energy into the training of the percussion band, and it is to their credit that the majority of the children can now read the score from coloured charts. Speech training has also reached a high standard and evidence of



this was clearly seen at the Open Day in May and the Nativity Play at Christmas time. The former was combined with a sale of work attended by parents, officials and members of the Mental Health Sub-Committee whilst the latter was combined with the Christmas party celebrations when County Alderman M. Whittock, Chairman of the Urban District Council, was present and County Alderman E. Taylor took on the role of Santa Claus and distributed the presents.

On her visit to the Centre in October, the Board of Control Inspector, Mrs. Milne Redhead, expressed herself well satisfied with the work carried out by the staff, with the cleanliness and good condition of the children and with the clinical facilities available for them.

One of the highlights of the year was the formation of a Parent-Teachers Association. Although the organisation of such an association had been discussed in previous years, it had always been felt that a venture of this nature would almost inevitably prove a failure, due not so much to a lack of enthusiasm but to the distance many parents would have to travel to attend the meetings. The association was formed in March, and so groundless have these early fears been that, as a result of the tireless efforts of the members, the Association has gone forward from strength to strength. Talks on appropriate subjects were given by speakers well qualified for the purpose and the various activities of the Association, combined with a £20 donation by the Leeds University Rag Day Fund, brought their receipts at the end of the year to £181. This money has been put to many useful purposes including the purchase of a velvet stage curtain and during the early months of the new year it is proposed to take the children to a Leeds Pantomime.

The annual outing in July was again held at Filey and, in view of the really fine day which we had, it proved a great success and the behaviour of the children was excellent. This outing was made possible by the generosity of the Mental Health Sub-Committee.

#### BRANSHAW VIEW OCCUPATION CENTRE, KEIGHLEY

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

The principal achievement during the year has been the consolidation of various arrangements relating to the general administration of the Centre.

The Supervisor submits monthly reports to the Divisional Medical Officer setting out details of children in attendance and he is thus enabled to follow up persistent non-attenders through the agency of the Mental Health Social Worker.

The relationship between the Centre and the Parents Association has been regularised, parents continue to make use of the Centre for social events and have expressed their appreciation by subscribing generously to its amenities.

The institution of a domestic science class proved a great success, but it had to be temporarily suspended whilst the Assistant responsible attended the Course for Supervisors of Occupation Centres. A puppet show was introduced, the glove puppets were found easier to manipulate than the string controlled puppets.

A summer outing was arranged to a farm at Luddendenfoot, transport was provided and the School Meals Service packed sandwiches for the event; 36 children, 5 staff and 3 parents formed the party, all returned happy and well satisfied.

Several successful social events punctuated the year including the Christmas party, tree and cinematograph show, also the Christmas open day and sale of work.

The attendances at the Centre were disturbed by a sharp outbreak of Dysentery during the month of February, nearly all the children were involved, the cases were of a mild type and all recovered.

Towards the end of the year consideration was given to the development of a vegetable garden and a small playing field for the benefit of the children. The possibility of a swimming class suitable for children attending the Centre was also explored. A report on the progress of these projects will be forthcoming next year.

The number of children in attendance at the Centre on the 30th November, 1954 was 27, whilst the number on the register was 36 in the following age groups:—

#### YEARS:

Sex	5	6	7	8	9	10	11	12	13	14	15	16	17	18
M	1	1	5	3	3	2	3	2	—	3	1	—	—	—
F	—	—	1	1	1	2	—	3	—	—	1	2	—	1

The staff continue to work harmoniously together, the interest and zeal taken in the work are a great source of satisfaction to both parents and Committee.

There can be no denying the real social need this Centre fulfils. The children are acquiring the means of interesting themselves, they are encouraged by their achievements, the fact that they are being scientifically cared for is a great source of comfort to their families, and our efforts on their behalf must never relax.



## PART X

### ENVIRONMENTAL HYGIENE

#### Milk

The County Council has again carried out its obligations as a Food and Drugs Authority (Section 64 of the Food and Drugs Act, 1938) and as a Licensing Authority for the Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949-53.

The following list gives the names and addresses of licensees at the 31st December, 1954:—

#### PASTEURISED MILK.

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

#### STERILISED MILK.

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

All premises licensed to produce pasteurised and sterilised milk were visited regularly and inspections carried out 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 thirty minutes. This is the "Holder" system and is in use at 11 of the dairies; (b) retained at a temperature of not less than 161°F. for at least fifteen seconds. This is the "High Temperature, Short Time" system and is in use at 14 dairies. All treated milk must be immediately cooled to a temperature of not more than 50°F.

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.

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

Number	PASTEURISED MILK				STERILISED MILK	
	Phosphatase Test		Methylene Blue Test		Turbidity Test	
	<i>Satisfactory</i>	<i>Unsatisfactory</i>	<i>Satisfactory</i>	<i>Unsatisfactory</i>	<i>Satisfactory</i>	<i>Unsatisfactory</i>
572	561	11	566	6	22	—
22						

Immediate investigations were carried out regarding the unsatisfactory phosphatase results and the Chief Area Milk Officer of the Ministry of Food was informed in each case.

Reports of samples are notified to the Medical Officer of Health concerned.



**Sampling of Milk produced at Hospital Farms.**— During the year, from March to November, at the request of the Ministry of Health, samples were obtained at 8 farms attached to the hospitals shown below and reports are as follows:—

<i>Hospital</i>	<i>Methylene Blue Test</i>			<i>Date of laboratory report</i>	<i>Brucella Abortus Examination (4 samples from each farm)</i>	
	<i>Number</i>	<i>Sat.</i>	<i>Unsat.</i>		<i>Agglutination</i>	<i>Culture</i>
Middleton, Ilkley	12	11	1	23.10.54.	1/640	Positive
Menston, Near Ilkley	12	9	3	29.12.54.	1/40	Positive
Scalebor Park, Burley in Wharfedale	12	7	5	23.10.54.	Neg.	Positive
Storches Hall, Kirkburton	12	10	2	23.10.54.	1/320	Positive
Middlewood, Near Sheffield	12	12	—		All negative	
St. John's, Wheathead Farm, Keighley	12	12	—		All negative	
Stansfield View, Todmorden	12	11	1		All negative	
Stanley Royd, Wakefield	12	10	2		All negative	

4 samples from each farm were also examined for tubercle bacilli and found to be negative in every case.

Arrangements are made for immediate notification to the Ministry of Agriculture and Fisheries in the event of any positive biological reports.

**"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.

During the year two "Specified Areas" came into operation, viz:—

*1st January. Milk (Special Designations) (Specified Areas) (No. 3) Order, 1953*, which included Ossett Municipal Borough along with the Urban Districts of Elland, Kirkburton and Mirfield.

Investigations carried out by the County Sanitary Inspectors revealed the following figures:—

	<i>Milk Retailers</i>	<i>Catering Establishments</i>	<i>Shops Selling Milk</i>
Ossett M.B.	27	34	33
Elland U.D.	62	90	11
Kirkburton U.D.	55	43	—
Mirfield U.D.	29	41	10
	<hr/> 173	<hr/> 208	<hr/> 54

*1st October. Milk (Special Designations) (Specified Areas) (No.2) Order, 1954.* This area includes the Municipal Boroughs of Batley, Brighouse, Morley and Pudsey and the Urban Districts of Heckmondwike, Spenborough, Denholme, and Queensbury and Shelf.

Details found at the surveys were as follows:—

	<i>Milk Retailers</i>	<i>Catering Establishments</i>	<i>Shops Selling Milk</i>
Batley M.B.		Own Food and Drugs Authority.	
Brighouse M.B.	48	77	42
Morley M.B.	39	85	130
Pudsey M.B.	53	76	61
Heckmondwike U.D.	22	27	35
Spenborough U.D.	65	80	67
Denholme U.D.	7	15	—
Queensbury and Shelf U.D.	34	24	13
	<hr/> 268	<hr/> 384	<hr/> 348

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 is necessary that arrangements are made and carried out in the County Administrative Area.



In connection with the duties entailed in carrying out the work under these Orders, I wish to accord my thanks to the Sanitary Inspectors in the County Districts concerned for their valuable assistance so willingly given to the County Sanitary Inspectors—a further instance of the close co-operation which exists in the County.

**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, the rest mainly tuberculin tested.

89 visits and enquiries were made in connection with school milk supplies, apart from the visits made as a routine measure to contractors who have licences for pasteurised milk production under the Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949-53.

<i>Total Number of Schools</i>	<i>Milk supplied</i>		
	Pasteurised	Tuberculin Tested	Ordinary
1,267	1,224 (96.6%)	40 (3.2%)	3 (0.2%)

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

	Total	Satisfactory	Unsatisfactory
Pasteurised	321	317 (98.8%)	4 (1.2%)
Raw	100	89 (89.0%)	11 (11.0%)
Total	421	406 (96.4%)	15 (3.6%)

It is very satisfactory to be able to record a high standard of milk supplied to schools, indicative of the care and attention given by all concerned.

In connection with the few raw milks supplied, these are periodically submitted to biological test for tubercle bacilli.

### Ice Cream

Number of samples submitted for bacteriological examination, with results:—

	Grade			
	1	2	3	4
Municipal Boroughs and Urban Districts	1,120	170	74	41
Rural Districts	375	89	15	17
Totals	1,495	259	89	58

### Atmospheric Pollution

In the North of England many years ago the expression “where there’s muck there’s money” was freely used, presumably inferring the prosperity of the mines, factories and other industrial concerns. Would it not be nearer the truth to say “where there’s muck there’s ill-health, damage and loss”?

Following the disastrous results of the smoke fog in Greater London in December, 1952, the Government decided that the whole problem of air pollution should be re-examined and set up, under the chairmanship of Sir Hugh Beaver, a Committee of Inquiry with the following terms of reference — “to examine the nature, causes and effects of air pollution and the efficacy of present preventive measures; to consider what further preventive measures are practicable; and to make recommendations”.

After years of comparative neglect, although recently informed opinion has altered somewhat, the seriousness of atmospheric pollution has been realised, and the Committee in their Report, published in November, 1954, makes a valuable contribution.

