The Committee will consider the following new petitions—

PE931 Petition by Helen Irons, on behalf of Skin Care Campaign Scotland, calling for the Scottish Parliament to urge the Scottish Executive to review its policy on tackling the growing skin cancer epidemic in Scotland.

PE913 Petition by Debbie Scott, on behalf of To Play or Not to Play, calling on the Scottish Parliament to urge the Scottish Executive to adopt a Play Strategy that recognises the right of all children in Scotland to a safe, accessible and challenging play environment.

PE915 Petition by Anne Mackenzie, on behalf of Hilton Primary School, calling for the Scottish Parliament to urge the Scottish Executive to ensure that all primary school children have access, on a regularly timetabled basis, to specialist visiting teachers, especially music, PE and art.

PE912 Petition by Sidney Gallagher calling for the Scottish Parliament to urge the Scottish Executive to commission research into membership of the freemasons within the police and judiciary.

PE926 Petition by Councillor Sam Mullin calling for the Scottish Parliament to urge the Scottish Executive to remove the tolls from the Erskine Bridge at the earliest possible opportunity.

PE924 Petition by Cumbernauld Mast Relocation Group calling on the Scottish Parliament to urge the Scottish Executive to ban the siting of 3G and Tetra masts in residential areas until all the evidence which suggests that they are a health risk has been examined by the Parliament.
Public Petitions Committee – a template for public petitions

Should you wish to submit a public petition for consideration by the Public Petitions Committee please complete the template below. Please refer to the Guidance on submission of public petitions for advice on issues of admissibility before completing the template. You may also seek advice from the Clerk to the Committee whose contact details can be found at the end of this form.

Details of principal petitioner:
Please enter the name of person and organisation raising the petition, including a contact address where correspondence should be sent to, email address and phone number if available

Helen Irons

Text of petition:
The petition should clearly state what action the petitioner wishes the Parliament to take in no more than 5 lines of text, e.g.

The petitioner requests that the Scottish Parliament considers and debates the implications of the proposed Agenda for Change legislation for Speech and Language Therapy Services and service users within the NHS

'The petitioner asks the Scottish Parliament to urge the Scottish Executive to review its policy on tackling the growing skin cancer epidemic in Scotland.'

In support of the above, please find attached a paper by Dr Jamie Inglis entitled 'Skin Cancer in Scotland 1973 – 2003'.

Additional information:
Any additional information in relation to your petition, including reasons why the action requested is necessary, should not be included here. However, it may be appended to the petition and will be made available to the Public Petitions Committee prior to its consideration of your petition. Please note that you should limit the amount of any additional information which you may wish to provide in support of your petition to no more than 4 sides of A4.
Action taken to resolve issues of concern before submitting the petition:
Before submitting a petition to the Parliament, petitioners are expected to have made an attempt to resolve their issues of concern by, for example, making representations to the Scottish Executive or seeking the assistance of locally elected representatives, such as councillors, MSPs and MPs. Please enter details of those approached below and append copies of relevant correspondence, which will be made available to the Public Petitions Committee prior to its consideration of your petition.

After a Skin Care Campaign Scotland Parliamentary Briefing on the issue of skin cancer earlier this year, Helen Eadie, MSP, suggested the route of the Public Petitions Committee to us during a meeting held with her on 25 August.

Petitioners appearing before the Committee
The Convener of the Committee may invite petitioners to appear before the Public Petitions Committee to speak in support of their petition. Such an invitation will only be made if the Convener considers this would be useful in facilitating the Committee's consideration of the petition. It should be noted that due to the large volume of petitions it has to consider, the Committee is not able to invite all petitioners to appear before the Committee to speak in support of their petition.

Please indicate below if you do NOT wish to make a brief statement before the Committee when it comes to consider your petition.

I do NOT wish to make a brief statement before the Committee

Signature of principal petitioner:
When satisfied that your petition meets all the criteria outlined in the Guidance on submission of public petitions, the principal petitioner should sign and date the form in the box below. Other signatures gathered should be appended to this form.

Signature

Date 19 November, 2005

Please note that any additional information, copies of relevant correspondence and additional signatures should be appended to this form and submitted to:
The Clerk to the Public Petitions Committee,
The Scottish Parliament,
Edinburgh
EH99 1SP
Tel: 0131 348 5186 Fax: 0131 348 5088
e-mail: petitions@scottish.parliament.uk
Mr Jim Johnston
The Clerk to the Public Petitions Committee
The Scottish Parliament
Edinburgh
EH99 1SP

19 December, 2005

Dear Mr Johnston,

You may recall that I spoke with you last Friday regarding our petition. I have enclosed this along with a supporting document, which I also mentioned to you. This document is actually 9 pages long, but would be very difficult to cut down to the recommended 4 pages. It was, however, produced by Dr Jamie Inglis, Consultant in Public Health Medicine to the Scottish Executive, and is designed to be easily read by non-medics.

I have informed our team that the new date is Wednesday, 8 February.

I hope that the enclosed is satisfactory, but should there be any problems, please do not hesitate to contact me.

With kindest regards and best wishes for the holidays,

Yours sincerely,

Helen

Helen Irons
Development Officer
Skin Care Campaign Scotland
Skin Cancer in Scotland

1975 - 2003

Summary

This review describes the changes in skin cancer epidemiology in Scotland since 1975 and also examines the underlying trends for both malignant melanoma and non-melanoma skin cancer.

Malignant or invasive melanoma is the least common skin cancer accounting for about 10% of all cases [650-700 cases year] but is the most dangerous resulting in 130-150 deaths in Scotland each year [60-70% of all deaths from skin cancer]. The term non-melanoma skin cancer covers basal cell carcinoma [BCC] and squamous cell carcinoma [SCC] and these two cancers make up about 90% of all skin cancer diagnosis in Scotland [about 6500 cases year]. Both types of non-melanoma skin cancer are very slow growing, tend not to metastasise and if treated are rarely fatal [about 50 deaths per year].

The most recent figures available demonstrate the scale and impact this has in Scotland with 7349 Scots diagnosed with skin cancer in 2001 and 197 Scots dying from skin cancer in 2003. Since 1975, cases of skin cancer in Scotland have increased over three times and deaths from skin cancer have increased by 40%. Cases of skin cancer have plateaued in the last five years following the peak in 1997, however deaths from skin cancer are probably still rising slowly.

The increase in cases has occurred almost equally in both sexes with men now accounting for slightly more diagnoses per year than women. The increase in deaths has occurred mostly in men who saw a 60% increase in deaths by comparison with a 9% increase in women such that deaths in men now outnumber deaths in women by a ratio of 5 to 4.

Registrations for malignant melanoma have increased almost threefold and deaths have doubled in the last 25 years. The increase has been greatest in men who have seen registrations increase over four times and deaths increase almost threefold. Despite the faster rise in men, registrations in women still outnumber those in men by a ratio of 4:3 but deaths in men now outnumber deaths in women.

There are now 5000 more cases of skin cancer a year in Scotland than there were 25 years ago and most of these are a result of cosmetic tanning. The rise in foreign holidays and sunbathing at home and abroad has been the principal driving force of the epidemic coupled with the increasing numbers, and use of, sunbed parlours throughout Scotland.

The priorities now must be earlier diagnosis in an effort to reduce the increasing number of deaths from skin cancer and a substantial and sustained prevention campaign to reverse the epidemic that has already occurred in Scotland.

