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.

Detail 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.

Caroline Paterson, on behalf of "Stirling Before Pylons".

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 requests that the Scottish Parliament......

Petition by Caroline Paterson, on behalf of "Stirling Before Pylons", calling for the Scottish Parliament to urge the Scottish Executive to acknowledge the potential health hazards associated with long-term exposure to high voltage transmission lines and to introduce as a matter of urgency effective planning regulations to protect public health.

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.


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 / No*

*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 ....24th January 2005 (original submission Dec. 20th)

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 1SF
Tel: 0131 348 5185    Fax: 0131 348 5088
e-mail: petitions@scottish.parliament.uk
Dr James Johnston  
Clerk to the Public Petitions Committee  
The Scottish Parliament  
TG.01  
Holyrood  
Edinburgh  
EH99 1SP  

May 29th 2006  

Dear Dr Johnston,  

I am writing with regard to PE812 on power line EMFs and public health and its  
progress. I submitted a response to the correspondence received to date and  
Lewis MacDonald’s consideration in particular at the end of March, which I hope  
was received.  

Last Monday I attended the first meeting of the CPG on this very topic in the  
Parliament. I was very disappointed to note that not one member of the Public  
Petitions Committee was present, despite the two speakers being amongst the  
most informed and influential in this field. There is little point in requesting my  
considered opinion on this subject, but then missing the opportunity to hear and  
question two internationally acclaimed experts in the field. I enclose a summary of  
my notes, which I hope very much you will copy to all members of the Committee.  
Please also inform them that the second meeting of the CPG will take place on  
Wednesday June 21st, 6-8pm when Edward Copisarow, Chief Executive of  
Children with Leukaemia will be giving a presentation (further details from Jean  
Turner MSP). Coincidentally, Scotland Before Pylons will be hosting a meeting on  
undergrounding in the Parliament at 1pm on the same day, with an Italian expert  
as speaker - if any Committee members wish to attend they should please contact  
us ASAP. In the first consideration of PE812 there was much discussion of  
undergrounding, and it may interest members to know that in Madrid 7.5 miles of  
400kV line has just been undergrounded at only 3x the cost of an overhead cable.  

As my notes detail, SAGE is due to have its final meeting in June and an  
announcement is expected in July. The leaked suggestion of a 70m prudent  
avoidance distance (Telegraph April 26th & 29th) would not address the very  
senior health risks for more than a small handful of individuals, and is unlikely to  
satisfy the 13,480 individuals who objected to the Beauty to Denny proposals  
specifically on the grounds of adverse health effects. I hope very much the Petitions  
Committee is keeping informed of all such developments and their implications for  
Scotland.  

Yours sincerely,  

Caroline Paterson  
Stirling Before Pylons
First public meeting of the CPG on Electromagnetic radiation and health
Tues May 23rd, Scottish Parliament

Prof Denis Henshaw (Bristol University) summarised international research into the adverse health effects of living close to power lines. The focus of this research has now gone beyond the internationally accepted doubled incidence of childhood leukaemia with exposure levels above 0.4 microtesla, with over a dozen reports on the night time disruption of melatonin production by EMFs, which could account for the increased incidence in adult leukaemias, brain tumours, ALS (motor neurone), depression, suicide and miscarriage recorded in proximity to power lines. Melatonin is a naturally produced anti-cancer agent, and so its disruption helps to explain the increased incidence of the various cancers. Reduced melatonin also triggers depression and possibly miscarriage too, helping to explain the range of diseases covered in epidemiological studies. Added to this, Henshaw's "corona ion" theory, involving the inhalation of electrically charged pollutants could account for thousands of additional cases of lung cancer in the UK, and may help to provide an explanation as to why the Draper Report (by the Oxford Childhood Cancer Research Group) recorded significant statistical increases in childhood leukaemia as far as 600m from high voltage power lines. Henshaw's research has led him to recommend a prudent avoidance distance for dwellings of 400m from high voltage lines (272 & 400kV) and urge the Scottish Parliament to "consider immediate strict precaution against the siting of power lines near houses or the converse".