“Air pollution”, says the Committee, “is caused by smoke, gases, grit and dust from domestic and industrial chimneys, locomotives and ships, exhaust gases from motor vehicles, and the solid and gaseous pollutants from chemical works and industrial processes”. The problem is great but the Committee expresses the emphatic belief that air pollution on the scale with which we are familiar in this country to-day is a social and economic evil which should no longer be tolerated.



There is no easy or quick solution to the problem and, if the Committee's aim of a reduction of total smoke by 80 per cent. in all heavily populated areas by the end of ten to fifteen years is to be achieved, it calls for a "continuous programme urgently and insistently carried out over a number of years".

Although scientific evidence about the effects of atmospheric pollution on human health is incomplete, there would appear to be no doubt that it is injurious to health and there appears a clear association between pollution and the incidence of bronchitis and other respiratory ailments. Many people suffer illness each year, brought about by air pollution, with the resultant loss of earnings and output, while others, many of whom might have had years of useful life ahead of them, die from the effects.

In addition, there is the economic loss incurred by way of physical damage or destruction of materials, buildings etc., as well as the loss of agricultural productivity. The Committee, in estimating that air pollution is costing the nation around £250 millions a year, has only included the losses which can be given a monetary value. To this must be added the value of fuel wasted through imperfect combustion; suspended impurity has been found to contain about 14 per cent. by weight of tarry matter and 71 per cent. of other combustible matter and must, therefore, be composed largely of the smoke which is produced when fuel is incompletely burnt.

The Committee is of the opinion that expenditure on curing this "social and economic evil of the first magnitude" would be a fraction of the savings which would result from the cure.

A number of far-reaching recommendations for tackling the problem effectively are made by the Committee; a brief summary of some of them is as follows:—

*Industrial Smoke:*—The Committee is satisfied that with a few exceptions, which entail technical difficulties, no industrial chimney need normally emit more than a slight haze of smoke and, subject to allowances being made for occasional soot blowing and raking of the fires, they suggest that the law should be amended to prohibit the emission of dark smoke. Much plant is obsolescent so that extensive modifications and improvements may be necessary. With this in mind, the Committee considers that the new legislation "should be deferred for a period of three years from the publication of the Report, which would allow time for any necessary re-equipment in the great majority of cases". Although, in the Report, stress is rightly placed on modernising the equipment, the conversion of hand-fired boilers to mechanical stokers or the fitting of smoke eliminating devices etc., it is suggested that stoking be recognised as a highly skilled job with suitable reward for trained and efficient firemen.

*Grit and Dust:*—Grit and dust are emitted from furnaces and many industrial processes whether there is visible smoke or not; though usually, while it can be proved that the prevention of smoke is advantageous, because of fuel saved, there is no similar incentive for the reduction or prevention of emission of grit and dust. The Committee, therefore, recommends that, with the exception of suggested "scheduled processes" which should be dealt with separately, it should be a statutory duty of the owners and occupiers of all industrial or trade premises which have furnaces fired by solid fuel to take all reasonably practicable steps to prevent the emission of grit and dust.

*Sulphur Pollution:*—When fuel is burnt, however efficiently, invisible but harmful sulphur gases are discharged into the atmosphere along with the chimney gases. The Committee finds that no known methods exist whereby the greater part of the sulphur from industrial and domestic chimneys can be prevented from pouring into the atmosphere. In the case of power stations, various methods of dealing with the problem have been tried, but they are not generally in operation due to the high cost.

The Committee, however, finding that power stations are responsible for slightly less than 20 per cent. of the total sulphur dioxide discharged into the atmosphere, recommends that "the most efficient practicable methods of removing sulphur from flue gases should be adopted at all new power stations in or near populated areas". This does not, however, solve the problem of the remaining four-fifths and the Committee asks that, as there is no present prospect of substantially reducing the emission of sulphur oxides from these other sources, intensive research should be made into the matter.

*Colliery Spoilbanks:*—In some colliery districts the spoilbanks, because of spontaneous combustion, are often to be seen smoking or glowing. These are unsightly enough when they are quiescent but when they burn and pollute the atmosphere with their smoke and fumes they affect not only buildings, crops etc. but also the health of the people living nearby. The Committee recommends that the law should be brought up to date and strengthened.

*Railway Smoke:*—"Over one-seventh of all smoke discharged into the atmosphere", says the Committee, "is caused by railway locomotives, most of the smoke being produced by shunting engines and stationary locomotives in the vicinity of stations, engine sheds and marshalling yards". It suggests that changeover from steam to diesel shunting engines should be accelerated and extended so as to replace the coal-fired engines in industrial areas by 1960, this being in addition to the acceleration and extension of the programme of electrification of the railways. It recommends that the laws which date from 1845 and 1868 should be revised and the powers of Local Authorities increased.



*Domestic Smoke:*—The problem of eliminating domestic smoke is a complex one. Nearly half the total smoke entering the atmosphere comes from domestic chimneys and while seldom is dark smoke emitted, there is the cumulative effect of light smoke from a large number of low chimneys. According to the 1951 Census there were nearly 12 million dwellings in England and Wales, of which the great majority have open fires. The Committee recognises that their recommendations for the prevention of "dark" smoke, though applicable to domestic as well as industrial chimneys, will have little effect on reducing pollution from domestic chimneys and recommends "that Local Authorities should have power under general legislation for the establishment of smokeless zones in which the emission of smoke from chimneys would be entirely prohibited, and smoke control areas in which the use of bituminous coal for domestic purposes would be restricted". This calls for conversion of the appliances in many cases and the Committee feels that financial assistance should be provided by Local Authorities and by the Exchequer towards the costs incurred by house owners in converting appliances in smokeless zones and smoke control areas.

*Administration:*—The Committee are of the opinion that, in the main, responsibility for administering atmospheric pollution legislation should remain with Local Authorities but the supervision of certain special plants (power stations, gas works, lime works etc.) should be by the central authority.

The Report concludes by calling for combined action and full co-operation from all concerned—the Central Authority, Local Authorities and the public. Clean air should be declared a national policy, recognised by all; "neither the Government nor Local Authorities are likely to achieve any real measure of success unless all interests co-operating and unless public opinion, individual and corporate, clearly demands and will support the action that is required".

Arising from this conclusion, their recommendation of a Clean Air Council "to co-ordinate all aspects of the work in future, to encourage research and development and to review the progress made in implementing any new legislation" should serve a very useful purpose in bringing the matter of air pollution more forcibly to the notice of all concerned.

It is pleasing to note that proposals are afoot for the matter of air pollution to be dealt with at national level in the Government's Clean Air Bill at present under consideration.

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 which was 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.

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 SO <sub>2</sub> in mg. per day Average	Situation of Daily Smoke Filter	Average Daily Suspended Impurity Milligrams per cubic metre Average
	Rainfall in inches		Total solids deposited in Tons per sq. mile				
	Monthly Average	Total*	Monthly Average	Total*			
Skipton—Behind Town Hall in industrial and residential area.	4.20	50.43	19.84	238.06	0.70	On top floor of Town Hall, in industrial and residential area.	0.185 for 11 months
Keighley—Abattoir, Hardings Road in mainly open country.	3.16	34.71 for 11 months	15.13	166.46 for 11 months	1.88	First floor of Public Health Dept., in a built-up area in centre of town.	0.197 for 11 months
Keighley—Oldfield, Oakworth in windy moorland country.	2.47	29.59	8.83	105.90	1.52 for 11 months		
Keighley—Low Bridge, dense industrial area.	3.24	38.88	17.29	207.42	1.74		
Keighley—Library, built-up area in centre of town.	3.49	41.89	17.71	212.46	2.49		
Bingley—St. Ives Research Station in parkland and residential area.	3.54	42.42	9.99	119.86	1.42	In grounds of St. Ives Research Station, in parkland and residential area.	0.048
Bingley—Town Hall in manufacturing and residential area.	3.11	34.17 for 11 months	11.36	125.00 for 11 months	0.87 for 11 months		
Shipley—Somerset House Clinic in manufacturing and semi-residential area.	2.96	32.58 for 11 months	14.27	156.92 for 11 months	1.50 for 11 months		
Horsforth—Broadgate Walk, residential area.	2.79	33.51	16.15	193.82	1.65		
Aireborough—Yeadon Moor, Yeadon Waterworks, Agricultural N.W. to S.E., manufacturing S.E. to W.	1.83	16.44 for 9 months	16.73	150.56 for 9 months	1.82 for 10 months	Sanitary Inspector's Office, Yeadon High Street, residential to W., open country to E.	0.108
Otley—Nursery Gardens, Westgate, manufacturing and semi-residential.	2.90	31.90 for 11 months	14.91	164.00 for 11 months	0.84	First floor of Council Offices, in town centre, mainly manufacturing.	0.098
Ripon—Engineer's Depot, residential area.	2.72	32.69	8.80	105.61	1.32	Health Dept., High Skellgate, in centre of country town.	0.106
† Harrogate—Roof of Municipal Offices, residential and commercial. Inland Spa.	2.93	29.28 for 10 months	8.35	83.49 for 10 months	0.97 for 11 months	Laboratory, Royal Baths. Inland Spa.	0.070
Wetherby—Council Offices, residential, surrounded by open country from $\frac{1}{4}$ to $\frac{1}{2}$ mile distant.	2.39	28.73	9.38	112.61	0.82	Council Offices, residential, surrounded by open country from $\frac{1}{4}$ to $\frac{1}{2}$ mile distant.	0.152

\* For period of full year unless stated otherwise.

† The instruments were previously at Meteorological Station, Valley Gardens, and were moved to present site on 1st September, 1954.