Keywords: skin cancer, Scotland, malignant melanoma, cosmetic tanning, sunbeds.
All Skin Cancer

The figures in Box 1 outline the scale of the skin cancer epidemic in Scotland. Comprehensive figures for all skin cancer diagnoses from 1975-2003 are available in the appendix Table 1 and these have been charted in Fig.1a registrations, Fig.1b deaths, Fig.1c. registrations in males and females, and Fig.1d. deaths in males and females.

<table>
<thead>
<tr>
<th>Box 1. All skin cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Diagnoses</td>
</tr>
<tr>
<td>1975</td>
</tr>
<tr>
<td>2113</td>
</tr>
<tr>
<td>2001</td>
</tr>
<tr>
<td>7349</td>
</tr>
<tr>
<td>Deaths</td>
</tr>
<tr>
<td>1975</td>
</tr>
<tr>
<td>139</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>197</td>
</tr>
</tbody>
</table>

A rise from 2113 diagnoses of skin cancer in 1975 to a total of 7349 diagnoses in 2001 represents a more than three-fold increase in this twenty-five year period. In a similar time period, deaths have risen from 139 in 1975 to 197 in 2003 representing a 40% increase. A substantial increase in deaths during that time but a modest increase by comparison with the increase in diagnoses.

The picture in Fig.1a. shows skin cancer registrations rising steadily from 1975 throughout the 1980s having doubled to 4273 by 1988 followed by a steeper increase through the early 1990s to reach a peak of 7346 cases in 1997. The last five years from 1997-2001 have seen a plateauing of cases ranging between 7100 and 7350 per year and averaging 7213 cases per year.

Deaths from skin cancer have also increased from 139 in 1975 to 197 in 2003 representing a 40% increase over that time period (Fig.1b). To remove the variation caused by examining single years three-yearly averages are used. The average number of deaths in the three years 1975-1977, was 141 and the average for the three-year period 2001-2003 was 197 deaths. This demonstrates a true and significant 40% increase over that time period but does represent a lower burden than would have been expected from the dramatic rise in skin cancer diagnoses seen in Figure 1.

When analysing skin cancer registrations by sex there has been a slight but noticeable change in the distribution between males and females. In the late 1970s and early 1980s, there were marginally more cases in females than in males (Fig. 1c.). In the last five years, there has been a noticeable alteration in the ratio of male to female cases. In 1997-2001, there were 18,296 diagnoses in males compared with 17,768 in females giving an average over the five-year period of approximately 3650 cases per year in men compared with 3550 cases per year in women. Approximately 100 more cases per year in men than women and this has remained stable for the last six or seven years.
The balance of skin cancer deaths between men and women has changed significantly over this twenty-five-year period (Fig.1). In the five years from 1975-1979, there were 327 deaths from skin cancer in men and 381 deaths from skin cancer in women. An average of 65.4 deaths per year in men and 76.2 deaths per year in women. In the most recent five-year period from 1999-2003, there were 514 deaths in men and 416 deaths in women. An average of 102.8 deaths per year in men and 83.2 deaths per year in women. This represents an almost 60% increase in deaths from skin cancer in men by comparison with an increase of less than 9% in deaths occurring in women. There are now approximately 103 deaths per year in men and 83 deaths per year in women. An excess of twenty deaths per year in men now by comparison with an excess of ten deaths per year in women twenty-five years ago. The higher death rate in men is partly explained by the site of the cancers, the back being the most common site in men and on the legs for women. This less visible site and later presentation by men often means the cancer is more advanced and more difficult to treat.

Looking at the changes over time since 1975 when there were approximately 40 diagnoses of skin cancer every week in Scotland, by 2001 this had risen to 140 diagnoses of skin cancer every week. Similarly, in 1975 there were between two and three deaths from skin cancer every week and this has now risen to almost four deaths per week. In parliamentary constituency terms in 1975 there were roughly thirty diagnoses per constituency per year in Scotland and this number has risen to one hundred Scots diagnosed with skin cancer in every constituency in Scotland every year. In 1975, almost two deaths from skin cancer would be recorded in every constituency every year and this figure has risen to almost three deaths recorded in every constituency in Scotland every year.

A complete geographical analysis of registrations has not been undertaken but on simple pro rata calculations this would imply 1,160 cases of skin cancer per year in Greater Glasgow [population 886,000] 665 in Edinburgh [population 500,000] 140 in Borders [population 108,000] and 52 per year in Orkney and Shetland [population 40,000].

**Malignant Melanoma**

The changes in the epidemiology of malignant melanoma in Scotland are highlighted in Box 2 below and in greater detail in the appendix under Table 2 Trends in incidence of and mortality from Malignant Melanoma and figures 2a Registrations, 2b Deaths, 2c Registrations, broken down by sex and 2d Deaths from malignant melanoma by sex.

**Box 2. Malignant Melanoma**

<table>
<thead>
<tr>
<th></th>
<th>1975</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses</td>
<td>186</td>
<td>694</td>
</tr>
<tr>
<td>Deaths</td>
<td>67</td>
<td>144</td>
</tr>
</tbody>
</table>
The outline of the epidemic of malignant melanoma in Scotland demonstrated in Box 2 shows diagnoses rising from 186 registrations in 1975 to 694 registrations in 2001. Similarly, deaths have risen from 67 in 1975 to 144 in 2003.

Registrations for malignant melanoma are shown in more detail in Fig.2a rising from 186 registrations in 1975 to a peak of 701 registrations in 1997. The most recent five years have seen a plateau in new registrations of malignant melanoma with between 630-700 cases registered per year, an average of 665 registrations per year. This compares with a range of 180-270 registrations of malignant melanoma for the five-year period 1975-1979 and an average of 230 registrations per year. Malignant melanoma registrations in Scotland have increased almost threefold over this twenty-five year period.

Deaths from malignant melanoma are described in Fig.2b and are shown to rise from 67 deaths in 1975 to 144 in 2003. The average of the three years 1975-1977 was 69 deaths per year and in the three year period 2001-2003 there were 421 deaths as a result of malignant melanoma an average of 140 deaths per year. Deaths from malignant melanoma have doubled between 1975 and 2003. Although registrations for malignant melanoma have increased almost threefold during this period deaths have only risen twofold suggesting either earlier diagnosis or improved treatment and survival or both.

Registrations for malignant melanoma in males and females are depicted in Fig.2c and a very marked preponderance of cases in women is evident across the whole time period. In 1975, there were 127 diagnoses of malignant melanoma in women and 59 diagnoses of malignant melanoma in men. In 2001, there were 390 registrations of malignant melanoma in women and 304 registrations of malignant melanoma in men. In 1975, women accounted for 68% of all registrations of malignant melanoma and this had fallen to 56% in 2001. The ratio of 2:1 female: male registrations has changed significantly to 4:3 female: male registrations.

To gauge the change in male-female distribution more accurately a three-year average is employed. In the period 1975-1977 there were 428 diagnoses of malignant melanoma in women an average of 143 per year. In the period 1999-2001 there were 1135 diagnoses of malignant melanoma in women an average of 378 per year implying an increase of 2.6 times over this twenty-five year period. In men in the period, 1975-1977 there were 204 diagnoses of malignant melanoma an average of 68 per year. In the period 1999-2001 there were 856 diagnoses of malignant melanoma an average of 285 per year confirming an increase of 4.2 times in that twenty-five year period. New diagnoses of malignant melanoma in men have risen at a much faster rate than the increase in diagnoses in women. There also appears to be a significant reduction in female registrations of malignant melanoma in 1998, which has been sustained to a certain extent until 2001. The cause for this is unclear but it is the significant contributor to the plateauing of malignant melanoma registrations between 1997-2001.

