《Jpanese》

# 森永ヒ素ミルク中毒事件
# 発生から50年

被害者救済事業の実施状況

恒久対策案の完全実施を求める有志

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《English》

# The Morinaga Milk Arsenic Poisoning Incident: 50 Years On

## A report outlining the Implementation Status of the Victims Relief Project

**Volunteers in support of the complete implementation of a permanent control strategy**
**by Eitaro NOSE**

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はじめに

森永ヒ素ミルク事件が発生してから、50年が巡ってきました。この事件の被害者は、僅かの例外を除き生後まもない乳幼児でした。1955年末の厚生省発表では患者11,778人、死者113人とあります。これほど多数の同年代の者が、一つの事件に遭遇するのは稀で、これもまたこの事件の特徴に数えられます。被害者たちも今年で50歳から51歳になります。事件が発生したのは1955年の夏のことです。森永乳業徳島工場で製造された粉ミルクに猛毒のヒ素が入っていました。被害者の多くが西日本に集中しているのは、工場近県に出荷されていたためです。

ミルクを飲んだのは、ものが言えない赤ちゃんだったので、よけいに被害が拡大し、原因究明にてまどりました。赤ちゃんにとっては命の糧のミルクに、猛毒が混入しているなどと誰も想像だにしませんでした。親は赤ちゃんの体調が悪くなっても、毒入りミルクを飲ませ続けました。もう少し大きかったら「おかあちゃん、ミルクをのむと腹が痛くなるの」といったかも知れません。しかし赤ちゃんはそのように思っていても、ただ泣くだけしかできません。泣くことで赤ちゃんは訴えていたのでしょう。親たちの証言によれば「夜泣きが激しくなってきた」といっていました。

それから50年の月日がたちました。多くの親たちはこの世を去り、生きていても高齢です。31年前に約一年間を費やして作った恒久対策案は、親たちの我が子を思う気持ちの結晶です。この案を完全実施すれば、すべての被害者に明るい「ひかり」がさしてくるのではないか、そんな気持ちから救済

## Preface

Fifty years has passed since the occurrence of arsenic poisoning caused by Morinaga Milk Company (hereafter known as Morinaga). Most victims of this incident except for a few were newborn babies. According to the report released by the ministry of Welfare at the end of 1955, the number of individuals affected was 11,778 and a further 113 had died. One of the most notable characteristics of the Morinaga milk incident is the large number of people from the same age group who fell victim to the poison. It is very rare for a single incident to impact such a large number of people as this one did. In 2011 the victims of the Morinaga milk incident will be turning 50 or 51 years old. It was the summer of 1955 when the powdered milk produced at the Morinaga factory in Tokushima was shipped to nearby prefectures in western Japan. The factory's location in Tokushima is the reason that the majority of poisoning victims were concentrated in the western region of the country.

The infants and babies affected by the poisoning were unable to communicate which made it difficult to isolate a reason for their illness. This, in turn, caused the damage to spread. As milk in an essential part of an infant's diet, consumers, particularly mothers, did not suspect it was causing the illness and therefore continued to feed the powdered milk to their children. If they had been only a little bit older, they could have told their mothers, "Mommy, when you give me the milk I always get a stomach ache," but instead all they could do was cry. Their tears were most likely caused by the pain and discomfort from the poisoning. In fact, it was reported that babies who were fed the poisoned milk cried louder than usual during the night.

Fifty years has passed since these events occurred. Many of the victims' parents have passed away or become very old. Their eternal love for their children was the driving force behind the permanent control strategy, which was developed over a twelve-month period,

機関に「ひかり協会」と名前をつけたのでした。

現在、ひかり協会の救済事業は不十分で恒久対策案は無視されています。私たちは、恒久対策案の完全実施を関係方面に要求しています。恒久対策案の実施状況を検証し、本当の姿を多くの人に知ってもらいたいのです。実施されていない項目については、その理由はなにかと考えてみました。この作業には具体的な資料に基づいた、正確な検証を心掛けました。
この冊子の発行が、被害者救済の進展に寄与することを願っています。

thirty-one years ago. We have named our victims relief association the “Hikari association”. “Hikari” is the Japanese word for “shine” and it is the families’ wish that when this strategy’s implementation is complete, a light will be able to “shine” on the victims of these terrible events.

The victims’ relief project and permanent control strategy by the Hikari association are insufficient and have been ignored so far. In the interest of the victims and their families affected by the Morinaga milk incident, all our efforts are required for this strategy to be effectively implemented. We would like to inspect the current status of this strategy’s implementation and increase public awareness of the lack of action taken thus far. We have been considering the reasons that some items are yet to be implemented and will endeavor to base our inspection on concrete evidence.

We hope that publishing this report will help the permanent control strategy to proceed further.

## 1　事件の概要

## 1. Outline of the incident

１９５５年の６月末ころから、西日本一帯の人工栄養児に奇妙な病気がはやっていた。多くの母親の話では、それまで元気だった赤ちゃんに下痢、発熱が続くようになっていた。その上飲んだミルクをたびたび吐くのであった。医者につれていっても、はっきりしたことはわからなかった。

At the end of June in 1955, a strange illness spread among bottle-fed children in the western part of Japan. According to their mothers, those children started suffering from fever and diarrhea without showing any other symptoms beforehand. They were also throwing up the milk that was fed to them and doctors were not able to identify a specific reason for their sickness.