Situation of Instruments	Deposit Gauge				Sulphur Measurements by Lead Peroxide Method (SO <sub>2</sub> ) per 100 sq. cms. per day	Situation of Daily Smoke Filter	Average Daily Suspended Impurity Milligrams per cubic metre
	Rainfall in inches		Total solids deposited in Tons per sq. mile				
	Monthly Average	Total*	Monthly Average	Total*			
Goole—Health Centre, Bartholomew Avenue, residential and industrial.	2.33	28.01	11.55	138.55	1.32	Div. Health Office, in residential and industrial area.	0.200 for 9 months
Castleford—Roof of Marks and Spencer's shop, Carlton Street, in centre of industrial town.	2.08	24.94	16.52	198.18	3.16	First floor of Div. Health Office, in residential area.	0.180
Castleford—Roof of Cleansing Station, Cinder Lane, manufacturing area.	1.95	23.36	22.18	266.10	3.89		
Castleford—U.D.C. Pumping Station, Ings Lane, manufacturing area.	1.67	20.05	15.26	183.12	2.58		
Castleford—U.D.C. Housing Depot, Redhill Road, Airedale. Industrial and residential area.	2.01	22.14 for 11 months	13.17	144.82 for 11 months	2.55		
Horbury—Carr Lodge Park, residential and manufacturing to north, open country to south.	2.81	30.93 for 11 months	17.84	196.21 for 11 months	1.69	Sewage Works, $\frac{1}{2}$ mile south of town centre, north manufacturing and residential, south open country.	0.098
Morley—Flat roof of Co-operative Society premises, residential, commercial and manufacturing.	2.84	34.04	19.65	235.75	2.34	Ground floor P. H. Dept., in centre of mixed residential, commercial and manufacturing town.	0.164
Batley—Flat roof of one storied building at rear of P. H. Dept., Market Place. Centre of town. Mixed residential, commercial and manufacturing.	2.69	32.32	19.14	229.67	2.11	Public Health Dept., Market Place, in centre of mixed residential, commercial and manufacturing area.	0.178
Rothwell—Central Clinic, Oulton Lane, residential.	2.46	29.54	13.95	167.35	2.10	Div. Health Office, Oulton Lane, in residential district.	0.134
Spensborough—Council's Depot, Marsh. North, south and west—manufacturing area, open country to east.	2.55	30.60	15.40	184.76	2.36	Div. Health Office, Elm Bank, in industrial and manufacturing area.	0.166
Elland—"Ellen Royd," Public Library in manufacturing area.	3.67	43.99	13.61	163.35	2.11	First floor of Council Offices, in manufacturing area.	0.162
Hebden Royd—Redacre Sewage Works, Mytholmroyd, residential and manufacturing area.	4.33	47.64 for 11 months	16.30	179.33 for 11 months	1.61	Redacre Sewage Works, Mytholmroyd, residential and manufacturing area.	0.115

\* For period of full year unless stated otherwise.



Situation of Instruments	Deposit Gauge			Sulphur Measurements by Lead Peroxide Method SO(3) per 100 sq. cms. per day Average	Situation of Daily Smoke Filter	Average Daily Suspended Impurity Milligrams per cubic metre Average
	Rainfall in inches		Total solids deposited in Tons per sq. mile			
	Monthly Average	Total*	Monthly Average			
Colne Valley—Sewage Works, Slaithwaite, in mixed residential and textile manufacturing district.	4.05	48.55	15.47	185.62	Town Hall, Slaithwaite, in mixed residential and textile manufacturing district.	0.121
Colne Valley—Marsden Park, residential and manufacturing area.	4.84	53.21 for 11 months	15.01	165.13 for 11 months		
Holmfirth—Sewage Works, Neiley, Brockholes, residential and manufacturing.	3.67	44.04	13.05	156.58		
Saddleworth—Sewage Works, Shaw Hall Bank, Greenfield. Open country.	3.66	40.21 for 11 months	14.53	159.82 for 11 months	Sewage Works, Shaw Hall Bank, Greenfield. Open country.	0.080 for 10 months
Wortley—Hallwood Hospital Grounds, Grenoside, open country and woodland.	3.06	33.63 for 11 months	9.82	107.97 for 11 months	Health Department, Council Offices, Grenoside, industrial and manufacturing area.	0.105
Hemsworth—Vale Head Park, parkland, surrounded by open country.	2.15	23.68 for 11 months	13.15	144.70 for 11 months	Div. Health Office, Adiscombe House, in residential district.	0.145 for 10 months
Darton—Grounds of Council Offices, semi-residential, colliery district.	2.76	33.08	14.74	176.85	Council Offices, semi-residential, colliery district.	0.165
Wombwell—Grounds of Divisional Public Health Office, The Gables, semi-residential, colliery district.	2.20	24.15 for 11 months	17.58	193.33 for 11 months	Div. Health Office, semi-residential, colliery district.	0.205
Rawmarsh—Roof of Clinic, Barbers Avenue, residential and industrial.	2.41	28.97	21.71	260.49	Sanitary Inspector's Office, in centre of residential and industrial area.	0.327
Rawmarsh—Grounds of Granby House, Aldwarke Road. Blast furnaces 200-300 yards distant.	2.35	28.17	69.93	839.11		
Bentley-with-Arksey—Bentley Park, Askern Road, semi-residential, colliery district.	2.22	26.62	14.78	177.40	Council Offices, in centre of semi-residential area, colliery district.	0.149
Doncaster—Between Church and Vicarage, Askern. Industrial and residential. Colliery district.	1.76	21.12	32.97	395.69	Council's Depot, Kirk Sandall, in open country, with large glassworks approx. 1 mile to north.	0.103
Thorne—Grounds of Council Offices, semi-residential, colliery district.	1.98	21.80 for 11 months	10.32	113.53 for 11 months	Council Offices, town centre in semi-residential and colliery district. Maltby—Council Offices, one mile west of town centre, semi-residential, colliery district.	0.140 0.121 for 10 months
Sulphur Measurements by Volumetric Method						
Situation of Volumetric Sulphur Dioxide Apparatus				SO(2) in parts per million Average		
Hebden Royd—Redacre Sewage Works, Mytholmroyd, residential and manufacturing area.				0.036		
Aireborough—Sanitary Inspector's Office, Yeadon High Street. Residential to W., open country to E.				0.039		

\* For period of full year unless stated otherwise.



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

	<i>No. of observations each of 30 minutes duration</i>	<i>No. of these showing excessive emission of black smoke</i>	<i>No. of cautions issued</i>	<i>No. of statutory notices served</i>	<i>No. of prosecutions</i>	<i>Bye-laws in force</i>	<i>Districts with colliery spoil-banks</i>	<i>Firing of spoil-banks</i>
Municipal Boroughs and Urban Districts (68)	2,305	299	173	9	1	39	30	23
Rural Districts (21)	131	25	25	2	—	5	12	9

The Acting Chief County Sanitary Inspector is a co-opted member of the West Riding of Yorkshire Regional Smoke Abatement Committee and is thereby enabled to keep in touch with the sanitary inspectors and other representatives of the County Districts on matters regarding smoke abatement.

### Sanitary Circumstances

**Housing.**—In the Municipal Boroughs and Urban Districts there were 385,780 dwelling houses and in the Rural Districts 132,156 giving a total number of 517,936.

<i>New Houses</i>	<i>Provided by</i>		<i>Totals</i>
	<i>Local Authority</i>	<i>Private Enterprise</i>	
	<i>Permanent</i>	<i>Temporary</i>	
Municipal Boroughs and Urban Districts	5,295	—	9,042
Rural Districts	2,495	—	5,065

**HOUSING CONDITIONS**—As in previous years the County Medical Officer has received letters and personal requests from residents in the County Districts in connection with their existing housing situation and, in every case, reference has been made to the Medical Officer of Health for the District concerned.

The following details have been extracted from the Housing Returns furnished by the County Districts:—

	<i>Unfit Houses</i>	<i>Houses not in all respects reasonably fit for habitation</i>	<i>Demolition Orders made</i>	<i>Houses demolished following Demolition Orders</i>	<i>Closing Orders made</i>	<i>Closing Orders determined</i>	<i>Number of cases of overcrowding at end of year</i>	<i>New cases reported during year</i>	<i>Cases of overcrowding relieved during the year</i>	<i>Number of defective dwelling houses rendered fit in consequence of Informal Action by their Officers</i>
Municipal Boroughs and Urban Districts	6,286	15,302	343	319	85	11	2,196	544	1,170	14,673
Rural Districts	4,306	6,718	58	137	17	1	1,122	79	504	1,734

According to the latest returns furnished by the County Districts, it is now estimated that the approximate number of back-to-back and some single-back types of houses is 40,000.

**HOUSING ACT, 1936: CLEARANCE AREAS AND ORDERS**—*Dearne U.D.* Public Inquiry held regarding a Clearance Order for 47 houses. Order Confirmed. *Skipton U.D.* Two Clearance Orders submitted to Ministry involving 22 houses. One Clearance Order (Council property) involving 9 houses. One Clearance Area—undertaking given by owner to demolish 5 houses. One representation for 18 houses. *Settle R.D.* 4 derelict houses demolished.

**HOUSING ACT, 1949: HOUSING REPAIRS AND RENTS ACT, 1954**—The following table shows the action taken during the year by County District Councils:—

<i>Advances for purpose of increasing housing accommodation</i>	<i>Grants to persons other than local authorities for improvement of housing accommodation</i>		
	<i>Applications granted</i>	<i>Schemes withdrawn</i>	<i>Applications rejected</i>
103	575	5	11



**HOUSING (RURAL WORKERS) ACTS, 1926-42**—The County Sanitary Inspectors made 250 inspections at cottages for which grants have been given under the above Acts. These cottages are situated 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 some are situated in the outlying parts of Todmorden Borough and Bingley Urban District. The inspections dealt with the matter of tenancies, structural conditions and rents. Detailed reports were made and forwarded to the Clerk of the County Council who informed the owners of any matters in need of attention. In several instances it was found necessary for the County Sanitary Inspectors to meet owners or agents at their cottages for discussions regarding the defective conditions.

**Closet Accommodation.**—

	<i>Total number of closets of all types</i>	<i>Number of closets on the water carriage system</i>	<i>Percentage of closets on the water carriage system</i>
Municipal Boroughs and Urban Districts	423,984	413,054	97.4
Rural Districts	143,310	124,355	86.8
Administrative County	567,294	537,409	94.7

There are approximately 13,300 pail or tub closets in the County Administrative Area.

14,659 closets were constructed for new houses.