Deaths from malignant melanoma in Scotland are described in Fig.2d. Deaths from malignant melanoma in women have increased from 38 in 1975 to 66 in 2003. Similarly, deaths from malignant melanoma in men have increased from 29 in 1975 to
78 in 2003. In the mid 70s to the mid 80s deaths of women outnumbered deaths of men and twenty-five years later deaths from men now outnumber deaths from women.

In the period 1975-1977 there were 128 deaths from malignant melanoma in women an average of 43 per year. This had risen to 191 deaths in the period 2001-2003 an average of 64 deaths per year and an increase of 50% over the twenty-five year time period. In men in the period 1975-1977 there were 78 deaths an average of 26 per year and in 2001-2003 there were 230 deaths an average of 77 deaths per year implying an almost threefold increase in deaths from malignant melanoma in men in Scotland.

Non-Melanoma Skin Cancer

The figures in Box 3 outline the changes in non-melanoma skin cancer over the twenty-five year period. Comprehensive figures for all non-melanoma skin cancer from 1975-2003 are available in the appendix Table 3 and these have been charted in Fig.3a Registrations, Fig.3b Deaths, Fig.3c Registrations in males and females, and Fig.3d Deaths in males and females.

**Box 3. Non-malignant Melanoma**

<table>
<thead>
<tr>
<th></th>
<th>1975</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses</td>
<td>1927</td>
<td>6655</td>
</tr>
<tr>
<td></td>
<td>1975</td>
<td>2003</td>
</tr>
<tr>
<td>Deaths</td>
<td>72</td>
<td>53</td>
</tr>
</tbody>
</table>

Diagnoses have risen from 1927 in 1975 to 6655 in 2001 the most recent figure available. Deaths in that time have changed from 72 in 1975 to 53 in 2003 an apparently significant reduction. However, as will be described later this apparent fall is more likely to be a chance finding and not significant.

A classic epidemic curve is demonstrated in Fig.3a with diagnoses of non-melanoma skin cancer rising from 1927 in 1975 to 6645 in 1997. This classic epidemic has been followed by a plateau over the last five years from 1997-2001. During that time, there has been a relatively narrow range of new registrations of non-melanoma skin cancer ranging from 6450 per year to 6650 per year with that five year period seeing 32,739 diagnoses an average of 6550 registration per year. This compares with the five-year period from 1975-1979 when the number of registrations ranged more widely from 1900-2400 per year, the five-year period seeing a total of 10,855 registrations an average of 2171 per year. This gives an almost exactly threefold increase in registrations of non-melanoma skin cancer in the twenty-five years from 1975-2001.

Deaths from non-melanoma skin cancer are depicted in Fig.3b and appear to show a fall from 72 deaths in 1975 to 53 deaths in 2003. The three-year period from 1975-1977 appears unusual with seventy-two deaths per year and this is likely to be a
chance variation similar to that seen in 1984 when deaths appear to have fallen to half their normal level. By comparison, the three-year period 1978-1980 saw a total of 155 deaths an average of 52 deaths per year. Comparing this with the most recent three yearly period 2001-2003 which has seen a total of 169 deaths an average of approximately 56 deaths per year. Consequently, although there has been substantial variation between years over the twenty-five year period there has been very little change in the number of deaths from non-melanoma skin cancer in total during that period.

Registrations for non-melanoma skin cancers in males and females are described in Fig.3c and the classic epidemic curve is also apparent for both sexes. Registrations in men rose from 1002 in 1975 to a peak of 3418 in 1997. A similar pattern is seen in females with 925 registrations in 1975 rising to a peak of 3227 in 1997. The last five years has seen a plateau in both male and female registrations with male cases ranging over a relatively narrow range of 3330-3420 and with females ranging from 3100-3260 during 1997-2001.

Throughout the whole time period there has always been a modest but persistent excess of registrations amongst men. In the 1975-1979 period there was an average of 1118 registrations in men and 1053 registrations in women, an excess of 60-70 registrations per year in men. In the most recent period 1997-2001 there has been an average of 3376 registrations per year in men and 3171 registrations in females in the same period giving an excess of around 200 additional registrations in males per year. This modest excess of cases amongst men has remained consistent with roughly 51.5% of cases being in men throughout the entire period.

Deaths from non-melanoma skin cancer are described in Fig.3d and a more complex picture is apparent. The highest number of deaths were recorded in the 1975-1977 period and are due primarily to the largest number of male deaths recorded occurring in 1975-1977 accompanied by a high number of deaths in women particularly in 1975 and 1977. In general, the figure shows smaller numbers and greater year-to-year variation making it harder to establish any obvious trends. Notably in most years, male deaths will have exceeded female deaths although there are occasional years when there are more female deaths. In an attempt to ascertain any underlying trend, the most recent five-year figures for deaths are compared with the similar period twenty years ago just after the statistical outliers in 1975-1977. In the five years from 1979-1983 there were 133 deaths from non-melanoma skin cancer in males an average of twenty-seven deaths per year. In the same period there were 108 deaths in females an average of 21.6 deaths per year. In the most recent five year period twenty years later ie 1999-2003 there were 157 deaths from non-melanoma skin cancer in males an average of thirty-one per year and in the same period in females there were 106 deaths an average of just over twenty-one deaths per year. This analysis suggests that over the last twenty years non-melanoma deaths in males have increased slightly while non-melanoma deaths in women are the same as they were twenty years ago. At present there is now a ratio of 3:2 deaths in males compared with females.
Other Issues

Incomplete Registration
Registrations of skin cancer are known to be incomplete and to underestimate the true numbers that are diagnosed every year. This is less true of malignant melanoma where between 93% and 100% had been registered in surveys of completeness of case ascertainment but under-reporting is a noticeable feature of the registrations for non-melanoma skin cancer. If 95% of melanomas and 90% of non-melanomas are recorded then the adjusted figure for skin cancer in Scotland in 2001 would be 730 malignant melanomas and 7395 non-melanomas, a total of 8125 skin cancers. In addition second and subsequent basal cell carcinomas are not recorded and this policy is estimated to capture only two out of three BCCs. The true figure for BCC is therefore likely to be approximately 8150 in 2001. Combining the adjusted figures for malignant melanoma [730], basal cell carcinoma [8150] and squamous cell carcinoma [1950] suggests a more accurate estimate of 10,830 or approximately 11,000 diagnoses of skin cancer in Scotland in 2001.

Cosmetic Tanning
In 1975, there were approximately 2100 cases of skin cancer diagnosed in Scotland and twenty-five years later this had risen to 7300 cases in one single year. This additional excess of over 5000 cases per year will have primarily resulted from cosmetic tanning. Preventable cases of skin cancer are probably even higher with reliable estimates concluding that 90% of non-melanoma skin cancer and two thirds of melanoma may be attributed to excessive sunlight exposure.

The principal contributors to this cosmetic tanning element include the rise in foreign holidays throughout the 1970s, 1980s and 1990s. The number of flights from the UK to Europe [principally Spain] increased over six times in the twenty years from 1975-1995. The 1990s onwards has also seen the addition of budget flights to the Mediterranean destinations. This is coupled with the dramatic rise in the availability of sunbed facilities in Scotland with some estimates suggesting a tenfold increase in the number of premises in the period 1980-2000. A Royal Environmental Health Institute of Scotland [REHIS] survey in 2003 identified 794 sunbed parlours in Scotland of which more than 50 were unmanned and unsupervised. Scotland has more sunbed salons per head of population than any other part of the United Kingdom and the local authorities reported a wide range of registered complaints. Glasgow city has the highest concentration with 181 salons including 27 unstaffed. There will also be a contribution from cosmetic tanning in Scotland principally during the summer months. The exact contribution that each of these elements contributes to the 5000 extra cases of skin cancer resulting from cosmetic tanning per year in Scotland requires further research and investigation.