このことが初めて新聞に報道されたのは、８月１０日の岡山の山陽新聞においてだった。この記事を書いたK記者にも赤ちゃんがいた。
記事は「赤ちゃん暑気当たり　県南部に多い　貧血起こし重患も」という見出しでかかれていた。内容は「続く猛暑で岡山県下とくに南部地区の乳幼児に暑さからくる貧血症状を呈する患者が出、重患者は生命も気遣われる者もある。ここ一週間に岡大付属病院、岡山赤十字病院に現れた重患者

It was on August 10th when this illness was reported for the first time, appearing in Okayama’s Sanyo newspaper. The writer of the article, Mr. K, was himself a parent with an 8-month-old daughter. The newspaper headline read “Babies affected by the summer heat; Many occurrences in the southern part of Okayama prefecture. Some serious cases with anemia.” The article went on, “Due to the

の中には血液の四分の一が減り、白血病のような症状を現しているものもあるので増血剤や輸血などで治療に当たっている」

continuous heat during summer, babies, particularly in the southern part of Okayama prefecture are suffering from anemia. This has resulted in some infants in a critical condition in Okayama University Hospital and Okayama Red Cross General Hospital in the past week. Extreme cases are exhibiting symptoms similar to those of leukemia sufferers. In these instances patients have lost up to a quarter of their blood and have required treatments such as blood-forming medicine or blood transfusions."

K記者の担当の中には岡山赤十字病院も入っていた。8月12日にこの病院の看護婦から「最近、黒い赤ちゃんが診察を受けにきている」ということを聞いて興味をおぼえた。そこで医長に聞くと「モリニヤだと思う。ペニシリンなどの抗生物質で、死なないカビが全身にはびこって皮膚が黒くなったものだろう」といった。

Mr. K had been covering Okayama Red Cross General Hospital at the time and was told by one of the nurses that "a 'black' baby has been coming for examinations recently". He became curious and enquired about this to the head doctor, to which the response was "I think it is Molinia. Some antibiotic medicines, such as penicillin, cause the whole body to become moldy and the skin to turn black."

K記者には生後八か月の長女がいて、そのうえ東京から弟の長女(十か月)も遊びに来ていた。どちらも人工栄養児であったが、Kの家では森永ミルクを飲んでいたので、この姪にも同じものを飲ましていた。すると二人とも下痢を始めたので、前記岡山赤十字病院の医長に診察をしてもらった。すると「別に心配はない。だが、森永ドライミルクはすぐやめて別の会社のミルクにしなさい」と言われた。「森永ミルクにヒ素が混入」と公表されたのは、これから12日後の8月24日であった。

At the time of the first report, Mr. K's brother and 10-month-old niece were visiting from Tokyo. Both Mr. K's own daughter and his niece were bottle-fed babies who had consumed Morinaga powdered milk. Soon after they were fed the milk, they started suffering from diarrhea. When they were presented at Okayama Red Cross General Hospital, their doctor said "You do not have to worry, but stop using the Morinaga powdered milk and change to one from another company."

It was not until twelve days later, on August 24th that the powdered milk produced by the Morinaga Milk Company was found to be mixed with arsenic.

K家の二人の赤ちゃんの下痢は、森永ミルクを飲むのをやめるとすぐにとまった。「これはおかしい」と思ったKはこれから毎日岡山赤十字病院へ取材に通うようになった。19日の朝、小児科の窓口に置いてある入院患者表を見ると、名前の上にMという文字が書いてある患者が16人もいた。この印は森永ミルクの飲用者であることがすぐに分かった。

Mr. K's daughter and niece recovered as soon as they stopped consuming Morinaga powdered milk. Mr. K started to wonder about this incident and frequent Okayama Red Cross General Hospital. On August 19th, he found the letter "M" on the records of 16 patients who had been hospitalized there. It turned out that all those who had been marked with an "M" were patients who had consumed Morinaga powdered milk.

Kは20日付朝刊に間に合うように「森永ミルクを飲んでいる乳児」と原稿に書いた。しかし朝刊には掲載されず夕刊に回され「森永ミルク」が「人工栄養児」という言葉に書き替えられていた。この理由をKは「デスクや社の都合」と書いている。これは『森永砒素ミルク闘争二十年史』の中の「「奇病」を追う」に、当時を回顧したK記者の手記から引いた。

Mr. K wrote a draft article which was due to be printed on the morning of August 10th. Its content included a reference to "infants who had been fed Morinaga powdered milk" but this draft was not published in the morning edition, rather it appeared later that day, in the evening edition. Moreover, during the editing process "fed Morinaga powdered milk" was changed to "bottle-fed". It is claimed that this change was made "for a reason ordered by the company", according to Mr. K's memoranda from 'Pursue a "strange illness"' in *20 years History of the Fight against Arsenic Poisoning by Morinaga.*

森永ミルクがおかしいということは、もう「8月5日ころからわかっていた」ようだ。岡大医学部小児科教授の浜本英次は『岡山県における粉乳砒素中毒症発生記録』に掲載した日記の中にそのように記述している。

It had been clear "since around August 5th" that something was wrong with Morinaga powdered milk products. In the publication, *A Report on the Occurrence of Arsenic Poisoning by Powdered Milk in Okayama Prefecture*, a diary entry written by Dr. Eiji Hamamoto, pediatrics professor in the Okayama University medical department, makes reference to this date.