**Public Cleansing.**—Details of methods in use during the year:—

	<i>Tipping</i>	<i>Tipping and Destruction</i>	<i>Separation and Salvage</i>	<i>Tipping Destruction and Disposal to Farmers</i>	<i>Tipping, and Disposal to Farmers</i>	<i>Number in which Public Cleansing covers whole District or greater part</i>
Municipal Boroughs and Urban Districts (68)	56	7	1	1	3	63
Rural Districts (21)	17	1	—	—	3	15

**Water Supplies.**—The table below shows the approximate number and percentage of dwelling houses on public supplies:—

	<i>Municipal Boroughs and Urban Districts</i>	<i>Rural Districts</i>	<i>Total</i>
No. of houses	385,780	132,156	517,936
No. of above on public supplies	375,005	122,128	497,133
Percentage on public supplies	97.2	92.4	96.0

The houses not on public supplies are mainly to be found in the outlying and isolated parts of the districts.

Details regarding water samples obtained by officials of the County Districts are as set out below:—

	<i>Chemical Analysis</i>			<i>Bacteriological Examination</i>		
	<i>Number obtained</i>	<i>Satisfactory</i>	<i>Unsatisfactory</i>	<i>Number obtained</i>	<i>Satisfactory</i>	<i>Unsatisfactory</i>
Municipal Boroughs and Urban Districts	475	452	23	2,758	2,545	213
Rural Districts	135	111	24	1,518	1,081	437

Particulars regarding the quality, quantity, extensions, closures or restrictions in water supplies during the year:—

Municipal Boroughs and Urban Districts	<i>Quality</i>	
	<i>Satisfactory</i>	<i>Hard Water</i>
	66	2
Rural Districts	<i>Quantity</i>	
	<i>Satisfactory</i>	<i>Periods of Shortage</i>
	62	3
	<i>Quality</i>	
	<i>Satisfactory</i>	<i>Low Pressure</i>
	21	3
	<i>Quantity</i>	
	<i>Satisfactory</i>	<i>Not Satisfactory</i>
	18	3



## Details of extensions, closures, restrictions etc.:—

## MUNICIPAL BOROUGH AND URBAN DISTRICTS:—

	<i>Extensions</i>	<i>Closures, Restrictions etc.</i>
<i>Adwick le Street U.D.</i>	To all new houses.	—
<i>Aireborough U.D.</i>	Shaw Lane Estate.	—
<i>Baildon U.D.</i>	Moorside, Coach Road, Bentley Close and Acre Rise.	Private supply to Moorside.
<i>Batley M.B.</i>	Extensions made.	Poor supply to Birstall rectified by completion of new service reservoir. Supply to new N.C.B. houses restricted for one month until chlorination of mains carried out, and houses not permitted to be occupied during that period.
<i>Bentley with Arksey U.D.</i>	—	Temporary restrictions at Wilsden due to main scraping operations.
<i>Bingley U.D.</i>	New properties and 4 old houses.	—
<i>Brighouse M.B.</i>	108 houses.	—
<i>Colne Valley U.D.</i>	Extensions made.	Water had to be delivered by cart to Conisbrough area during part of summer to conserve water.
<i>Conisbrough U.D.</i>	In Conisbrough area.	On occasions when pressure was low some houses were without water at first floor level.
<i>Darfield U.D.</i>	New housing site.	—
<i>Dearne U.D.</i>	New houses.	Position at Emley improved by temporary main. Pumping of Huddersfield water still restricted.
<i>Denby Dale U.D.</i>	Sykehouse and Emley.	—
<i>Denholme U.D.</i>	New housing scheme.	—
<i>Dodworth U.D.</i>	South Road No. 2 scheme.	—
<i>Garforth U.D.</i>	New estates.	—
<i>Goole M.B.</i>	New estates.	—
<i>Harrogate M.B.</i>	Extensions made.	—
<i>Hemsworth U.D.</i>	—	Restrictions at Fitzwilliam during heavy load periods.
<i>Horbury U.D.</i>	747 yds. — 4ins. 84 yds. — 3ins.	—
<i>Horsforth U.D.</i>	New premises.	—
<i>Hoyland Nether U.D.</i>	Housing scheme.	—
<i>Kirkburton U.D.</i>	1,103 yds. 4ins. main at Shepley. 760 yards 4ins. main at Farnley Tyas.	—
<i>Knaresborough U.D.</i>	New houses.	—
<i>Knottingley U.D.</i>	New houses.	—
<i>Maltby U.D.</i>	—	Poor pressure in parts of higher level of district.
<i>Meltham U.D.</i>	New houses.	—
<i>Mexborough U.D.</i>	—	Restrictions during early part of year owing to shortage.
<i>Normanton U.D.</i>	New houses.	—
<i>Ossett M.B.</i>	New houses.	—
<i>Otley U.D.</i>	New estate, Weston Lane.	—
<i>Pontefract M.B.</i>	New estates.	—
<i>Pudsey M.B.</i>	New estates.	—
<i>Rawmarsh U.D.</i>	New houses.	—
<i>Rothwell U.D.</i>	Building site.	—
<i>Royston U.D.</i>	To new houses.	—
<i>Saddleworth U.D.</i>	3 houses connected to public supply.	—
<i>Selby U.D.</i>	200 yards.	—
<i>Shipley U.D.</i>	New estates.	—
<i>Silsden U.D.</i>	—	Outfall from reservoir restricted during summer to conserve supplies.
<i>Sowerby Bridge U.D.</i>	129 yards — 2in. main. 236 yds. — 3in. main. 447 yds. — 6in. main.	—
<i>Stanley U.D.</i>	New estates.	—
<i>Wath upon Dearne U.D.</i>	New houses.	Restrictions for one week due to breakdown in plant.
<i>Wombwell U.D.</i>	New houses.	—
<i>Worsborough U.D.</i>	New houses.	—



	<i>Extensions</i>	<i>Closures, Restrictions etc.</i>
<b>RURAL DISTRICTS:—</b>		
<i>Bowland</i>	Council taken over the administration of the water undertakings at Waddington and Sawley from the previous owners. Waddington — 233 dwellings. Sawley — 30 dwellings. 108 yds. — 3in. cast iron main and 113 yds. — 3in. asbestos main laid to Grindleton housing site.	—
<i>Doncaster</i>	New houses.	Clayton with Frickley — private supply temporarily closed on account of excess lead.
<i>Goole</i>	Marshland supply scheme completed, consisting of 6,960 yds. — 6in., 2,200yds.—4in., 9,960yds.—3in. and 3,300 yds. — 2in.	—
<i>Hemsworth</i>	New houses.	—
<i>Kiveton Park</i>	Extensions made.	—
<i>Nidderdale</i>	Small extensions only.	—
<i>Osgoldcross</i>	New estates.	—
<i>Penistone</i>	Parishes of Carlecotes and Crowledge.	—
<i>Ripon and Pateley Bridge</i>	Summerbridge and Dacre parish.	—
<i>Settle</i>	New houses.	—
<i>Skipton</i>	Extensions made.	—
<i>Tadcaster</i>	In seven parishes.	—
<i>Thorne</i>	8,994 yards laid.	—
<i>Wakefield</i>	Yes.	—
<i>Wetherby</i>	—	17 private wells abolished.
<i>Wharfedale</i>	Bramhope, 125 yards, Fewston, Norwood, 10,895 yards.	—
<i>Wortley</i>	Small extensions made by Sheffield Corporation for eight houses.	Ministry approval received for installation of chlorination plant on Hallbroom 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 of lead per gallon is deleterious to health and that the plumbosolvency of such water should be neutralised. During the year 294 samples were obtained from the 64 supplies. In the case of 8 supplies lead was found to be present in quantities considered injurious to health and appropriate action was taken.

**Drainage and Sewerage.**—The following details have been extracted from the returns made by the County Districts:—

	Portions of district still requiring sewerage	Portions of district still requiring improvement of sewers	Re-drainage work carried out	Houses not connected to sewers	Inadequacy of sewage disposal works	Complaints by Rivers Boards
Municipal Boroughs and Urban Districts	50	19	20	9,334	35	17
Rural Districts	20	13	7	11,535	18	9

**MUNICIPAL BOROUGHS AND URBAN DISTRICTS:—**

	<i>Sewer Extensions</i>	<i>Sewage Disposal Works Extensions and Remarks</i>
<i>Adwick le Street U.D.</i>	To meet new building developments.	—
<i>Aireborough U.D.</i>	Shaw Lane, Guiseley.	—
<i>Baildon U.D.</i>	—	Coach Road Housing Estate, Acre Rise and Bentley Close.
<i>Barnoldswick U.D.</i>	60 yds. surface water sewer.	—
<i>Batley M.B.</i>	New housing estate — Birstall.	—
<i>Bentley with Arksey U.D.</i>	New housing estates.	—
<i>Bingley U.D.</i>	—	Modifications to storm water overflows completed.



MUNICIPAL BOROUGH  
AND URBAN

## DISTRICTS:—

Brighouse M.B.

Castleford U.D.

Colne Valley U.D.

Conisbrough U.D.

Darfield U.D.

Darton U.D.

Dearne U.D.

Denby Dale U.D.

Denholme U.D.

Garforth U.D.

Goole M.B.

Harrogate M.B.

Hemsworth U.D.

Holmfirth U.D.

Horbury U.D.

Horsforth U.D.

Hoyland Nether U.D.

Keighley M.B.

Kirkburton U.D.

Knaresborough U.D.

Knottingley U.D.

Mexborough U.D.

Mirfield U.D.

Morley M.B.

Normanton U.D.

Ossett M.B.

Otley U.D.

Penistone U.D.

Pontefract M.B.

Pudsey M.B.

Rawmarsh U.D.

Rothwell U.D.

Royston U.D.

Saddleworth U.D.

Selby U.D.

Shipley U.D.

Silsden U.D.

Skipton U.D.

Stanley U.D.

Stocksbridge U.D.

Swinton U.D.

Todmorden M.B.

## Sewer Extensions

All sewers in Field Lane Housing Site, No. II.

New housing estates.

1,172 yds. to new housing estates. Coal Industry Housing Association site.

Phase II of Sewerage Improvement scheme almost complete.

New estate — Barugh Green.

Housing site at Whyn Wood Estate, Thurnscoe and N.C.B. site.

207 yds. Tipping Lane, Emley and 70 yds. New Lane, Skelmanthorpe completed.

40 yds. — 15 in. at Doe Park Works. 363 yds. — 6 in. at Minorca Farm Housing site.