With almost three quarters of young adults and nearly half of all ages intending to get a sun tan when they go on holiday prevention efforts still have a long way to go.

Skin Cancer in Younger Adults
Skin cancer generally tends to be a diagnosis made in older members of the population partly as a result of the twenty to thirty year lag between exposure and development of visible disease. A separate analysis not included here of changes in the epidemiology of skin cancer in under fifty year olds over the last twenty years
suggests similar changes have been seen in the younger population as have been seen in the population in total. An epidemic of skin cancer has unfolded in the younger members of the population as well.

Discussion
An epidemic of skin cancer has unfolded in Scotland throughout the 1970s, 1980s, and 1990s, rising from 2113 registrations in 1975 to 7346 registrations in 1997. Subsequently the five years from 1997 onwards have seen a plateau in the number of new registrations ranging between 7100 and 7350 cases averaging 7200 per year. The reason for this plateau and the probable future course of the skin cancer epidemic requires further research and investigation. Over the same time period deaths from skin cancer remained reasonably stable during the late 1970s and early 1980s ranging between 110 and 150 deaths per year. Since the mid-1980s deaths from skin cancer have risen slowly from an average of 141 deaths per year in the late 1970s to an average of 197 deaths per year in 2001-2003 representing a 40% increase in deaths over this period. Almost all of this increase in deaths has occurred in males. Deaths amongst females have increased only slightly during this period. Similarly, a small excess of cases amongst females has over the twenty-five year period become a small excess of cases amongst men averaging 100 more cases of skin cancer per year in men than women.

Registrations of malignant melanoma have also shown a classic epidemic curve between 1975 and 1997 rising from 186 registration in 1975 to 701 registrations (the highest number to date) in 1997 followed by a similar five year plateau. The last five years has seen an average of 665 registrations per year compared with 230 registrations in the late 1970s an increase of almost threefold during the twenty-five year period. During that period, deaths have doubled from an average of 69 per year in the mid-1970s to 140 per year from 2001-2003. This implies that earlier diagnosis and more effective treatment have prevented the number of deaths rising inline with the number of registrations. Registrations of malignant melanoma in women have exceeded those in men throughout this period and have grown just over two-and-a-half times. By comparison, registrations in men have increased over fourfold and this has altered the previous ratio, which saw 68% of registrations in women in 1975 now reduced to 56% of registrations in 2001. The most striking change over this period has been the reversal of the burden of deaths, which initially saw more deaths in women than men but now sees more deaths in men than women. Deaths in women have risen significantly by almost 50% over this twenty-five year period however deaths in men have increased almost threefold during the twenty-five year period.

For non-malignant melanoma, a similar epidemic is seen from the mid-1970s to 1997 when cases peaked. In the five years from 1997 onwards an average of 6550 cases are registered each year within a relatively narrow range plus or minus 50-100 per year. There has been an almost exactly threefold increase in non-melanoma skin cancer during this period. During this same period deaths from non-melanoma skin cancer have remained essentially stable in women but have risen slightly in men and now account for a ratio of 3:2 deaths in males to females or alternatively there are 50% more deaths in men than women each year from non-melanoma skin cancer.
Conclusions

An epidemic of skin cancer developed in Scotland from at least the mid-1970s until 1997 when cases of skin cancer trebled in Scotland and deaths from skin cancer increased by approximately 40% to a total of 7349 registrations in 2001 and 197 deaths in 2003. This epidemic appears to have plateaued over the last four or five years but further research and investigation is required to understand the cause of this plateau and whether this is a temporary situation likely to increase or decrease in the future. Even if the epidemic has plateaued it still exerts a tremendous burden of mortality and morbidity on the Scottish population with 140 diagnoses of skin cancer and almost four deaths occurring every week. Over 85% of these skin cancers are considered preventable suggesting almost 6500 cases could be prevented each year. Similarly given the nature of the factors contributing to the epidemic it is likely that at least 5000 or more cases per year occur as a result of cosmetic tanning. The priorities now must be earlier diagnosis in an effort to reduce the increasing number of deaths from skin cancer and a substantial and sustained prevention campaign to reverse the epidemic that has already occurred in Scotland.

Dr James Inglis
Consultant in Public Health Medicine
NHS Health Scotland

17 May 2005

Acknowledgements

All of the data used in this review has been provided by ISD Scotland, part of NHS National Services Scotland and is available on their website www.isdscotland.org. My thanks to Dr David Brewster, CPHM and Head of Cancer Programme at ISD Scotland for very helpful comments on the manuscript and in particular help with the estimates of actual numbers of skin cancers diagnosed in Scotland. My thanks also to Patricia Gray at NHS Health Scotland for invaluable help preparing the manuscript, tables and figures.
Skin Care Campaign Scotland (SCCS)

List of those attending before the Public Petitions Committee on 8 February, 2006

Presenting on behalf of SCCS:

Polly Buchanan, Skin Care Campaign Scotland, Skin Cancer Support
Professor James Ferguson, Photobiology Unit, Ninewells Hospital, Dundee
Dr Jamie Inglis, Consultant in Public Health Medicine, The Scottish Executive

Attending:

Rosemary Gierthy, Chair, SCCS
Helen Irons, Development Officer, SCCS
Barbara Page
Leigh Smith
Dr Harry Moseley
Public Petitions Committee – a template for public petitions

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Details of principal petitioner:
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Debbie Scott
To Play Or Not To Play

Text of petition:
The petition should clearly state what action the petitioner wishes the Parliament to take in no more than 5 lines of text, e.g.
The petitioner requests that the Scottish Parliament considers and debates the implications of the proposed Agenda for Change legislation for Speech and Language Therapy Services and service users within the NHS

We call on the Scottish Parliament to urge the Scottish Executive to adopt a Play Strategy that recognises the right of all children in Scotland to a safe, accessible and challenging play environment.

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Action taken to resolve issues of concern before submitting the petition:

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- ‘To Play Or Not To Play’ are a group of parents from North Glasgow. We ran a participatory investigation into play and environmental issues that resulted in ‘A Waste of Space?’, a report that drew attention to the amount of derelict land and lack of good play space locally.
- In March 2005 we hosted ‘Not a Waste of Space’, a community conference linking play, health and wellbeing attended by decision-makers and workers from the fields of health, childcare and community regeneration and addressed by Phil Hanlon, Professor of Public Health at Glasgow University.
- Since then we have been making contact with other interested people, trying to create child-friendly spaces in our own community and, through the CHIP project (a partnership between Barnardos and Stepping Stones for Families), have engaged the support of Barnardo’s Scotland in preparing this petition.
- Parliamentary Questions tabled by Sarah Boyack MSP (S2W 16583 – 16586, 17765, 17766) indicated that the Executive have no plans for a Play Strategy.
- A campaign by Play Scotland last year, calling on the Scottish Executive to develop a Play Strategy, has not been successful.
- The 1999 partnership agreement “Making it Work Together” committed the first Executive to “providing children with a stimulating environment for playing, developing and learning” but no policy on this matter has been produced.
- Discussions with a range of Barnardo’s services around Scotland have highlighted that this is a national concern.