岡山赤十字病院の小児科の医師は、すべて浜本教授の弟子だった。その当時は岡大から医師が手伝いに行っていたので、情報はすぐ両方に伝わった。 このころに「森永ミルクの飲用中止」を発表していたら……、せめてK記者に注意を喚起した8月12日にでも発表していたら、被害はよほど少なくなっていただろう。しかし岡大医学部法医学教室で、森永ミルクの中からヒ素が検出された24日まで発表はのばされた。

All of the pediatricians at Okayama Red Cross General Hospital were pupils of Dr. Hamamoto and some doctors from Okayama University Hospital had sought help there. This meant information about the recent events reached both hospitals immediately. This begs the question, what if they had announced the danger of Morinaga powdered milk in early August when it was first detected? Furthermore, had they made an announced on August 12th when Mr.K presented his baby, the damage would have been significantly less. Instead, the announcement was postponed until August 24th, when arsenic was found in the Morinaga powdered milk products tested at the forensic medicine laboratory within Okayama University medical department.

1955年8月24日の朝刊各紙は、この事件を大きく報道した。朝日新聞の見出しは「人工栄養児に奇病　岡山で三人死亡」とあり、地元の山陽新聞の見出しにも「森永」という字は無かった。記事を読んでいくと森永ミルクと分かるが、見出しだけみると「人工栄養児」全体の問題と思えてしまう。このことによって、ミルクで赤ちゃんを育てている家庭をあ

On August 24th 1955, this incident was given extensive coverage in every newspaper. The Asahi newspaper headline read "Strange illness occurring in bottle-fed babies. Three dead in Okayama", however, the word "Morinaga" did still not appear in the headline of Okayama's Sanyo newspaper. As a result of this, readers

わてさせた。赤ちゃんをつれた母親は病院につめかけ、炎天下にもかかわらず、長蛇の列が病院を取り巻いた。そのことは次の数字にも現れている。25日岡大小児科での受診患者197人中、森永ミルク飲用者でヒ素中毒新患者は94人、人工栄養児で体調不良児が大挙して押し寄せたのである。

were not aware that consumption of Morinaga powdered milk was the cause of illness unless they read the whole body of the article. It was assumed by many that the issue was common to all bottle-fed babies. Numerous mothers who became upset by the article rushed to hospital and lined up outside in spite of the hot weather to present their babies. Out of 197 bottle-fed babies who were presented to Okayama University Hospital on August 25th, 94 were found to be suffering arsenic poisoning from Morinaga powdered milk.

岡山赤十字病院では入院患者が多くてベッドが不足し、廊下にまでベッドを並べて患者を収容した。25日の新聞では岡山県下で患者216人、近畿、中国、四国の各府県で百人以上が出ているという。岡山で5人の死者が出ていてさらに増える見込みだとある。患者の症状は高熱と下痢、皮膚の色が黒くなり、腹がふくれてくるのであった。翌日はさらに患者が増え全国で1463人、死者は23人に達していた。

In Okayama Red Cross General Hospital there was not enough room for all the patients so some were forced to occupy beds in the halls. A newspaper article on August 25th reported the number of patients in Okayama prefecture to be 216, and more than 100 in each prefecture of Kinki, Chugoku, Shikoku regions. In Okayama, five patients had officially died from the poisoning and even more deaths were estimated. It was reported that patients were showing symptoms of high fever, diarrhea, darkened skin, and their abdomens had swollen up. The following day, the number of patients nationwide reached 1463, and 23 were dead.

ヒ素中毒の治療に使われたのはバルという薬であった。これは第二次大戦中にヒ素性毒ガスの解毒剤として、英国で研究発見されたものだった。赤ちゃんが母乳の代わりに飲む粉ミルクに、猛毒のヒ素が混入するなどということは常識では考えられなかった。どんな物質に混じって入ったのか、情報は混乱した。森永ミルクの中でも徳島工場製（MF缶）だけからヒ素が検出された。そこで徳島工場からミルクに添加されている物質13種類を取り寄せて、岡大医学部で分析したがヒ素は検出されなかった。

The medicine used to treat the arsenic poisoning was British anti-Lewisite (BAL). BAL was originally discovered in the United Kingdom during the Second World War as an antidote for arsenic gas used in combat. Who could ever have imagined that such a virulent poison was being mixed with powdered milk designed for babies? The information about why arsenic was present in the powdered milk was the cause of much confusion. Arsenic had only been found in a powdered milk product called “MF Can” which was produced at a factory in Tokushima. While thirteen of the elements added to the powdered milk were taken to Okayama University medical department for examination, no trace of arsenic was detected in any of them.

ヒ素を検出したと発表したのは森永徳島工場であった。ヒ素は岡大へ送ってきたカルシウムなどの添加物からではなく、安定剤として使った第二リン酸ソーダに含まれていた。これはどこへも送ってい

It was actually the Morinaga factory in Tokushima who announced that arsenic had been found in sodium phosphate, a chemical being used as a stabilizer. The stabilizer had

なかったので、検査機関は無駄な努力を続けていたことになる。

not been sent for examination so all of the tests performed during the investigation had effectively been done so in vain.

粉ミルクの製造に安定剤が使われていることなど、業界関係者以外はしらなかったのだ。当時はまだ保冷設備のついたタンクローリーは無かったため、酪農家から集乳した原料乳を遠路工場まで運ぶ間に酸化が進んだ。品質の悪くなった牛乳を粉ミルクに加工すると、飲む時の溶解度が悪くなる。新鮮な牛乳だけを使えば問題は起きないのだ。腐敗寸前のものまで用いために、第二リン酸ソーダのような安定剤を使う必要があった。森永の発表によると、この薬品を使用し始めたのは1952年からだという。

It had not been known to anybody but producers that a stabilizer was being used in the powdered milk. At the time, there were no refrigerated tanker trucks for transportation, so the milk was becoming oxidized on the long trip from the farm to the factory. The quality of the milk used was a major factor. If milk of low quality is used for powdered milk products, it is difficult to dissolve in water for consumption. This problem does not occur if good quality milk is used. In the case of Morinaga, the milk being used was almost rotten therefore they needed to add sodium phosphate as a stabilizer. According to the press release by Morinaga, they had been using this stabilizer since 1952.