New housing estates.

New housing estates.

9 in. S.W. Hookstone Wood Road. 9 in. soil and 6 in. S.W. Ashville Grove, Leadhall View, Leadhall Way, Greenway, Firs Cote, Firs Drive, Firs Close.

Sheffield Road to Staley Royd, New Mill.

113 yds.—6 in. and 193 yds.—9 in. West End Lane.

Housing schemes.

2,685 yds. — new sewer.

48 yds. — 6 in. Shawcross, Kirkheaton. 17 yds. — 6 in. Tandem, Kirkheaton.

Mossop's Estate commenced.

New estates.

New surface water sewer, Highwood's Estate.

Housing estates — London Park, Coppin Hall, Shillbank.

Westerton Hall Estate.

Illingworth Avenue.

Housing sites.

Housing developments — Weston Lane.

Housing site, Avenue Park.

New Coal Industry Estate.

50 yds.—Glenholme Road. 300 yds.—Meadowhurst. 70 yds. — Dorset Grove.

New housing estates.

Housing sites.

Housing developments.

New houses.

93 yds. — 6 in. 50 yds. — 9 in.

New estates.

Bradley Road area for new housing site.

Skipton Road area for private house.

Extensions to surface water and foul sewers.

New estates.

New estates.

Housing schemes.

Housing site.

Sewage Disposal Works  
Extensions and Remarks

—

Extension to Airedale Sewage Works.

—

—

—

Scheme awaiting approval.

New outfall sewer constructed at Bolton on Dearne.

—

Reconstruction of Doe Park Sewage Disposal Works completed.

—

—

—

Additional sludge beds at Hemsworth. New pump house and pump at Hemsworth.

Scheme under consideration for closing New Mill Sewage Works and extension of Neiley Sewage Works.

Reconstruction of Sewage works in progress.

—

—

3 new humus tanks and percolating filter at Kirkburton works.

—

—

—

Works discontinued and all sewage treated by arrangement with Dewsbury C.B.

—

—

—

—

Carleton Works reconstruction commenced.

New pump house at Smalewell Works and a 3 in. rising main.

—

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MUNICIPAL BOROUGH  
AND URBAN

## DISTRICTS:—

Wath upon Dearne  
U.D.

Wombwell U.D.

Worsborough U.D.

## Sewer Extensions

New housing site at West Melton.

New housing estate and new  
privately owned development sites.  
980 yds. new foul sewer and 830  
yds. surface water provided for  
new houses.Sewage Disposal Works  
Extensions and Remarks

Works damaged by mining subsidence.

New filter completed at Lundhill Sewage  
Works.

Improvements to settling tanks.

## RURAL DISTRICTS:—

Bowland

33 yds. — 9 in. extension to  
Grindleton Housing Site.

Doncaster

New housing estates at Campsall  
and Rossington.

Hemsworth

Kiveton Park

New housing estates in 11 parishes.  
Extension of sewer at Todwick  
commenced.

Nidderdale

Marton cum Grafton to Council  
Housing Site.

Osgoldcross

Womersley Estate.

Ripon and Pateley

Bridge

Rotherham

Extensions to Sledgate Lane.  
Wickersley and all new housing  
estates.

Sedburgh

200 yds. — 12 in. outfall sewer  
laid.

Selby

Housing sites, 310 yds. new sur-  
face water sewer.

Settle

Skipton

Tadcaster

83 yds. — 6 in. sewer at Bradley.  
2 housing sites. New scheme for  
Bilbrough Village. One exten-  
sion at Whinmoor.

Thorne

Wakefield

Wetherby

South Common Housing Estate.  
Warmfield and Crigglestone.  
Kearby, Kirkby Overblow, Hare-  
wood and North Ripton.

Wharfedale

12 yds. — 9 in. at Pool. 167  
yds. — 9 in. at Bramhope.Womersley Estate — filter bed, humus  
tank and pumping station added.  
Erection of new works at Shaw Mills.Additional sludge beds at various  
works.

Settling tanks and outfall sewer.

New tanks at Burton in Lonsdale.

New works at Bilbrough.

New works at Warmfield.

New works at Kearby.

One works repaired and overhauled.

## Nuisance Inspection and Action.—

	Total No. of Inspections made in 1954 for nuisances only	Notices for Abatement of Nuisances						Total No. of Summonses etc.
		Informal			Statutory			
		Outstanding at 31.12.53	Issued in 1954	Abated in 1954	Outstanding at 31.12.53	Issued in 1954	Abated in 1954	
Municipal Boroughs and Urban Districts	50,596	2,980	15,050	14,655	629	2,454	2,073	51
Rural Districts	5,894	678	2,823	2,616	134	326	307	27
Totals	56,490	3,658	17,873	17,271	763	2,780	2,380	78

## Swimming Baths, Pools etc.—

	Public Swimming Baths or Pools	Privately owned Baths or Pools open to the Public	Paddling Pools	Baths in use at Schools	Holiday Camp Bath
Municipal Boroughs and Urban Districts	31	2	2	5	1
Rural Districts	2	5	—	—	—

In general, these baths and pools have filtration and chlorination plants and regular supervision and sampling is carried out.



**Prevention of Damage by Pests Act, 1949.**—During the year 20 inspections were made by the County Sanitary Inspectors at school kitchens regarding rats and mice infestation. Reports on the structural conditions were forwarded to the Chief Education Officer. Disinfestation treatment was carried out by the County District Sanitary Inspectors and their staffs. The majority of inspections were carried out jointly by the County Sanitary Inspectors and the County District Inspectors and I wish to accord my thanks to the latter for their willing co-operation at all times.

The following table shows the action taken by the County Districts:—

	<i>Number of Inspections</i>	<i>Infestations dealt with</i>
Municipal Boroughs and Urban Districts	38,711	5,963
Rural Districts	10,568	3,752

Attention has also been given 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
Denby Dale U.D.	Joint sewerage scheme—Cumberworth area. (With Kirkburton U.D.)	16.4.54	£4,915	
Hemsworth R.D.	Water Supply: Huntwick, Nostell, Hessle, Hilltop, etc.	29.7.54	£5,670	
Kiveton Park R.D.	Water supplies to Dinnington and Firbeck.	21.7.54	£4,000	Sent to Ministry 6.1.55
Penistone R.D.	Dunford Bridge sewage disposal works.	6.1.54	£2,500	
do.	Ingbirchworth sewerage and sewage disposal.	9.11.54		
Ripon and Pateley Bridge R.D.	Sawley sewerage and sewage disposal.	6.2.54	£7,800	
do.	Sawley water scheme.	2.7.54	£4,580	
do.	Birstwith sewerage scheme, Broomfield and Collin Bank areas.	3.7.54	£14,200	
do.	Water supplies, Summerbridge and Dacre. Extension to Smelthouses.	5.7.54	£700	
Sowerby Bridge U.D.	Drainage of Norland Town and district.	28.7.54 (2nd App.)	£9,264	
Tadcaster R.D.	Water supply—Newthorpe Barracks and farm.	17.5.54	£2,055	
do.	Askham Bryan water supply.	15.7.54	£650	
do.	Tadcaster water area.	15.7.54	£122,785	
do.	Great and Little Preston re-drainage scheme.	2.11.54	—	
Wharfedale R.D.	Denton sewerage and sewage disposal.	4.3.54	£4,480	
Skipton R.D.	Water supply—Coniston Cold and Bell Busk.	14.5.54	£3,800	
do.	Sutton sewerage—extension to Sutton Fields.	25.5.54	£990	

**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, 1949-53	614
Number of samples of pasteurised and sterilised milk obtained (572 and 22)	594
Number of samples of school milk	421
Visits to contractors' premises and enquiries regarding school milk	89
Visits to hospital farms for milk sampling purposes on behalf of the Ministry of Health	96
Visits regarding milk supplies at school kitchens	13
Investigations regarding the Food and Drugs Acts, "Specified Areas"	1,400
Visits regarding water supplies	17
Water sampling at special schools	18



Inspections at school kitchens regarding infestations by rats and mice .....	20
Investigations regarding general insanitary conditions, including housing .....	22
Visits to school swimming baths .....	3
Inspection of refuse tip .....	1
Visits regarding the Pharmacy and Poisons Acts .....	216
Ministry of Housing and Local Government Inquiries regarding water supplies and sewerage and sewage disposal schemes .....	3
Inspections made at cottages in connection with the Housing (Rural Workers) Acts .....	250
Meetings between the County Sanitary Inspectors, Divisional Medical Officers and Sanitary Inspectors, etc. ....	36
Attendance at meetings of the West Riding of Yorkshire Regional Smoke Abatement Committee .....	4
Visit in connection with Private Streets .....	1

### 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 the control of the Chief Inspector of Weights and Measures, Mr. J. W. Hopkinson, who has supplied the following details.

Sampling duties under the Food and Drugs Act are carried out by Inspectors of Weights and Measures, who, during the period under review, have procured 4,273 samples of foods and drugs, of which 3,048 were milks and 1,225 other foods or drugs. 4,004 samples were taken formally and 220 informally. 49 "Appeal to Cow" samples were taken at milking times arising from sub-standard milks previously purchased or taken from bulk in churns.

The Public Analyst, Raymond Mallinder, Esq., B.Sc., F.R.I.C., of the Borough Laboratory, Halifax, has analysed all the samples procured during the year and he has already reported on his work and submitted a schedule of the various foods and drugs which have been analysed, together with particulars of samples "not genuine". I have received certificates from the Public Analyst certifying 3,829 formal and 192 informal samples as genuine and certificates relating to 175 formal and 28 informal "not genuine".

As the sale of milk by retail in a considerable area of the Administrative County is covered by current Milk (Special Designations) (Specified Areas) Orders the number of retailers has been considerably reduced. Once milk has been consigned to pasteurisation depots in bulk, subsequent retailing is carried out direct from the dairies, and in most areas is confined to a few large concerns, including Co-operative Societies. Throughout the year visits have been made to pasteurisation depots and dairies to which raw milk was consigned for treatment and bottling. As a rule the dairy management warn farmers or refuse acceptance of milk if found of poor quality, but where adulteration is suspected I have asked the managements to contact my department at once. This co-operation has proved invaluable by the fact that practically all adulterated milks which have resulted in legal proceedings have emanated from information received, resulting in sampling from bulk in transit or whilst the churns were still in possession of the producer.