Petitioners appearing before the Committee

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I do NOT wish to make a brief statement before the Committee

Signature of principal petitioner:

When satisfied that your petition meets all the criteria outlined in the Guidance on submission of public petitions, the principal petitioner should sign and date the form in the box below. Other signatures gathered should be appended to this form.
Signature ...

Date 5/12/05

Please note that any additional information, copies of relevant correspondence and additional signatures should be appended to this form and submitted to:

The Clerk to the Public Petitions Committee,
The Scottish Parliament,
Edinburgh
EH99 1SP
Tel: 0131 348 5186  Fax: 0131 348 5088
e-mail: petitions@scottish.parliament.uk
Play in North Glasgow: a Parents’ Perspective

Poor people: poor environment

North Glasgow postcode areas have been near the top of the Scottish Area Deprivation Index and Scottish Index of Multiple Deprivation. A large proportion of its families live on low incomes and the environment is of very poor quality. In other words, a lot of families in our communities are short of money and our children have a very harsh, inhospitable play environment. Recent research suggests that across Scotland people affected by poverty tend to lack access to green space. We understand that our particular circumstances are not shared by every community in Scotland, but we believe that play is important for children wherever they live.

What parents say

Parents we have spoken to have identified the following issues in relation to children’s play:

Accessibility
• The cost and expense of having to go out with where we live as there is very little available locally.

In a low-income area parents find it difficult to afford to buy access to good play environments and activities (car trips to the country etc).

Play Environments: not just Playgrounds
• There needs to be space for children not just chutes and swings.

Fenced off play grounds with fixed equipment are not a bad thing, but they are only part of the solution. They tend to be used mostly by pre-5s accompanied by children in the day time. Their night time use by teenagers is often seen, rightly or wrongly, as a problem by older residents.

Safety
• You can’t just send children out to play any more: it isn’t safe now.

Children’s Health

Without access to safe, clean and green play environments a generation of children are growing up without the necessary stimulation they require. In light of all the recent evidence concerned with obesity levels in children, we feel this is completely unacceptable. If children have nowhere safe to play how can they take the necessary exercise that would keep them healthy? And why would parents take the risk of letting their children play in sites that are unsuitable for their children’s needs?

1 Scottish Office 1998
2 Scottish Executive 2004
3 Investigating environmental justice in Scotland: links between measures of environmental quality and social deprivation (2005), a report produced by SNIFER for the Scottish Executive, Forestry Commission, SEPA and Scottish Natural Heritage
Some images of play environments in Possilpark, North Glasgow

What we want to happen

We believe it is totally unacceptable for children to play in these conditions. As there are currently very few alternatives for these children, we are calling on the Scottish Parliament to urge the Scottish Executive to adopt a play strategy that recognises the right of all children in Scotland to a safe, accessible and challenging play environment. This should ensure that our children and the rest of Scotland's children will have their right to quality outdoor play experiences recognised.

We want those responsible for the provision of spaces for children to provide areas to the highest specification. And finally we want children's play to receive the recognition and importance it is due.

To Play Or Not To Play Parents' Group, October 2005
A Play Strategy for Scotland

November 2005

Barnardo’s Scotland fully supports the call for a Play Strategy in Scotland. Now more than ever play provides a targeted and effective response to the needs of our children and young people:

- The open-ended learning through play has been linked to psychological and personal development, building crucial skills (physical, language) and attitudes (concentration, tolerance, perseverance).
- Play has a social dimension, and the interaction, negotiation and teamwork promoted by group play can play an important part in developing children’s social skills.
- With 33 per cent of 12-year-olds in Scotland classified as obese or overweight, the physical exertion involved in most play provides exercise, promotes physical co-ordination and develops motor skills.

Article 31 of the UN Convention on the Rights of the Child states: “State parties recognise the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.”

If the Executive is to realise its vision of children as “confident individuals, effective contributors, successful learners, responsible citizens” (and the vision document explicitly recognises that “Children and young people should be active with opportunities and encouragement to participate in play and recreation, including sport.”) then it needs to support opportunities for children to play.

Defining “play”

Defn.1) “For the purposes of the review, play meant what children and young people do when they follow their own ideas and interests, in their own way and for their own reasons. . . . . . Play is essential for children’s social, physical, intellectual, creative and emotional development. Play is the way children express their impulse to explore, experiment and understand.” From “Getting Serious About Play”.

Defn. 2) “Play is first and foremost the process of a child’s own, self-directed learning and as such is a process that has a validity for all ages of children. It is such a vital component of a child’s life that the child’s capacity for positive development will be inhibited or constrained if denied free access to the broadest range of environments and play opportunities.” From “Best Play”.

Play provision – the current situation

In a study carried out for National Play Day in August 2005, the National Children’s Bureau found that children said that poor provision of play spaces, and the fear that the outdoor world is unsafe, leads them to stay indoors. Other supporting facts and figures produced at this time include (UK figures):

- Although the UK still has the highest child road-death rate in Europe, the volume of accidents is decreasing so that, in 2003, 186 children were killed and 4,000 injured. Incidences of child abduction have remained virtually unchanged since 1950. Despite these trends, fears for children’s safety are on the increase. The radius around the home in which children are allowed to roam has shrunk to a ninth of what it was in 1970. In 1971, 80% of seven- and eight-year-olds walked to school alone. In 1990 the figure had fallen to 9%.
- For every acre of play space there are 80 acres devoted to golf courses.
- Playing fields have been lost at a rate of one a day in the last eight years.

Barnardo’s Scotland would add that lack of access to play space also deprives children of important opportunities to socialise and risks leaving them bored and frustrated. A recent Scottish Children’s Reporter Administration report stated that “A lack of structured leisure activities was cited in social work reports as a factor contributing to offending behaviour for 59% of the sample.”
Detailed figures on play provision in Scotland are hard to come by. Responding to recent Scottish Parliament questions requesting the sums spent on play provision by local authorities and the amount of play space provided, the Executive stated that such figures are not held centrally. The Executive also indicated at this time that they had no plans to implement a Play Strategy for Scotland or to implement the recommendations of the recent “Getting Serious About Play” report.

The Scottish Executive currently funds Play Scotland as the lead agency for play in Scotland. However there is no Executive staff team devoted to play, which comes under Early Years provision. The Executive has published a physical activity strategy, which is welcome but does not specifically relate to children – and of course physical activity is only one part of the play agenda. In the 2001 General Election the UK Government pledged that £200 million of National Lottery money would be earmarked for new and improved children’s play facilities. It has been confirmed that England’s £155 million share will be distributed to play projects via a designated Big Lottery Fund scheme. The Big Lottery Fund will be announcing it’s funding criteria in Scotland on November 22nd, indications are that it is unlikely to have a designated fund for play.

The Welsh Assembly has now published a comprehensive Play Policy and the associated implementation Group has produced a series of detailed recommendations.

**Barnardo’s and play**

Barnardo’s and the Children’s Play Council have recently completed a partnership project to administer Better Play - a four year £10.8 million England wide grant programme resulting in 225 local schemes bringing better play opportunities to an estimated 80,000 children. Evaluation of the programme has provided a wealth of information on producing local play strategies, inclusive play provision, play in public space and environmental play. It is now clear that a significant body of best practice with regard to developing local play space now exists – if the political will and funding are in place.

In May 2004, Barnardo’s was a project partner in a new report from The Green Alliance and Demos. “A Child’s Place: why environment matters to children”. The report showed that outdoor play improves children’s health, well being and personal development. However children living in areas of high deprivation have restricted access to such opportunities. Barnardo’s therefore called on ministers and policy makers to provide more safe and accessible green play spaces for all children, particularly in disadvantaged neighbourhoods and provide the funding to enable local authorities to adequately supervise and maintain play areas.