第二リン酸ソーダには純度によって試薬1級、試薬2級、工業用にわかれている。森永徳島工場が使ったのは、選りによって工業用であった。工業用第二リン酸ソーダの用途は、ボイラーの洗浄用、殺虫剤などに使われている。その頃、徳島工場の秤は壊れていて、牛乳へ入れるのも目分量でいれたそうである。だから、製造された日付け（ロット番号）によって検出されるヒ素の量が違っていた。

Sodium phosphate can be classified into three grades of purity, known as reagents, these are: the first reagent, the second reagent, and the grade suitable for industrial use. Believe it or not, the type of sodium phosphate that Morinaga had been adding to their milk was the one for industrial use, which is more commonly used as an insecticide or for cleaning boilers. In fact, during the time in question, the scales at the factory were broken so the stabilizer was not measured before being added. This is why the amount of arsenic found in each product was different depending on the date of production and lot number.

ヒ素の入っていた第二リン酸ソーダは産業廃棄物から製造された。日本軽金属清水工場でボーキサイトをアルミニウムに精練するとき出たものである。これははじめ機関車の洗浄用に国鉄（現在のJR）に納入されたものだが、ヒ素が混じっているといって返品された。それが薬品業者の間を転々として、協和産業から森永徳島工場へ納入された。

The sodium phosphate in which the arsenic was found was actually produced from industrial waste. This particular waste was generated during the process of refining bauxite into aluminum at the Nippon Light Metal Company, Ltd. factory in Shimizu. It was first delivered to Japanese National Railways (currently JR) but was returned due to the presence of arsenic.

この「薬品」について、日本軽金属は静岡県衛生部を通じて厚生省に、ヒ素化合物が含有しているので「毒物及び劇物取締り法」の毒物に該当するか否かの問い合わせをした。それは54年の11月のことで、厚生省から返事がきたのは、翌年の11月であった。厚生省がもっと早く適切な処置を取っ

This sodium phosphate was delivered to Morinaga factory in Tokushima after being rejected by many medicine companies. The Nippon Light Metal Company made an inquiry to the Ministry of Welfare via Shizuoka

ていたら、ヒ素ミルク事件はおこらなかったといえる。
　それにしても、食品の粉ミルクに使うのであるから、機関車の洗浄用に使うより以上の注意義務があるのは論を待たない。

Prefectural Sanitation as to whether this "medicine" would constitute as a poison, in accordance with the "Poisonous and Deleterious Substances Control Law" of November 1954. They did not receive an answer from the Ministry of Welfare until November 1955, the following year. If their response had been completed much earlier, this incident would never have occurred. Aside from these details, it is needless to say that all producers have a responsibility to their customers when it comes to product quality. Including components that are best used for cleaning trains, as demonstrated by Morinaga, is nothing short of irresponsible and dangerous.

森永がどれほど弁解しても注意義務、安全感覚の欠如がこの事件を生んだのは明白である。

Nothing can excuse the actions of Morinaga. It is clear that they neglected both their duty of care as well as and security practices, which in turn lead to this incident.

　しかし刑事裁判で森永側の主張は「薬品会社にだまされた」ということであった。いままで使っていたものと、同じ薬品が納入されていると思って検査もしなかった。そうでなかったことは「信頼の原則」に反するというのであった。だが、納入した薬品会社の言い分は、品質の悪いものを納入したことを認めているのである。「森永が用途を明らかにしてくれたら、それ相当のものを納入した」という。会社は用途をしゃべらない、秘密にしたがるので聞きもしなかったといっている。

In contrast, once the investigation was underway Morinaga insisted in criminal court that they had been "deceived by the medical company". Morinaga claimed to have thought the medicine was the same as what they had been using before, therefore did not check for quality. They claimed this was an offence by the medical company against "the principle of trust". The response from the medical company was mixed. On one hand they accepted the fact that they had actually delivered a low quality product. On the other hand, they stated, "if Morinaga had made it clear what the medicine was to be used for, we would have delivered the proper product." The medical company did not ask about the usage of their medicine because Morinaga wanted it to remain confidential.

　なぜ粗悪な牛乳までも原料として使用しなければならなかったか、そこには森永の上手な宣伝による粉ミルク市場の占有率拡大がある。赤ちゃんコンクールをやり、また有名人をコマーシャルに使い、55年にはついに市場占有率が50%を越すまでになった。集乳量を大手三社で比較すると50年から55年までで森永は約3．1倍増、雪印が2．0倍増、明治が2．6倍増となり森永が他を引き離している。

The reason Morinaga chose to use low quality milk as a material was due to a sudden increase in their share of the powdered milk market. This growth was the result of an effective marketing campaign, which included a baby contest and commercials featuring well-known personalities. Their market share had exceeded 50% by 1955. The amount of milk Morinaga collected increased by 3.1 times over the period between 1950 and 1955. Morinaga

再び言うが新鮮な牛乳を原料に使えば、安定剤は必要ではなかった。それがよく売れたために、品質の悪い牛乳までも原料にした。MF印より高級なベータドライミルクは安全だと当時森永は宣伝していたが、最近の論文では、これもあやしいことが分かってきた。（中島貴子著『森永ヒ素ミルク中毒事件50年目の課題』社会技術研究論文集 Vol3,90-101, Nov.2005）

had outdistanced their competitors, Yukijirushi and Meiji, by 2 times and 2.6 times respectively.