The Public Analyst reported 15 cases of milk having up to 10 per cent. of added water, 11 exceeded 10 per cent., 2 exceeded 20 per cent., 3 exceeded 30 per cent., 3 exceeded 40 per cent., and 2 samples actually contained more water than milk. In each of these cases proceedings were taken against the producer or retailer concerned resulting in convictions with penalties ranging from £1 5s. 0d. to £129 9s. 0d. being imposed on these offenders. In addition, 4 samples of milk were found on examination to be deficient in fat and again proceedings were instituted with convictions in each case.

Proceedings were instituted against three Ice Cream Vendors for selling ice cream low in fat and against two butchers for deficiency in the meat content of pork sausage and potted beef. Whilst no standard is now required by Regulation for meat content in sausage, butchers generally maintain not less than 65 per cent. of meat in pork sausage and not less than 50 per cent. of beef in beef sausage.

In the course of inspection to traders' premises generally, at a time when Weights and Measures inspection is being carried out, careful attention has been paid to the labelling of many proprietary brands of pre-packed foods. Purchases for the purpose of analysis have been made to ensure the validity of manufacturers' claims in such matters as Vitamin content, standards of purity, and in the case of drugs, reference to British Pharmacopoeia Standards.

The following is the Annual Report for 1954, 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:—

During the year, a total of 4,273 samples were submitted by your Inspectors under the Food and Drugs Act, 1938-1950. The full details of these are contained in the four Quarterly Reports, but I hope that the following summary will be of interest:—

	Total Samples	Adulterated or below standard	Percentage adulterated or below standard
Milk (Appeal to Cow)	49	—	—
Milk	2,999	164	5.5
Foods and Drugs	1,225	39	3.2
All samples	4,273	203	4.7

These results of adulterated or substandard samples compare favourably with those of other large Authorities.

During the year, Butter, Margarine and Cooking Fats were freed from rationing and price control. The Food Standards (Margarine) Order, 1954, set up standards for Vitamins A and D in Margarine. Being equipped with a spectrophotometer, we have been able to check the Vitamin A concentration in Margarine, Cod Liver Oil and other Vitamin A preparations. In every instance the samples were correct in this respect.

With the de-rationing of Margarine, we have seen the re-appearance of proprietary brands at competitive prices. Another reminder of pre-war days is Margarine containing 10 per cent. Butter. All samples of this latter commodity were found to contain the correct proportion of Butter.



**Butter Sweets**—Since 1951 there has been a Code of Practice requiring all Butter drops, Butter mints, Butter toffee etc. to contain at least 4 per cent. of butter fat. If the product contains less than this proportion it should be labelled "Butter flavoured" drops, mints, toffee, etc. Several "butter" sweets were analysed and only two were found to be deficient in butter.

**Foreign bodies in Food**—Throughout the country complaints have arisen about the occurrence of foreign bodies in food. Some of these concern cigarette ends, bandages, dish cloths, glass, nails, beetles, rodent droppings and other disgusting or harmful fragments; in our administrative area we have happily been free from these troubles during the year.

**Ice Cream**—Of the 88 samples of Ice Cream analysed, only 3 have been found below standard, all these were deficient in fat.

**Jeeling Linctus**—Two samples were submitted following a complaint that this particular brand of linctus was so horrible to taste that the purchaser thought it might be poisonous. Both samples contained six times as much acetic acid as indicated on the label. This was the only defect, but this gross excess of acetic acid would completely account for the complaint.

**Labelling**—One important part of our work is to check the analysis of foods against the list of ingredients published on the label. We find that these labels are generally correct.

A notable exception was brought to light by the analysis of two samples of Scotch Shortbread (from one manufacturer.) The list of ingredients stated:—"Flour, butter, sugar, veg. colouring," but the fat was not pure butter. It consisted of a mixture of fats, of which not more than 50 per cent. was butter.

Exception was also taken to a sample of Strawberry Lollipops and one of Orange Lollipops; the label stated "Full of full Cream". This should mean that the sweetmeat contains a considerable proportion of either cream or full cream milk. Being able to find only a negligible proportion of butter fat, we reported adversely on both samples.

Another sweet with the ambiguous name "Old Style Special Scotch" received adverse comment because of its label. This stated that the sweet was "The Pride of the Old English Butter Scotch profession", thereby implying that the product was actually butter scotch which should contain at least four per cent. of butter fat; the total fat content was only 1.7 per cent. of which less than one fifth was butter fat.

**Milk**—As usual the majority of unsatisfactory samples were of milk; 164 samples were found to be adulterated or below standard. Some of these were heavily watered and others were seriously deficient in fat.

**Channel Islands Milk**—Most of the 22 samples of this superior grade were correct; only 2 contained less than the requisite 4 per cent. of fat.

**Preservatives**—The majority of samples are examined for preservatives in accordance with The Public Health (Preservatives etc. in Food) Regulations. During the year the attention of Local Authorities was drawn to the unwelcome practice of some growers who used Thiourea to prevent development of mould on oranges. Diphenyl in strictly limited concentration is allowed on the paper wrappings of oranges. The one sample of oranges submitted was free from Thiourea, and its wrapper contained diphenyl well within the prescribed limit.

**Prohibited Colouring Matters**—No prohibited dyes were found in foodstuffs during the year.

**Sausages**—In the absence of a legal standard for Sausages, most Public Analysts expect Pork Sausage to contain 65 per cent., and Beef Sausage to contain 50 per cent. of meat. Of 141 samples submitted, only 17 fell below standard. One more sample contained an excessive proportion of sulphur dioxide preservative, and another contained sulphur dioxide without having had its presence declared by a suitable notice, thus infringing the Public Health (Preservatives etc. in Food) Regulations.

**Shredded Beef Suet**—The Food Standards (Suet) Order, 1952, requires Shredded Suet to contain at least 83 per cent. of Beef Fat. Of 18 samples analysed, two were found to be deficient in fat. The trouble with this commodity is that the ground rice or flour coating falls away from the shreds of suet and is then unevenly distributed in the bulk of the suet. Even though the manufacturer is careful to add a proper amount of starch or flour, it sometimes happens that an odd packet contains a little too much flour with a corresponding deficiency of beef fat.

**Vinegar and Non-brewed Condiment**—All the samples of Vinegar were correct, and only one sample of Non-brewed Condiment was found below standard as regards its acetic acid content.

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 1954 was 310 of which 9 were found to be adulterated or below standard.



## PART XI

### OTHER SERVICES

#### The Welfare of the Epileptic and Spastic

The following are the particulars of known epileptics and spastics:—

<i>Adults.</i>	<i>Number</i>	
	<i>Epileptics</i>	<i>Spastics</i>
1. Provided with accommodation under Part III of the National Assistance Act, 1948:—		
(a) in colonies for epileptics .....	56	—
(b) in County establishments and establishments where County Council has "right of user" .....	49	13
2. Registered under the County Council's Scheme of Welfare Services for Handicapped Persons .....	45	38
<i>Children.</i>		
Number ascertained as handicapped:—		
(a) Attending ordinary schools .....	Not known	114
(b) Attending special schools .....	26	80
(c) Receiving home tuition .....	—	10
(d) Receiving no education .....	—	16

The register of handicapped persons, including epileptics and spastics, under the approved scheme has been kept up to date, together with their medical classification and assessment of their being suitable for employment. During the year, much thought has been given to furthering the County Council's approved scheme under Sections 29 and 30 of the National Assistance Act, 1948. Owing to the geographical size of the County and the relative smallness of numbers of handicapped persons in any one community in the County, the setting up of craft and social centres has not developed considerably, but such centres are being established in appropriate areas in the near future. A few centres are already being operated through the agency of voluntary organisations in County Boroughs, serving the immediate West Riding Areas. More progress is reported in the development of handicraft services in the homes of handicapped persons, and two full-time Handicraft Instructresses have been working in the County during the year. Through this agency over 200 handicapped persons were actively engaged in home handicraft work, and of this number, 21 were epileptics and 15 were spastics; a further 9 epileptics and 5 spastics were visited with a view to partaking of handicraft instruction but were found by the Handicraft Instructresses to be either unsuitable for or undesirous of training. It is anticipated there will be an increase in the number of Handicraft Instructresses during next year. Advice to handicapped persons on their various problems, and assistance and liaison with other statutory bodies is effected through the 9 Divisional Welfare Officers. The County Council has made grants to various organisations providing voluntary services for handicapped persons, including spastics and epileptics in the County area.

During the year the question of employment of handicapped persons in open industry has been considered, and arrangements made for the employment of a Placement Officer. The employment of handicapped persons under 18 years of age is essentially a matter for the Youth Employment Officer who in turn receives relevant information from the School Medical Officer and Welfare Officer. Over the age of 18, the question of employment is essentially one for the Welfare Services themselves.

#### Certification and Treatment of Blind and Partially Sighted Persons

The following table gives particulars of new registrations during 1954 of blind and partially sighted persons (other than handicapped school children):—

	Disability (B. — Blind, P.S. — Partially Sighted)									
	Cataract		Glaucoma		Retrolental Fibroplasia		Others		Total	
	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.
(i) No. of cases registered during the year in respect of which para. 7(c) of Form B.D.8 recommends:—										
(a) No treatment									357	114
(b) Treatment (Medical, Surgical or Optical)	75*	30†	11	7	—	—	24	28	110	65
(ii) No. of cases at (i)(b) above which received treatment.	36‡	15	6	5	—	—	19	21	61	41

\* Includes 8 cases of cataract with glaucoma.

† " 1 case " " " "

‡ " 5 cases " " " "



## Health Education

Health Education continues to play an increasingly important part in our aims of preventing disease and maintaining good health. Much illness could be prevented by teaching the individual where to find the root cause of many complaints and therefore we should increase our efforts to help the people to achieve health more and more by their own actions and efforts. Health Education is receiving the attention of the World Health Organisation and in the first report of the Expert Committee on Health Education of the Public the following comment appears:—

"Health education begins therefore with the interest of people in improving their conditions of living, and aims at developing a sense of responsibility for their own health betterment as individuals, and as members of families, communities, or governments.