The Children’s Inclusion Partnership (ChIP) project in Glasgow, run jointly by Barnardo’s and Stepping Stones for Families, has supported local parents campaigning for increased play space in their communities. A number of Barnardo’s services around Scotland, particularly those supporting disabled children and their families, see play provision as a crucial element of their support.

**What are we calling for?**

Barnardo’s Scotland agrees with the statement in Best Play that “a body of knowledge has accumulated which allows the fundamental need for children’s play to be asserted”. Every Scottish child should have somewhere safe, accessible and challenging to play and we want to see Scottish Executive action on play in pursuit of this policy goal. Elements of such a strategy should include:

1) Lessons from the Better Play project;
2) Opportunities to increase the funding available for play provision;
3) Recommendations from the Dobson Report, Getting Serious About Play, which was based on an extensive UK-wide consultation with children and young people, communities and the play sector; and
4) Lessons learned from the Welsh Assembly Government’s Play Policy and review of provision.
Public Petitions Committee – a template for public petitions

Should you wish to submit a public petition for consideration by the Public Petitions Committee please complete the template below. Please refer to the Guidance on submission of public petitions for advice on issues of admissibility before completing the template. You may also seek advice from the Clerk to the Committee whose contact details can be found at the end of this form.

Details of principal petitioner:
Please enter the name of person and organisation raising the petition, including a contact address where correspondence should be sent to, email address and phone number if available

Text of petition:
The petition should clearly state what action the petitioner wishes the Parliament to take in no more than 5 lines of text, e.g.
The petitioner requests that the Scottish Parliament considers and debates the implications of the proposed Agenda for Change legislation for Speech and Language Therapy Services and service users within the NHS

Petition by Anne Mackenzie, on behalf of Hilton Primary School, calling for the Scottish Parliament to urge the Scottish Executive to ensure that all primary school children have access, on a regularly timetabled basis, to specialist visiting teachers, especially music, PE and art.

Additional information:
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Action taken to resolve issues of concern before submitting the petition:
Before submitting a petition to the Parliament, petitioners are expected to have made an attempt to resolve their issues of concern by, for example, making representations to the Scottish Executive or seeking the assistance of locally elected representatives, such as councillors, MSPs and MPs. Please enter details of those approached below and append copies of relevant correspondence, which will be made available to the Public Petitions Committee prior to its consideration of your petition.

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I do NOT wish to make a brief statement before the Committee

Signature of principal petitioner:
When satisfied that your petition meets all the criteria outlined in the Guidance on submission of public petitions, the principal petitioner should sign and date the form in the box below. Other signatures gathered should be appended to this form.

Signature

Date 5th December 2005

Please note that any additional information, copies of relevant correspondence and additional signatures should be appended to this form and submitted to:
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The Scottish Parliament,
Edinburgh
EH9 1SP
Tel: 0131 348 5186 Fax: 0131 348 5088
e-mail: petitions@scottish.parliament.uk
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Sidney McKechnie Gallagher

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The petitioner requests that the Scottish Parliament considers and debates the implications of the proposed Agenda for Change legislation for Speech and Language Therapy Services and service users within the NHS

The petitioner requests that the Scottish Parliament......

Commisions a substantial programme of research into membership of the Freemasons among the police and judiciary.

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In discussing Petition 593, the petitions committee decided not to take any further action. One of the reasons given by a committee member was that there was insufficient information available on Freemasonic influence and membership. Written answer S2W-14529 makes clear that no attempt has since been made to gather factual information on this subject. I gather that the Parliament of Norway has passed legislation on this issue and I believe it would be appropriate for the Scottish Parliament to examine the possibility of doing so.

Request to speak:

All petitioners are given the opportunity to present their petition before the Public Petitions Committee. The Convener will then make a decision based on a number of factors including the content of the petition and the written information provided by the petitioner as to whether a brief statement from the petitioner would be useful in facilitating the Committee’s consideration of a petition.

Please indicate below whether you wish to request to make a brief statement before the Committee when it comes to consider your petition.

Yes

*Delete as appropriate

Signature of principal petitioner:

When satisfied that your petition meets all the criteria outlined in the Guidance on submission of public petitions, the principal petitioner should sign and date the form in the box below. Other signatures gathered should be appended to this form.

Signature

Date 10TH JULY 05

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The Scottish Parliament,
Edinburgh
EH99 1SP
Tel: 0131 348 5186 Fax: 0131 348 5088
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<table>
<thead>
<tr>
<th>Councillor Sam Mullin JP</th>
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<tbody>
<tr>
<td>Renfrewshire Council</td>
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<td>HQ (North Building)</td>
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<td>Cotton Street</td>
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<td>PAISLEY</td>
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The petitioner requests that the Scottish Parliament considers and debates the implications of the proposed Agenda for Change legislation for Speech and Language Therapy Services and service users within the NHS

Petition by Councillor Sam Mullin calling for the Scottish Parliament to urge the Scottish Executive to remove the tolls from the Erskine Bridge at the earliest possible opportunity.

### Additional information:

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Hugh Henry MSP, Trish Godman MSP, Henry Alexander MSP,
Full Labour Group Re:Represenative Council (21)

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I do NOT wish to make a brief statement before the Committee ☐

Signature of principal petitioner:

When satisfied that your petition meets all the criteria outlined in the Guidance on submission of public petitions, the principal petitioner should sign and date the form in the box below. Other signatures gathered should be appended to this form.

Signature.

Date 19/12/2005.

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The Scottish Parliament,
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EH99 1SP
Tel: 0131 348 5186 Fax: 0131 348 5088
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Details of principal petitioner:

*Please enter the name of person and organisation raising the petition, including a contact address where correspondence should be sent to, email address and phone number if available*

Barbara Harvey

Text of petition:

*The petition should clearly state what action the petitioner wishes the Parliament to take in no more than 5 lines of text, e.g.*

The petitioner requests that the Scottish Parliament considers and debates the implications of the proposed Agenda for Change legislation for Speech and Language Therapy Services and service users within the NHS

Petition by the Cumbernauld Mast Relocation Group calling on the Scottish Parliament to urge the Scottish Executive to ban the siting of 3G and Tetra masts in residential areas until all the evidence which suggests they are a health risk has been examined by the Parliament.

Additional information:

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Have written an open letter to the Health Committee, Communities Committee, respective Ministers and other MSPs.

Petitioners appearing before the Committee

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Signature of principal petitioner:

When satisfied that your petition meets all the criteria outlined in the Guidance on submission of public petitions, the principal petitioner should sign and date the form in the box below. Other signatures gathered should be appended to this form.

Signature

Date ....18 Aug 2005

Please note that any additional information, copies of relevant correspondence and additional signatures should be appended to this form and submitted to:

The Clerk to the Public Petitions Committee,
The Scottish Parliament,
Edinburgh
EH99 1SP
Tel: 0131 348 5186 Fax: 0131 348 5088
e-mail: petitions@scottish.parliament.uk

We wish to express our concern about the potential health risks of mobile phone masts. In many cases they are being erected close to housing in contravention of the British Government's own planning guidelines. There is mounting evidence of the dangers which these structures present, and a precautionary approach has been advised. Yet in practice the genuine concerns of local residents are being overruled in favour of the mobile phone companies.

We would like to draw your attention to the following trials:

The REFLEX was an EU funded study. It's project leader, Franz Adlkofer stated:

"We have proven that electromagnetic field, in high and low frequencies, damage cells in individual systems. These results can't readily be transferred to human beings... if similar findings were ever achieved in living organisms such as rats or mice, then we have a big problem."