The emphasis of Dr John Swanson's presentation, (scientific advisor to the National Grid) was different. He acknowledged the "possibility" of an associated increased risk in childhood leukaemia and advised the adoption of a proportionate response. This acknowledgement of a "possible" association should be seen in the context of Dr Swanson being a co-author of the Draper Report (BMJ June 2005), a study of 29,000 children with cancer over a 33 year period, which concluded that "there is an association between childhood leukaemia and proximity of home address at birth to high voltage power lines", and that that children living within 200 metres of high voltage power lines are nearly twice as likely to have childhood leukaemia as those living beyond 600 metres.

Dr Swanson outlined industry's compliance with current ICNIRP (International Committee on Non-Ionizing Radiation Protection) guidelines, but failed to mention that at 100 microteslas (which as Henshaw pointed out is 250 times greater than the level at which a doubling of childhood leukaemia occurs and is accepted by Dr Swanson as occurring), these guidelines are totally meaningless and allow a 400kV power line to pass directly over homes. Prof Henshaw contrasted the EMF situation with that taken by industry over chemical carcinogens, where there is substantially less epidemiological evidence, yet the safety threshold is rigorous compared with that for EMFs. Dr Swanson tried to convince those present of the responsible role taken by industry, but Peter Pearson of Stirling before Pylons informed the group that Scottish & Southern Energy (SSE) had issued misleading information on the number of homes to be affected by the Beauly to Denny proposal, claiming that less than 10 homes would be within 100m of the proposed line, when in fact detailed survey revealed 50 homes within 100m of SSE's deviation corridor within Stirling alone. There are currently nearly 1000 homes within 600m of the deviation corridor in Stirling.
Although Dr Swanson was advocating precaution, he put emphasis on the terms "the balance of evidence" and "proportionate response". He referred to negative evidence, yet this was largely due to his failure to refer to studies covering the electrical field, in addition to the magnetic field element; and reference to laboratory experiments, which as Prof Henshaw pointed out fail to replicate studies within the human population and epidemiological studies. Dr Swanson's reference to a "proportionate response" was countered in the discussion by Caroline Paterson of Stirling Before Pylons, speaking up for the 0.2% of the UK population whose health is currently seriously compromised and the thousands currently threatened by the Beauty to Denny proposals. Caroline, supported by Sylvia Jackson MSP stressed that public health protection should be of paramount importance and not compromised by the financial interests of shareholders and industry. The advantages of undergrounding which remove the adverse health effects almost entirely were raised, as was the existing compensation structure, which is currently only available if a line physically crosses your ground and is therefore meaningless in terms of adverse health effects. Recently 7.5 miles of 400kV line has been undergrounded around Madrid at only 3 x the cost, a cost that is irrelevant when compared with the potential loss of health and life, not to mention the cost benefits from a landscape perspective.

The discussion was a timely one in view of an announcement expected next month from SAGE - the Stakeholders Advisory Group for EMFs, which was set up by the Department of Health in Westminster in 2004 to introduce precautionary measures. Dr Swanson supported the notion of SAGE with its various stakeholders saying that "the Electricity industry should not be trusted to set the safety limits for EMF exposure". His plea for the precautionary principle to be applied in a proportionate way should be seen in this context. Henshaw noted that other countries had introduced precautions years ago (Sweden over a decade ago) when far less evidence for adverse health effects was available.

The issue is a very important one for Scotland, with Scottish and Southern Energy and Scottish Power's Beauty to Denny 400kV proposals lodged with the Executive, now pending public inquiry. There is great public concern within Scotland regarding the adverse health effects, with 13,480 objections on the health issue alone, which has not been a consideration in the routing proposals, with adverse health effects being denied by the applicants. Both speakers had been briefed not to answer questions specifically relating to the Beauty to Denny power line application in advance of SAGE's announcement expected next month. However, the leaked suggestion of a 70m prudent avoidance distance (Telegraph April 26th & 29th) would be an unacceptable outcome, when the Draper Report records a 70% increased risk in childhood leukaemia at 200m, with significant effects recorded up to 600m distant.

Caroline Paterson
Stirling Before Pylons
Public Petitions Committee

Petitioner's views on responses to PE812 which requested that the Scottish Parliament urge the Executive to acknowledge the potential health hazards associated with long-term exposure to electromagnetic fields from high-voltage transmission lines and to introduce precautions, as a matter of urgency, effective planning regulations to protect public health.