Health is but one of the elements in the general welfare of the people, and health education is only one of the factors in improving health and social conditions. It is, however, an indispensable factor and should therefore be integrated with other social, economic, health, and educational efforts."

During the year, in the Administrative County, approximately 40,000 leaflets were distributed to the public through the various health workers of the Department. The leaflets were mainly those of the Central Council for Health Education, the Royal Society for the Prevention of Accidents and the Central Office of Information of the Ministry of Health. In addition a number of leaflets from the National Baby Welfare Council and the National Association for the Prevention of Tuberculosis were also distributed. Nearly 1,000 posters were displayed throughout the County in clinics, shop windows and on hoardings, in addition to which some 300 picture display sets provided by the Central Office of Information were also shown.

Display frames on loan from the Central Council for Health Education were issued to six of our Divisions, the topics being interchanged periodically. The topics displayed during the year have included the following subjects:— Diphtheria Immunisation, Cafe and Canteen Hygiene, Accidents in the Home, Vaccination, Sanitary Inspector, and Foot Infections. Divisional Medical Officers have again co-operated with the Central Office of Information with regard to the inserting of advertisements in certain local weekly newspapers drawing attention to the safeguards afforded by diphtheria immunisation and giving information as to the times and places at which children could be immunised.

Talks, in some cases illustrated by films or film strips, have been given at schools, clinics, meetings of parent-teacher associations, etc. by Divisional Medical Officers and their staffs, and it is unfortunate that, while more and more satisfactory film strips are now being made, many of the strips dealing with health matters are partially or wholly out of date. The number of sound films on health subjects suitable for the general public is also relatively small, but during the year a few have been shown in the Administrative County under arrangements made by Divisional Medical Officers.

In the Administrative County this teaching of how to avoid ill-health and how to achieve and maintain better health in mind and body is done in varying ways. There can be no standard pattern for the County as it contains wide rural areas which are sparsely populated and other parts which are highly industrialised and densely populated. It follows that our activities must follow the lines which are most suited to the area, e.g. in the sparsely populated areas the work is undertaken in the main by the health visitor when making domiciliary visits, reinforced with the teaching of children in school. In the more heavily populated areas, while the health visitor still carries the main responsibility for imparting propaganda, more use can be made of visual aids in the form of posters, films, film strips and exhibitions.

The task of organising health education propaganda within the various Divisions rests with the Divisional Medical Officers and Dr. M. Hunter, whose Division has approximately 58,250 population but extends over some 160,000 acres and comprises the Urban Districts of Barnoldswick, Earby, Silsden and Skipton together with the Skipton Rural District, has supplied the following brief description of the work carried out in his Division during the year:—

"Health Education plays an increasingly important part in the work of the Health Visitor. In addition to the individual teaching given at home visits and at Child Welfare and Ante-Natal Clinics, group teaching, displays, films, and other media of publicity should be supplementary.

In this Division one aspect of preventive medicine is emphasised each month at the Child Welfare Clinics, and a special display of posters and leaflets arranged to catch the eye of the visiting mothers. This is supplemented by small group discussions, when interest has been aroused.

From October to December, Film Strips were shown at the Child Welfare and Ante-Natal Clinics on various aspects of Child Care and Home Safety. The mothers at Ante-Natal Clinics and relaxation classes were a most attentive audience for film strips on Ante-Natal care, and these were combined with mothercraft classes held by the Health Visitors.

At the senior schools films on 'Posture', and the 'Work of the Health Visitor' proved of great interest, and these were shown to interested groups of adults."

The pattern of activities in a more densely populated area where more ready-made audiences are available is illustrated in the statement given below which has been compiled by Dr. W. M. Douglas, who is Divisional Medical Officer for the Spensborough and Mirfield Division, which has an acreage of 11,645 and slightly over 48,600 population:—



"Talks are given at intervals throughout the year to various organisations, principally Parent-Teachers Associations by School Medical Officers and Health Visitors. Sanitary Inspectors have given talks to representatives of the food handling trades, and the Midwives and Health Visitors have addressed Parent Craft Classes, which are held in the Health Department fortnightly for expectant and nursing mothers.

The main concentration on Health Education is by way of formal lectures to the senior girls at the two large Secondary Modern Schools. These are given three times a week at South Parade Secondary Modern School, and twice a week at Mirfield Secondary Modern School. The lectures follow a set syllabus and deal in the main with fundamental health principles, physiology and development. The objectives, briefly, are as follows:—

- (a) To train the girls to take an intelligent and informed interest in the everyday familiar matters pertaining to health, e.g. in diet, personal hygiene, exercise, rest and clothing.
- (b) To instruct them in basic health principles relating to the care of infants and young children and their day to day management. To give them interest in the management and development of others within their own homes or neighbourhood, and as some slight preparation for future motherhood.
- (c) To impart knowledge of the physiological changes and their significance.
- (d) To indicate common causes of illness in infancy and childhood. The significance of such illness and measures taken for prevention.
- (e) Incidence and types of accidents in the home, their causes, methods of prevention and minor first aid treatment.
- (f) To impart knowledge concerning Health Services available to the public.

Approximately twelve main headings are dealt with each term.

These lectures are given by the Health Visitors, who also set examinations on the subjects which have been covered, and scrutiny of these tests provides an indication of the interest with which they have been received by the pupils. It is sometimes surprising how much fundamental knowledge has been retained, even although the pupil's ability to express herself in writing may be limited. These courses have been well received by the Headmasters of the schools concerned, and it is largely owing to their interest, co-operation and encouragement, that this has become one of the Health Visitors' more pleasant routine tasks. It is my personal belief that, whereas this may not be the only worth while form of Health Education, it is by far the most likely to show profit in the long run."

Dr. J. M. Paterson, who is Divisional Medical Officer of the Public Health Division which comprises the Urban Districts of Castleford and Normanton and is a typical mining area with a population of 61,350 and an acreage of 7,460, has supplied the following report:—

"Experience has taught over a period of years that in a mining area, and for maximum results, our efforts in the field of health education can most fruitfully be directed along two channels. In the one, endeavours are made in a passive way to establish a basic interest amongst that section of the community which we wish to influence by our propaganda and then during the other which may run concurrently or, preferably, follow the first, our object is to stimulate a positive interest in the subject sufficiently strong to spur to action. The first method employs all the time-honoured aids, comprising posters, pamphlets, press matter, cine films etc. whilst the second aims at making either a direct personal approach or else a group approach, just as individual circumstances dictate. A combination of the two measures has been found to be most effective in our diphtheria immunisation campaign, whilst the second method has been found to work well in our more recent campaigns directed towards the eradication of tuberculosis.

*Diphtheria.* The Health Visitor, by reason of her unique position and opportunity to make contact with mothers of children of all ages, must be regarded as a key worker in this field of preventive medicine, since she can invariably command a good hearing, to discuss this vital subject either among groups of mothers at the Infant Welfare Centre, or singly in the district. The lead thus given by the Health Visitor can be closely followed up by the Medical Officer in charge of the Infant Welfare Centre, since it is he who confers the immunity, and the Divisional Medical Officer can also, by a judicious interest in the subject, exert a co-ordinating overall influence. It has been noticed not infrequently that a public utterance or press account by a prominent public personality, not essentially medical, can also exercise a certain amount of influence over the general public, whilst certain psychological features can have a direct bearing for the good on health education and this is particularly noticeable in the case of school children who are found to accept immunisation more readily than in the pre-school group, presumably because they do not wish to feel the 'one man out' amongst their fellows.

*Tuberculosis.* For the most effective use to be made of the periodic visits of the mobile Miniature Mass Radiography Units, especially having regard to the various industrial priority groups, it is essential that there should be a very close liaison existing between officers of the Regional Hospital Board and the Local Health Authority and a most striking instance of what can be achieved by such a union was afforded during a recent mobile Miniature Mass Radiography survey in this area. Up to then there had been no local set policy as regards the regular X-ray of the mining community and it was felt desirable that something should be done in this direction as soon as possible. Since this was a relatively new venture which might give rise to misunderstandings it was felt that an approach would have to be made direct to the men themselves and in this way a team consisting of the local Chest Physician, the local Medical Officer of Health, and the Regional Organiser of the Miniature Mass Radiography Unit was organised. It paid a visit to the five collieries in this area and discussed at a joint meeting of the management and men at each of them the various aspects of tuberculosis, and one got the impression that many doubts which had existed previously in the minds of the men were cleared up. During the sustained survey which was held in this area at that time there is every reason to believe that this novel method of approach was fully justified.

The use made of the different channels available to us in the teaching of health education has without doubt in the past exercised a profound influence for the good over the various activities with which we in preventive medicine concern ourselves but we cannot but feel they do not go nearly far enough. Whilst we may at times look askance at the methods employed by publicity departments in industry we cannot but be struck by the effectiveness of their techniques, and the more this realisation is borne in upon us, the stronger must become our conviction that future preventive medicine tactics must be based on those practised in industry and commerce. Only in this way can we hope to give education that degree of impetus which is so necessary to its final success."



# 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	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	II
North Regional Association for the Blind, "Oaklands", Huddersfield Road, Holmfirth .....	31	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
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
Miss A. Fildes and Mr. P. Lowe, "Gledhow", 23 Park Drive, Harrogate .....	9	I
Mrs. D. Tearse, 78 Kingsley Road, Harrogate .....	2	I

\*Part I — Homes for Old Persons.

Part II — Homes for Disabled Persons.

Part III — Homes for Old and Disabled Persons.



## 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 to secure the necessary care and attention for such persons. This action is taken under the provisions of Section 47 of the National Assistance Act, 1948, or, if immediate action is necessary, under the National Assistance (Amendment) Act, 1951.

From the reports of Medical Officers of Health it is clear that these powers are used with the utmost reluctance and only as a last resort after all efforts at persuasion have failed to encourage the persons to take advantage of care and attention voluntarily in a hospital or other suitable place.

It was necessary to remove compulsorily 2 men and 12 women to hospital, and 2 men and 4 women to accommodation provided under Part III of the National Assistance Act, 1948.