Similar findings have in fact been achieved in rats - exposed to far weaker fields than those used in the REFLEX study (Drs. Lui & Singh, University of Washington, Seattle). These findings were confirmed by several other laboratory trials. Other reputable scientific studies have also raised questions regarding health issues.

The phone companies are quick to dismiss the mounting evidence as irrelevant, stating that it is inconclusive - by its very nature scientific evidence relates to the situation in which testing takes place. However, if living cells are being destroyed in laboratory conditions, even if it is only some cells, then most people would see this as a cause for concern, and as a reason for adopting a precautionary approach. What the NRPB considers inconclusive, many would regard as sufficient evidence to give rise to serious concerns.

Indeed the existing situation, which disallows health as legitimate grounds for objection, is in itself a cause for great concern: who is interested in the colour of a mast when it may be threatening their long term health and that of their family?

We would ask you to treat our concerns seriously, and as our elected representatives, make representation on our behalf to facilitate the enactment of legislation which would enforce the removal of phone masts from the centre of housing areas, and effect a ban on the future erection of masts in these situations.

We feel that there is a need for existing legislation to be re-examined in the light of scientific evidence, and urge that no more masts should be erected until this has taken place. We believe that this situation needs to be addressed as a matter of urgency: masts are being given the go-ahead against the expressed wishes of residents and our concerns are being dismissed.

Other, safer systems exist and should be investigated.

Your comments, advice and support would be greatly appreciated. Thank you.

The Abronhill Mast Relocation Group, Cumbernauld.

[Contact Address: 156 Lime Crescent, Cumbernauld, G67 3PH 01236 735671]

Dear Jim,

A summary of this submission is below, followed by the submission itself.

The purpose of this petition is to present evidence that amounts to proof that mobile phone mast radiation is dangerous and that masts emitting it should not be placed in close proximity to people. The document that we have handed over to you contains most of the trials conducted since WWII, by numerous reputable scientists, worldwide.

The phone companies still claim that trials are inconclusive when closer examination of these trials show, as Dr Cherry, the world renowned expert on the effects of radio frequency radiation says, “that this is just not true.”

So strong is the evidence to those who are able to examine it that a Chief Environment Court Judge in New Zealand has said, “Any country that adopts the International Committee (ICNIRP) safety guidelines” (which our ‘protection board’ the NRPB does,) “is putting its population severely at risk.”

What we want is – Parliament to examine the evidence submitted, which shows that mobile phone mast radiation is genotoxic, mutagenic, carcinogenic and teratogenic in animals and people at non-thermal levels, followed by -

1) A ban on the erection of all new mobile phone masts in close proximity to housing in Scotland.
2) The removal of those already erected and
3) Exclusion zones round towns, villages and places of habitation as recommended by Tayside University Hospitals in 2000.

The Cumbernauld Mast Re-location Group. (CMRG)
Dr. Jim Johnston, Clerk to the Petitions Committee, 
Ladies and Gentlemen, Members of the Petitions Committee.

In Cumbernauld recently there has been an increase in applications to the planning 
department to erect mobile phone masts in very close proximity to housing. This is 
a matter of concern for us since we (the CMRC) have discovered over the past year 
that there are many documents which describe scientific trials which show that living 
close to a source of radio frequency radiation, may in all likelihood be harmful to 
health, particularly long term and that it encourages various debilitating malfunctions 
in the body’s biological mechanisms, probably culminating in cancer, if the exposure 
is long enough or if the individual is weak. A large number of these documents 
challenge the claims that only levels that are high should be considered dangerous and 
challenge the claims of the National Radiological Protection Board (NRPB) that no 
real evidence of risk exists or that only thermal radiation should be considered as 
potentially harmful.

This is the problem which we present to you and which you have in your power to help 
rectify. The International Commission for Non-Ionizing Radiation Protection (ICNIRP) and 
the NRPB, the board appointed to protect us, above, still claim that there is no evidence that 
cell phone radiation is harmful, when there is, according a large number of respected 
scientists, a growing body of published scientific studies that show that it is. The bulk of 
these scientific studies have been lodged with Dr. Johnston, a collection of hundreds of 
scientific trials conducted by many different scientists and compiled by Dr Cherry of Lincoln 
University in New Zealand which show evidence of biological malfunction in people or 
animals after exposure to this type of radiation. Many of the trials required that animals be 
exposed to this type of radiation up to two hours every day. People living in close proximity 
to these masts, are, at this point in time, being irradiated for up to 24 hours a day. 
Among these scientists who have found evidence of adverse effects following exposure to 
this type of radiation. Dr Goldsmith of the Ben Gurion University in Tel Aviv, describes how 
the Russians irradiated the American Embassy between 1953 and 1976. Eventually the 
Ambassador came down with leukaemia and so was removed from post and another 
Ambassador was sent out to replace him. He too came down with leukaemia and it was only 
then that some serious attention was given to the problem and blood samples were sent back 
to the U.S. These were found to show an increased frequency of DNA abnormalities. This 
was Radio-Frequency Sickness Syndrome that the Russians knew could be induced by using 
extremely low frequency, ELF, radiation. This knowledge enabled them to protect their own 
people, with stringent safety levels, but attack the enemy by irradiating them with it. Prior to 
the probable onset of cancer the Russians knew that RF radiation would debilitate the 
American Embassy Staff. You can do this by using extremely low level, radio frequency 
radiation to induce the inability to concentrate, the inability to sleep and the inability to think 
coherently, and these symptoms, it is now generally accepted, can be induced at extremely 
low frequencies.

The problem for us is that the NRPB and the International Commission who define the safety 
standards that our NRPB accept, either totally ignore the vast amounts of scientific literature 
that exists on the debilitating effects of extremely low frequency radiation exposure or 
dismiss it, by claiming that the methodology of the trial was flawed. They also use the phrase 
not “mainstream science” when most, if not all of the evidence is what most people would 
consider to be mainstream science, published by scientists from reputable American, British 
or European Universities or commissioned by the EU.
An example of this dismissive approach is the response to the REFLEX study, funded by the EU, which conducted trials in 12 different laboratories, in 7 different European countries and found that some living cells, in vitro, were damaged when exposed to radio frequency radiation levels consistent with that used for cell phones, and some, the scientists noted, following damage, could not repair themselves. These findings were dismissed by the phone companies representatives as “inconsistent” possibly because although damage was found, the amount of damaged, varied. The project leader said that these results were worrying and would now need to be replicated in mice, but there are already many trials where DNA strand breakage has been found in rats (Lai & Singh) and these trials have been replicated. The call for more trials seems entirely unnecessary when so many trials exist already which show cause for concern. Dr. Cherry says “To this day cell phone companies and some government bodies still claim that there is no evidence to suggest that radio-frequency radiation is harmful,” but this, he says, “is just not true.”

Section 6: On pages 18 and 19, he describes how radio-frequency radiation inhibits the production of melatonin, in animals and people. This, he says has been established from multiple independent studies. Since melatonin is vital for healthy sleep and the scavenging of free radicals that takes place during sleep, it is needed to promote the activity of a healthy immune system.

Section 7.8.3.: On page 24, Drs Lai and Singh identified its lack in irradiated rats and they also identified DNA strand breakages in these rats, conditions necessary for the development of cancer. The Reflex Study funded by the EU, was only one of many trials, to confirm the DNA strand breakage effect of radio-frequency radiation, following the findings of Drs Lai and Singh.