As previously mentioned, there would have been no need to use a stabilizer at all if only Morinaga had used fresh milk as a material. Although they had been advertising that Beta Dry Milk, a higher-ranking product than MF Can, was safe, it turned out not to be true according to a recent thesis. (Nakashima. T, 2005, *50 years since the case of arsenic poisoning caused by Morinaga Milk,* Vol. 3, p. 90-101).

この裁判は一審の徳島地裁で森永側無罪の判決（63年10月25日）があった。控訴審では高松高裁で原判決破棄、差戻し（66年3月31日）上告審では最高裁で上告棄却（69年2月27日）。徳島地裁での差戻審は、森永徳島工場の製造課長に禁固三年の判決（73年11月28日）がありようやく確定した。起訴から18年間もかかり、裁判史のなかでも10指にはいる長期裁判であった。

Morinaga was found not guilty at the first trial in Tokushima district court on October 25, 1963. At a review by an appellate court in Takamatsu high court on March 31, 1966, the original decision was reversed and remanded. Following this, at a hearing in the Supreme Court, a final appeal was rejected on February 27, 1969. Eventually, it was through Tokushima district court that the head of factory production at Morinaga, Tokushima was sentenced to three years' imprisonment. Eighteen years had passed since the indictment was first issued. It was one of the top ten longest lawsuits in history.

## 2 事件の処理

## 2. Treatment for the incident

被害をうけた家族は団結して、森永乳業等と交渉しようとする動きが8月27日から始まった。「森永ドライミルクに依る被災者家族中毒対策同盟趣意書」を岡崎哲夫が書いた。彼の長女は岡山赤十字病院へ入院して治療を受けていた。「趣意書」は同じ階に子供を入院させている親たちが手分けして、各階の患者家族へ配って回った。「趣意書」を読んだ親たちは即座に賛成して、団結して闘うことを表明した。

From August 27th, 1955, the families of the victims started coming together to move towards a negotiation with Morinaga. Mr. Tetsuo Okazaki wrote a leaflet containing a proposition "for an alliance of families of the Morinaga Milk arsenic poisoning victims". Mr. Okazaki's own daughter had been receiving treatment in Okayama Red Cross General Hospital. This leaflet was handed out to the family of each victim on every floor of the hospital by some victims' parents. Families agreed to the proposition as soon as they read it and eagerly expressed their support for the alliance to proceed.

次の日にこのことが新聞報道されると、岡大病院、倉敷中央病院でも同盟が結成された。31日に

The movement was reported in the newspaper the following day, which resulted in other

はこれら三つの病院の代表が集まり、９月３日に総決起大会を開くことで合意した。総決起大会では岡山県砒素中毒被災者同盟の結成を決議し、初代委員長に岡崎哲夫が選出された。この大会で選出された委員は、森永の岡山駐在員事務所を訪ねて同盟結成の通告をした。今後、会社と協議し速やかな事件処理をしたいと申入れをした。　９月６日、本社役員との団体交渉で森永は、患者急増で会社経理の危機的状況を理由に、治療費、入院見舞金1万円、通院患者に3千円の支払いを約束したにとどまった。

alliances being organized in both Okayama University Hospital and Kurashiki Central Hospital. Representatives of each hospital gathered on August 31st and agreed to hold a rally on September 3rd. At the rally, an alliance of arsenic poisoning victims from Okayama prefecture was decided upon. Mr. Okazaki was selected as the first chairman. Members of this alliance visited a Morinaga resident office in Okayama and gave notice that the organization had been formed. Their proposal was that, after due consultation, Morinaga should enact an immediate response to the incident. At the group negotiation with Morinaga executives on September 6th, Morinaga ended up promising to pay only 3,000 yen to each non-hospitalized patient and 10,000 yen to each hospitalized patient to cover doctor's fees and as general compensation.

岡山での同盟結成を契機に、全国各地で被害家族の組織化の機運が高まった。９月１８日には9府県の代表30人が参加して、岡山市で森永ミルク被災者同盟全国協議会（以下全協）の発足集会が開催された。各地からは入通院にかかる費用による困窮、後遺症の不安、森永の不誠実な対応、費用支払いの地域による不平等などが報告された。

Following the establishment of these alliances, families of victims nationwide started to rally together as well. On September 19th, thirty representatives from nine prefectures gathered in Okayama city and held an inauguration meeting, the "National conference of the Morinaga Milk Incident Victims' Alliance". Members of Zenkyo reported that they were suffering financial difficulty from doctor's and hospital fees and expressed concern about possible aftereffects of the poisoning. They also stated their dissatisfaction with Morinaga's insincere attitude toward the events, as well as the inequality in their reimbursements.

１０月３日から3日間全協と森永が交渉した結果、患者一人につき一日430円の付添費、通院に要した交通費の実費、通院の諸費用として一日に１５０円支払う。通院患者への見舞金3千円に2千円を追加する。患者一人につきミルク代の払戻しの意味で別のミルク3缶を贈るなどが決まった。次回１０月２３日の交渉では、森永から死者に対する弔慰金の試案を提出するとの回答があった。

It was announced after three days of negotiation between Zenkyo and Morinaga that Morinaga would pay; 430 yen per day towards carer costs, the actual cost for commuting, and 150 yen per day for any other cost relating to commuting. They also decided to raise the payment for non-hospitalized patients by 2,000 yen and provide three cans of milk per patient as replacement for the contaminated milk they had purchased. Morinaga further responded that they would propose a tentative plan for condolence money for deceased patients.