## Registration of Nursing Homes

*(Public Health Act, 1936, Sections 187 —195).*

Four Homes were registered during the year and the number of Homes on the register at 31st December was 38, providing 37 beds for maternity cases and 289 beds for other cases. Thirty-nine 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. The only licensed agency in the Administrative County operated satisfactorily but closed in November.

## 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, a fee of 25/- being paid in this case 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 1,314 persons were medically examined as set out in the table below and of these 66 were not approved.

Examined by County Council Medical Officers .....	1,224
Examined by Medical Officers of Other Local Authorities .....	29
Examined by General Medical Practitioners (Fee of 25/- payable by County Council) .....	61

In 39 cases a specialist's opinion was obtained.

In addition 61 Special Medical Examinations were arranged at the request of employing Departments and 21 medical examinations were undertaken at the request of other Local Authorities.



## PART XII

## STAFF

(1st March, 1955)

J. Wood-Wilson, T.D., M.D., Ch.B., D.P.H.

(County Medical Officer and Principal School Medical Officer).

## HEADQUARTERS

J. Leiper, M.B.E., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.	Deputy County Medical Officer.
J. M. Anderson, M.R.C.S., L.R.C.P.	Senior Medical Officer.
A. Marshall, M.B., Ch.B.	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.(Eng.), Dip. Orth.R.C.S.(Eng.), 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 ( <i>On leave of absence with World Health Organisation</i> ).
Miss A. Carey, S.R.N., S.C.M., H.V. Cert.	Superintendent Health Visitor ( <i>Acting Superintendent Nursing Officer</i> ).
Miss R. O'Brien, S.R.N., S.C.M., H.V. Cert.	Superintendent Health Visitor.
Mrs. M. Craig, S.R.N., S.C.M., (Part 1), H.V. Cert.	Acting Superintendent Health Visitor.
Miss M. G. Edwards, S.R.N., S.C.M., (Part 1), H.V. Cert.	Health Visitor Tutor.
Miss E. M. Taylor, S.R.N., S.C.M., M.T.D.	Supervisor of Midwives.
Miss N. M. Everitt, S.R.N., S.C.M., M.T.D.	do.
Miss G. Jones, S.R.N., S.C.M., H.V. Cert.	Supervisor of Home Nurses.
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 Mindors.
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), (10)	Acting Chief County Sanitary Inspector.
R. D. Irving (1), (2), (6), (8), (9)	County Sanitary Inspector.
F. C. Brookes (1), (2)	do.

## CLERICAL STAFF

J. Colman (1), (3), (7)—Chief Clerk

Sectional Senior Clerks—G. Richardson (6), H. Bywater, J.H. Milne (6), R. S. Marshall, H. Beatson,  
T. R. Schofield (6), W. J. Battye.

- (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) Diploma in Public Administration.  
 (7) Associate Chartered Inst. of Secretaries.  
 (8) Sanitary Science Cert. (Liverpool University).  
 (9) Cert. in advanced knowledge of Sanitary Inspectors' Duties, Royal Sanitary Inst.  
 (10) Building Trades Course Certificate, Lancashire and Cheshire Inst.

## 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).



## 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).
R. S. Hynd, M.B., Ch.B., D.P.H.	.. No. 25 (Barnsley).
D. J. Cusiter, M.B., Ch.B., D.P.H., D.T.M. & H.	.. No. 26 (Wath upon Dearne).
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).
Vacancy	.. 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)

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 (Barnsley).
E. M. R. Bell-Syer, M.B., B.S.	.. No. 10 (Goole).
R. M. Bowker, B.A., M.B., Ch.B.	.. No. 16 (Rothwell).
P. Brodwin, L.R.C.P., L.R.C.S.	.. No. 18 (Brighouse).
*G. Buckle, M.B., B.S.	.. No. 4 (Shipley).
*P. S. R. Burrell, M.B., Ch.B., D.P.H.	.. No. 8 (Harrogate).
M. T. Burton, B.A., L.M.S.S.A., L.M.	.. No. 28 (Doncaster).
F. M. Cox, M.R.C.S., L.R.C.P.	.. No. 15 (Batley).
*E. E. Cromb, M.B., Ch.B., D.P.H.	.. No. 23 (Hemsworth).
G. Cust, M.B., Ch.B.	.. No. 17 (Spenborough).
*B. R. A. Demaine, M.B., Ch.B., D.P.H.	.. No. 30 (Mexborough).
C. M. Dornan, M.B., B.Ch., B.A.O.	.. No. 28 (Doncaster).
J. E. Fahy, L.R.C.P., L.R.C.S.	.. No. 11 (Castleford).
D. M. Fisher, M.B., Ch.B.	.. No. 15 (Batley).
D. E. Gledhill, M.B., Ch.B.	.. No. 3 (Keighley).
*N. E. Gordon, M.B., Ch.B., D.P.H.	.. No. 19 (Todmorden).
*A. P. Gorrie, M.B., Ch.B.	.. No. 31 (Rotherham).
J. A. G. Graham, M.B., Ch.B.	.. No. 9 (Wetherby).
E. P. Griffiths, M.R.C.S., L.R.C.P., D.C.H., D.Obst. R.C.O.G.	.. No. 31 (Rotherham).
*K. M. C. Haigh, M.B., Ch.B., D.C.H., D.Obst.R.C.O.G.	.. No. 20 (Colne Valley).
D. J. Haiste, M.B., Ch.B.	.. No. 11 (Castleford).
M. J. Hallinan, M.R.C.S., L.R.C.P.	.. No. 31 (Rotherham).
I. Hargreaves, M.B., Ch.B.	.. No. 13 (Ossett).
C. Harris, B.A., M.B., B.Ch.	.. No. 1 (Skipton).
S. G. A. Henriques, M.B., Ch.B.	.. No. 25 (Barnsley).
M. A. Hillis, M.B., Ch.B.	.. No. 6 (Otley).
A. Kropacz, L.R.C.P., L.R.C.S.	.. No. 27 (Adwick le Street).
R. B. Laidlaw-Becker, M.D., Ch.B., M.R.C.S., L.R.C.P., D.P.H., D.P.M.	.. No. 29 (Thorne).
*B. M. Leakey, M.B., B.S.	.. No. 3 (Keighley).
I. H. Lewis, M.B., Ch.B.	.. No. 23 (Hemsworth).
H. F. Lindsay, M.B., Ch.B.	.. No. 30 (Mexborough).
S. Lindsay, M.B., Ch.B.	.. No. 22 (Wortley).
M. J. Lowe, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., D.C.H.	.. No. 10 (Goole).
G. M. Mayhall, M.R.C.S., L.R.C.P.	.. No. 12 (Pontefract).
M. R. Menzies, M.B., Ch.B.	.. No. 26 (Wath upon Dearne).
*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).
N. M. E. Robertshaw, B.Sc., M.B., Ch.B., D.C.H., D.Obst. R.C.O.G.	.. No. 2 (Settle).
A. Seelig, M.D. (Strasbourg).	.. No. 19 (Todmorden).
E. D. Shaw, M.B., B.Ch., B.A.O.	.. No. 20 (Colne Valley).
*J. J. Smith, M.B., Ch.B., D.P.H.	.. No. 22 (Wortley).
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).
D. M. Summers, M.B., Ch.B.	.. No. 16 (Rothwell).
C. Taylor, M.B., Ch.B., D.C.H.	.. No. 5 (Horsforth).
D. C. Wall, B.A., M.R.C.S., L.R.C.P.	.. No. 4 (Shipley).
J. C. White, M.B., B.S., M.R.C.S., L.R.C.P., D.C.H.	.. No. 12 (Pontefract).
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. &amp; 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.

**SCHOOL DENTAL OFFICERS (95% School Health)**

M. Bentz, 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.  
 J. M. Davison, L.D.S.  
 W. H. Dyke, L.D.S.  
 J. B. W. Edwards, B.Ch.D. (part-time).  
 J. K. Ellwood, B.Ch.D.  
 P. F. A. Eltome, L.D.S.  
 M. P. Freedman, B.Ch.D. (part-time).  
 M. M. Gibson, L.D.S.  
 J. S. Griffith, L.D.S. (part-time).  
 M. Hattan, L.D.S.  
 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).  
 F. Lister

J. Lynn, L.D.S. (part-time).  
 E. S. Midgley, L.D.S.  
 E. Millward, L.D.S.  
 S. Mitchinson, L.D.S.  
 B. Neville, L.D.S. (part-time).  
 D. B. Owen, L.D.S.  
 M. H. Platford, L.D.S.  
 H. Rawnsley, L.D.S. (part-time).  
 D. G. Rennie, L.D.S.  
 H. N. Saffer, B.Ch.D. (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.  
 G. B. Stanley, L.D.S. (part-time).  
 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.  
 6 Senior Technicians.  
 2 Boy Dental Apprentices.

**HEALTH VISITORS, MIDWIVES, MEDICAL AUXILIARIES, etc.**

6 Divisional Superintendent Health Visitors.  
 299 Health Visitors and School Nurses.  
 6 Orthopaedic Nurses and Physiotherapists (three part-time).  
 13 Tuberculosis Visitors.  
 280 Home Nurses and Home Nurse Midwives  
 193 Midwives.  
 1,594 Domestic Helps (79 whole-time, 1,515 part-time).  
 4 Venereal Diseases Social Workers (Qualified Health Visitors).  
 8 Speech Therapists.  
 1 Chiropodist (part-time).  
 1 Supervisor of Mental Health Occupation Centres and Home Teachers (Vacancy).  
 16 Mental Health Social Workers.  
 17 Mental Health Home Teachers (one part-time).  
 46 Dental Attendants.

**COUNTY ANALYST (part-time)**

R. Mallinder, B.Sc., F.R.I.C.  
 J. C. Harrel, F.R.I.C. (Deputy).

**DAY NURSERIES**

17 Day Nurseries—total nursing staff 90.  
 1 Nursery Nurses Training Hostel, One Oak, Ilkley.

**MENTAL HEALTH OCCUPATION CENTRES**

Castleford. Staff—1 Supervisor; 3 Assistant Supervisors or Nursery Assistants.  
 Keighley. Staff—1 Supervisor; 3 Assistant Supervisors or Nursery Assistants.



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