Section 10.5.1.: Page 28 – Larsen et al. identified (1991) increased rates of abortion and foetal malformation and in section 10.5.3. - Lancranjan et al. (1975) found “male sexual function significantly reduced, in extremely low frequency and radio-frequency microwave occupational exposure situations.”

Section 10.7.: Page 31 – gives details of trials where mice that were irradiated became sterile. (Magras & Xenas)

Section 10.7.: Page 32 – “There is repeated evidence of RF/MW induced infertility in rodents strongly showing the RF/MW have genetically damaged the cells of the animals. This suggests that there could be reproductive and genetic damage in RF/MW exposed humans.”

Section 13.3.2.: Page 39 – Johnson Liakouris, Mild et al., identified significant dose response relationships for the following symptoms from the use of mobile phones: “Memory loss, Difficulty in Concentrating, Headache, Fatigue. Hence it is now shown and known that RF/MW exposure from extremely low but chronic exposure over many years, occupational exposure and cell phone use, all produces significant and consistent neurological symptoms.”

Table 14 same page, highlighted – “The dominant cancers are brain tumour, leukaemia and reproductive organ cancer. But this study, like the Korean War Study, confirms that extremely low level chronic microwave exposure is associated with very significant increases in illness and mortality in organs across the whole body, consistent with widespread cellular chromosome damage.”

Section 14.1.5.1: Page 45 - Szmigielski et al. “found and present evidence of immunosuppression and immunostimulation associated with RF/MW exposure of cells to a wide range of frequencies, modulations and intensities.”

Section 14.3.: Page 47 - “In the 1988 data analysis, three sub-categories of leukaemia and lymphoma were significantly increased with RF/MW exposure.”

Section 17.2: Page 53 – Maskarince et al (1985) found “An unusual number of children with leukaemia were identified living in the vicinity of broadcasting facilities– An increased
incidence of malignant brain tumours has been reported in children of fathers exposed to electromagnetic fields and electronic solvents: Johnson & Spitz (1989)- - - Page 54 - Dosemecli & Blair (1994) found 'excess risks of connective tissue cancer among engineers and technicians; office workers; telephone operators, and mechanics and repairers - - - Many statistical studies confirm the large number of findings from laboratories showing an increased incidence of cancers in exposed populations.

Section 17: Page 52 - Lester and Moore (1982a) tested the hypothesis that radar might increase the risk of cancer by noting that Wichita, Kansas, used radar from airforce bases on two opposite sides of Wichita. They tested the hypothesis by separating population into those exposed to no radar signals (in the valleys) one radar signal, on one or other hill slope, and two radar signals received by those living on ridges. The cancer incidences were 303, 429 and 470 per 100,000.

These are only a small number of the trials collated and submitted to you. 73 pages of this type of evidence has been handed over to the Clerk. Please note that responses occur with extremely weak fields.

A variety of dismissive approaches are used by the ICNRP and the NRPB, the 'inconsistent' charge was illustrated earlier. Statistical evidence is often also dismissed as being 'unscientific' yet the stance of the ICNRP and NRPB that no adverse effects are possible because they have decided that only radiation that heats, thermal radiation, can be dangerous and that as a result, non-thermal radiation, that does not heat, is safe is an assumption that is nothing if not 'unscientific.' Dr Hyland of Warwick University has done much work to refute these particular claims.

The trials that Dr Cherry cites, show a need to take action to protect public health. He says in Section 4.4 : page 12 'Both animal and human evidence cover a wide range of RF/MW exposure conditions. Across the same frequency range multiple independent laboratories have observed significant DNA-strand breakage and enhanced chromosome aberrations. Hence there is strong evidence that Radiofrequency/Microwave Radiation is genotoxic, mutagenic, carcinogenic and teratogenic in animals and people at non-thermal levels of RF/MW exposure.'

Our Government in London have, eventually been forced to concede a possible danger and have recommended as you probably know, 'the Precautionary Principle,' whereby they advise that mobile phone masts should not be erected close to schools or hospitals or housing. However, despite the support of our North Lanarkshire Planning Committee in refusing applications for masts in close proximity to housing, these applications arrive with recommendation from the planning department, who do not seem to have the same understand of the precautionary principle as the many local people who do not want masts a stone's throw from their houses. Any refusal by the Planning Committee to erect masts in close proximity to housing can be overturned quite quickly by an Inquiry Reporter since applications are accompanied by a safety certificate from the NRPB, which is intended to preclude all discussion on matters of health. The evidence handed in to you questions the validity of all ICNIRP guidelines that claim to prescribe safety limits. They are, (Page 52) "many orders of magnitude above the levels at which known adverse human health effects occur" and so therefore do not appear to ensure safety. As against the mountain of evidence that suggests that this type of radiation is unsafe there is no evidence which proves that it is safe, yet even the rudimentary precautionary principles advised by the British Government do not seem to be being adhered to by some planning departments.

Where some planning authorities have been able and willing to observe the precautionary principle, it seems to have been possible, to place masts on the outskirts of towns, where they seem to be located well beyond the residential area. This is where all mobile phone masts
should be, irrespective of the social class or the financial status of the people whose health will probably be put at risk. Systematically debilitating our most valuable asset, our people, does not seem to be a sensible economic strategy, yet could well be the result of this process, unless the problem is addressed.

The medical report of Tayside University Hospitals made recommendations to the Government in 2000 for clear exclusion zones around cell phone masts and Dr Becker, twice nominated for the Nobel Prize in recognition for his work on the effects of electro-magnetic fields on the human body, recommends that all masts be situated at least one half mile away from where people live or work. Dr. Cherry says much the same ‘Base station placements should be remote from where people live and work, remote from homes, remote from schools, remote from hospitals.’

In the light of the very strong evidence presented that exposure to extremely low frequency, ELF radiation, of the type emitted by cell phone towers, is potentially health threatening, we wish to petition the Scottish Parliament to ban the siting of these masts in residential areas and impose a one mile exclusion zone around all residential sites.

We would also like the remit of the NRPB to issue safety certificates to be removed, on the basis that these safety certificates are grounded, as the evidence handed in shows, on flawed science since much material evidence has been either misinterpreted or ignored. (Page 2.) The trials presented “soundly challenge the ICNIRP assumptions and approach. The ICNIRP assessment of biological mechanisms is reviewed and found to be selective, limited and flawed. The ICNIRP assessment of RF/MW effects on reproductive outcomes is shown to be limited, misleading and flawed. The cancer assessment is shown to be selective, misleading, inappropriate and flawed. An incorrect epidemiological approach is consistently applied.”

To the NR PB who still maintain that no firm evidence exists that these emissions are likely to be harmful, can we point to the 15 pages of small print that list hundreds of scientists from Adey to Zurawaska, who have conducted trials which show that in all likelihood it is.

In New Zealand, the ICNIRP guidelines are regarded as so seriously flawed that they are unlawful. The Chief Environmental Court Judge, Judge Sheppard (P26) said ‘It is grossly inappropriate for any country to adopt the ICNIRP guidelines for public health protection because it is scientifically challengeable, as it is based on serious errors and omissions.’ He concludes on page 52 ‘Any country which adopts the ICNIRP guidelines, (as the British NR PB does) is putting its population severely at risk.’

We hope to have convinced you that the evidence gives cause for concern and that remedial action needs to be taken, to remind the phone companies, that in the light of the evidence presented, they cannot continue to regard it as their right to choose sites which could compromise the health and safety of so many people, without challenge.

We trust in your good judgement and thank you for any decision that will help to address this serious matter.

The Cumbernauld Mast Re-location Group.