ところが10月17日になって森永は交渉延期を通告してきた。10月22日の新聞に「森永ミルク中毒の補償問題について森永からも何分の指示を得たいという申出があったので、厚生省では森永に対し、中立の立場にある有識者の委員会を作って解決を一任することを勧告した。」という発表が厚生省からあった。この委員会のメンバーは内海丁三、小山武夫、田辺繁子、正木亮、山崎佐の五人であった。五人は森永が勧告に絶対に従うことを条件に、就任を受託し森永もこれを了承した。

Morinaga, however, gave notice on October 17th that further negotiations would be postponed. On October 22nd, the Ministry of Welfare announced to the media, "Morinaga has requested advice from the Ministry of Welfare about the issue of compensation for the poisoning incident. The Ministry of Welfare has advised that a neutral committee of well-informed persons be organized and that a solution to this problem be left for this group to decide." Members of the committee were Mr. Teizo Utsumi, Mr. Takeo Koyama, Ms. Shigeko Tanabe, Mr. Ryo Masaki, Mr. Tasuku Yamasaki. All five of them agreed to become members on the proviso that Morinaga would follow their decision unconditionally. Morinaga accepted this request as well.

森永が全協にした説明はこれとは違っていた。「突然に五人委員会ができて、我々は厚生省から弔慰金その他一切の問題について今後全協とは交渉するなといわれたので、これ以上の交渉はしない」といった。全協は五人委員会は認めないという決議をした。

The explanation Morinaga gave to Zenkyo was different from this official version. They claimed that, "All of the sudden a five-member committee has been organized and we were told to cease negotiations about reimbursements, condolence payments or otherwise, with Zenkyo from now on. We will not continue our negotiations". Zenkyo decided against the five-member-committee.

12月15日、五人委員会の意見書が発表された。問題は被害者に対する補償と後遺症対策であった。その要点をまとめると次のようになる。

On December 15th, an opinion report by the committee was published. Zenkyo saw problems with the compensation amount for victims and with the question of aftereffects. It can be summarized as below.

1 死者にたいする補償は25万円。
2 生存者は軽症と重症を問わず一律1万円。
3 後遺症の心配はほとんどない。
4 森永が入院患者にしている追加約束の限度は2千円までとする。
5 森永が今までに払った見舞金はこの金額から差し引かれる。

Compensation for the dead
250,000 yen
Compensation for surviving victims
10 000 yen, regardless of seriousness
No consideration of aftereffects
Additional compensation for hospitalized patients is maximum 2,000 yen
The amount of compensation Morinaga has already paid is to be deducted from the figures shown above.

この結論は今まで森永が払った金額に権威付けをして、それ以上の補償をしないことを、お上の力を借りて言ったまでのことである。この結論に導く

This conclusion demonstrates the way in which Morinaga borrowed the power of the

のに約三万字を使っているのだ。後遺症についての結論を全部引用すると、つぎのようになる。

「これ等各専門医家の意見を総合すると、「本件の中毒症には、概ね、ほとんど後遺症は心配する必要はないといってよかろう。今なお引続き治療を受けているものは、後遺症ではなくして原病の継続である」ということであったので、本委員会は本件の補償基準をきめるについては、第六章結論、第一節総説（3）に記述する外は特に後遺症に対する補償をきめないことにした。」これが全部で、僅か170字で最も重要なことを片付けた。

この意見書に対して、当時の新聞に批判でも載っているかと探したが、無かった。生後一歳ほどの赤ちゃんに「原病」(※1)とはどんなものをいうのだろうか。この意見書の内容は、刑事裁判での森永の主張と同じものである。それは森永を薬品会社にだまされた被害者にしあげることであった。これが「公正・中立」と称して厚生省の委嘱で作られた委員会の正体であった。 発表の翌日には被害者のもとへ、意見書全文と「意見書の内容を直ちに実施する」と書いた森永の通告が送付された。そして次の日に、全入院者と通院者に見舞金の残額が現金書留で送られてきた。ご丁寧にもすぐ投函できるように、官製はがきに印刷された領収書も同封されていた。

（※1「原病」という呼称については第2章の章末に詳細解説）

全協は五人委員会の結論とは関係なく死者50万円、定期検診制度の確立、砒素中毒症の研究機関の設置、今後六年間重症、中症患者に毎月2

government to authorize compensation that had already been paid. This ensured they would not have to reissue any payments following the outcome. In the committee's report, the lead up to the conclusion was around 30,000 characters long. On the other hand, in the actual conclusion, which is the most critical part, only 170 characters were used. The conclusion reads as follows:

> "These special doctors have considered all the opinions and concluded that 'there is generally no need to worry about the aftereffect of this poisoning. The symptoms which are present now are not an aftereffect of the poisoning, rather they are GENBYO.' We have decided not to set any other standard for compensation besides those outlined in the conclusion of Chapter 2, and in general remarks (3) of the 1st paragraph."

I wondered if there would be any criticism of this opinion report and checked some newspapers but found nothing. I thought to myself, what could be an "original illness" for mere 1 year-old baby? The content of this opinion report was the same as what Morinaga had put forward in criminal court. The intention of this report was to depict Morinaga as a victim who had been deceived by a medical company. That was what the "neutral," five-member committee was really about. The day following this announcement, a copy of the opinion report and a notice from Morinaga stating, "the content of this opinion report will be in effect immediately" were sent to each victim. The rest of the owed compensation was sent to all hospitalized and non-hospitalized patients by registered mail next day. It was very polite of them to enclose a government–printed post card as a receipt so that the victims could post it with ease. In spite of the committee's decision, Zenkyo made the following request:

> Payment of 500,000 yen as compensation for the dead

千円の健康管理費の支給等の要求をした。

Establishment of a regular check-up system
Establishment of a research laboratory for arsenic poisoning
Six years Payment of 2,000 yen per month as health management money for serious and moderately serious cases.

これらの要求がいれられない場合は、不買運動等の実力行使に訴えるとした。森永は「意見書」を妥当なものと考えるので、要求には応じられない、定期検診と研究機関については具体案を作ってみると回答した。この回答を不満として、全協は森永製品の不買運動を開始した。国鉄（現在のJR）など被害者を多くかかえた職場ではこれに協力した。国鉄の物資部からは森永製品は追放されたが、一般大衆にまで運動は浸透せず、森永に打撃を与えるまでにはいたらなかった。

Zenkyo decided to boycott Morinaga if their request was refused.
Morinaga responded to Zenkyo by saying that their opinion report was official and they would therefore not accept the request. They said that besides this they would create a detailed plan for regular check-ups, as well as the laboratory for arsenic poisoning. To represent their discontent with this response, Zenkyo initiated a boycott. Companies such as Japanese National Railways who were associated with many victims, cooperated with the boycott and removed Morinaga products from their supplies section. Despite this, the boycott did not spread to the general public so it ended up not causing large-scale damage to Morinaga.

森永は被害者側の運動を混乱させるための分裂工作として、役員への誹謗中傷、買収などあらゆることをした。その手法からは一方的な過失で多数の死亡者をだした加害企業として、一片の悔悟心も見られない。

Some members of Zenkyo were abused or bribed by Morinaga in a maneuver intending to split and confuse the movement. No repentance was shown by Morinaga whose actions had already led to the death of many people in what was clearly a mistake on their part.

世界で発生したヒ素中毒事件は数件あるが、小児のそれは皆無であった。厚生省は10月6日付けで日本医師会に依頼し小児保健学会に小委員会を設け「診断基準」を作成させた。

Prior to this incident, there had been some cases of arsenic poisoning in the world but none involving children. On October 3rd, the Ministry of Welfare asked the Japan Medical Association to establish a small committee within the Society of Child Health and introduce “Standards for diagnosis”. According to “Standards for judgment of healing”:

それによると「治癒判定基準」として①必須条件、イ　一般症状が完全に消失していること。ロ　血液像が略正常に復していること。ハ　肝臓が軟らかくなり大きさも二横指以下に縮少していること。②付帯条件、イ　心電図が正常に復していない者は、以後の管理を要す。ロ　眼症状が正常に復していない者は、以後の管理を要す。ハ　色素沈着は多少残存しても顧慮するにはおよばない。ニ　中毒者で

1. Essential conditions: a) general symptoms are not seen, b) blood condition has recovered and is almost normal, c) kidney has become soft and shrunk to the size of two fingers.
2. Collateral conditions: a) if the

以上の基準外にあると思われる者は、特に専門的な検討により決定すること。

electrocardiogram does not appear normal, continuing control is essential, b) if the state of the eyes does not appear normal, continuing control is essential, c) some pigment deposit left does not have to be considered, d) for addicts with symptoms other than those above, a decision will be made following special examination.

この基準で大半の患者は全快を申し渡されたが後のち大問題となる。

Most of the patients had been told they had recovered. This led to huge problems later on.

依然として後遺症の不安は拭えず56年3月末、全協の役員は事態の打開のため、森永と交渉を重ね、厚生省へも陳情した。その結果、厚生省は後遺症対策として関係都道府県へ精密検診実施について通達をだした。

Anxious about the risk of aftereffects, members of Zenkyo persevered with the Morinaga negotiations and at the end of March 1956 also petitioned the government in order to find a solution to this situation. As a result, the government gave an official notice to each prefecture asking that they establish a closed examination system for managing aftereffects. The notice said;

⑴通入院等により現在治療中の患者
⑵回復者であっても予後後遺症等につき不安を感じている者
を各科を具備した医療機関をあっせんし、中毒が原因と考えられれば治療を受けるよう指導する。その費用は森永が負担する、というものである。

(1) Available to both hospitalized and non-hospitalized patients who are undergoing treatment
(2) Patients who are concerned about aftereffects following convalescence should be admitted to a hospital with various departments and are advised to undergo treatment if their symptoms are a result of poisoning.
All costs are to be covered by Morinaga

その頃になると全協の闘争資金は底をついていた。各県本部からも妥協を探るように要請がきていた。役員たちは、残念だが闘いの幕を引く潮時として、これが最後の時との判断をかためた。
4月9日に前記内容⑴⑵を骨子として、森永との間で次のような妥協が成立した。精密検診以外では「一周忌香華料、研究機関等の件」として

Around that time, Zenkyo was running out of struggle funds. Zenkyo head offices in each prefecture had been calling for compromise. Members of Zenkyo decided that they would not continue their struggle any longer. On April 9th, a compromise agreement including items (1) and (2) as mentioned above was reached between Morinaga and Zenkyo and entitled "Matters of a laboratory and further offers". The details are as follows:

1 会社は死亡者に一周忌香華料並びに法要諸費金三万円を贈呈する。
2 会社は研究助成の機関としての公益法人を設立する。
3 全被災者にベータードライミルク（1ポンド入）2缶を贈呈する。

Morinaga will offer 30,000 yen for all deceased victims to cover the cost of a memorial service, incense and flowers for the first anniversary.
Morinaga will establish a public corporation to support research.
Morinaga will offer two cans of Beta dry milk (1 pound each) to all victims.

親たちの心配は、ヒ素中毒の後遺症であった。岡山同盟が会員にアンケート調査をしたところ、56年2月の段階で137名中全快と回答をした人は18名であった。森永は56年1月に全家族に通知をだした。

Parents were still worried about aftereffects. According to the questionnaire done by Okayama association in February 1956, only 18 out of 137 members answered they had recovered perfectly. Morinaga sent out a notice to all the victims saying,

「1月末をもって各病院での治療は打ち切る。不安のある人は岡山大学病院小児科で診て貰い、そこで中毒症ないし中毒に関係ありと認められれば会社負担で治療してもらう」というものだった。

"Treatment underway at each hospital will be discontinued at the end of January. Patients who remain concerned can be examined at Okayama University Hospital pediatrics unit. If it is deemed that symptoms were caused by arsenic poisoning, patients will able to receive treatment at the expense of Morinaga."

岡大病院以外の病院での証明は受付ないというが、岡大病院では2、3人を除いてみんなヒ素中毒は全快といわれた。しかし肝臓肥大、貧血、皮膚病、眼病、下痢などは残った。これらは「原病」の継続であり治療費は自己負担になってしまった。

This meant that only a certificate from Okayama University Hospital would be accepted. Though all patients except for a few were told that they had recovered perfectly, they were still suffering from hypertrophy of kidney, anemia, skin diseases, eye diseases and diarrhea. These symptoms were considered by Morinaga to be a *GENBYO* and the fee was on the patients.

森永と岡山県の関係の強さを示すものとして、全国で最初に「赤ちゃんコンクール」が行われたのは岡山県だった。『森永乳業五十年史』の中の座談会で森永の社員は、岡大小児科の浜本教授の世話になったこと、山陽新聞が好意的だったこと、県庁、保健所などの公的機関が協力的だったことを述べている。そのおかげで今まで森永のシェアーは20%しかなかったのに、以後70%を越すまでになった。岡山での被害が大きかった理由は、これら産学官と地元新聞の癒着が原因かもしれない。

The strength of the bond between Morinaga and Okayama prefecture can be seen by the fact that first place of the Morinaga baby contest was awarded in Okayama. At a round-table discussion for "50 years history of Morinaga Milk", a Morinaga employee spoke about how Professor Hamamoto of Okayama University Hospital had been a great help, and how Sanyo Newspaper had been very favorable, as had official institutions such as Okayama prefectural office and a state health center. Thanks to them, their marketing share

had increased by over 70% where it had previously been only 20%. The extensive damage caused by the poisoning in Okayama prefecture might have be due to a cozy relationship between industries, universities, official institutions and a local newspaper company.

※1
“原病”
---当時、診断基準を作成する小委員会は、「原病」という一見、専門的な響きのある用語を登場させた。しかし、これは医学用語ではないことに注意が必要だ。素人には、親の遺伝体質を起源にもつ病気のようにも聞こえる。だが、もし仮に、“遺伝病”だとすれば、親の遺伝体質を解明した場合、それとの整合性がとれずに虚偽となる。だから遺伝病とは言わなかったのだろう。では“原病”とは何か？つまりここで、「公正中立であるはずの」第三者機関である小委員会が展開したのは、砒素中毒とは関係のない生後直後に罹患した別の中毒もしくは病気が引き続いている症状であって砒素摂取による後遺症ではないのだ、という主張であろう。

ところが、小委員会は、その、「赤ちゃんが生まれた直後にかかった中毒や病気」がなんであるかを解明する必要性を説いていない。むしろ、後遺症ではないのだ、という一点を強調しているにすぎない。その期待効果は以下のようになる。
親は最終的に、生後直後になんだかわからない“病気や中毒”にかかった自分の赤ちゃんの不運を嘆きながらも、天災と同様にあきらめ、自己責任で対処療法を続けるしかない”ということである。

つまり小委員会は、「人為による犯罪」を、「科学の名」によって「天災」にすり替えたのである---

※

*GENBYO*

The committee selected to make a ruling against Morinaga coined the term *GENBYO*, which literally translates as ‘original illness’. It was devised to sound like a technical term but is in fact not based on any medical definition. The average person may have thought it was a reference to some kind of illness, the origin of which was the parents’ genetic constitution. The reason it was not called a “hereditary disease” was that if a parent’s genetic constitution became clear and turned out to have no connection with the child’s illness, information would have been inconsistent.

The committee insisted that the aftereffects shown by victims were not a product of arsenic poisoning but rather symptoms of a previous illness that pertains no relation to arsenic. It was not deemed necessary to find out what “an earlier poisoning or a disease” might have been. The committee emphasized that the symptoms were not related in order to convince parents that their babies were unluckily suffering from an unidentified poison or disease. The outcome of this was that parents were forced to accept their babies’ misfortune as if it was some kind of natural disaster and take responsibility for ongoing treatment.

In short, the committee intentionally misled the public into believing that poisoning aftereffects were not the result of a perpetrated crime but rather an unfortunate natural disaster.