Whilst not claiming to be an expert on powerline electromagnetic fields (EMFs), I have spent much time studying the subject. Likewise, all the responses to the Petitions Committee, with one exception, have been written by individuals with no specific expertise in the field of EMF health effects. There is however a difference of perspective, with the majority of responses coming from industry, whereas mine is that of someone currently threatened with the prospect of a 400kV extra high voltage overhead powerline (Beauly to Denny) being constructed alongside my home. The motivation underlying PE812 has arisen from a desire to protect the health of my family and all those potentially threatened by this line and others planned in the future.

February 8 2006 was the second consideration of PE812, and I will concentrate on Lewis Macdonald's response which was under consideration at that meeting, whilst referring where relevant to some of the correspondence generated by the first consideration of PE812 in Feb. 2005. A copy of Stirling Before Pylon's comment on the health section of the Environmental Statement for the Beauty to Denny proposals is attached, as this responds to SSE's position and should be read in conjunction with this report.

The main issues raised by Lewis Macdonald are as follows:
SAGE (Stakeholders Advisory Group on EMFs): Lewis Macdonald concludes that the UK Health Departments consider the 'SAGE' process the appropriate one for introducing precautionary measures below the ICNIRP (International Commission on Non-ionizing Radiation Protection) 100 microtesla limit (in recognition of the doubled risk of childhood leukaemia above 0.4 microtesla - Ahlborn et al. 2000). This has yet to happen, despite SAGE being operational for 2 years - next main meeting is May 16th 2006. Policy recommendations and implementation may be several years away and may not be of a sufficient level to actually afford the public any real protection. Short distance recommendations will protect very few members of the public. It must be remembered that the Draper Report recorded statistically significant increases in childhood leukaemia up to 600m, Prof. Henshaw recommends at least 400m clearance, and at 200m there is still a 70% increased risk of childhood leukaemia. In the interim, the precautional principle should be applied where new lines are proposed, otherwise we risk compounding a problem already recognised, but not yet acted upon. Not to act or act responsibly in the light of today's international research, could result in the very costly possibility of litigation, and the need to re-route powerlines. Major UK Insurance companies already regard living close to high voltage powerlines as a future risk for the insurance industry.
Draper Report: Lewis Macdonald’s dismissal of this massive, publicly funded (including Scottish Ministers) report is extremely selective and provides no alternative explanation for the epidemiology of ill health associated with high voltage overhead powerlines.

I take issue with the following comments:

"no accepted biological mechanism to explain the epidemiology" - accepted by whom? There have been enormous advances in understanding several possible mechanisms (possibly acting together) by which magnetic fields and separately electric fields/corona ions may cause increased risk of childhood leukaemia. For magnetic fields this includes at least nine studies into the disruption by magnetic fields of the nocturnal production of melatonin - a powerful antioxidant - which could account for the increases in various cancers (including childhood leukaemia), depression and miscarriage.

"indeed the relation may be due to chance or confounding" - this is a standard cover for all statistical reports, but given the scale of this study (29,000 children with cancer studied over 33 years), and the consistent results which even exhibit a grading in levels of childhood leukaemia relative to distance from powerlines, the report is very robust and the probability of the results occurring by chance or confounding very low. Indeed, the Draper Report actually concludes:

"There is an association between childhood leukaemia and proximity of home address at birth to high voltage power lines, and the apparent risk extends to a greater distance than would have been expected from previous studies".... "The most obvious explanation of the association with distance from a line is that it is indeed a consequence of exposure to magnetic fields"

Moreover, previous pooled international studies showed a similar doubling of childhood leukaemia for those living in close proximity to power lines (with exposure levels > 0.4 microtesla) - see summary in the Draper report, and Prof. Henshaw’s letter to the Petitions Committee which predates Draper. The NRPB acknowledged the leukaemia link in 2004 (read also the attached response to the Beauty to Denny Environmental Statement).

Although Macdonald tries to play down the number of children affected by stating that “only 4% of children in England and Wales live within 600m of high voltage lines at birth”, for those unfortunate children the risks of leukaemia are high, nearly double for those within 200m. So when the Department of Health talks of any future guidelines being “proportionate” - it is essential to remember that these risks are not evenly spread over the whole population, but are very high for those living in pylon corridors. This is moreover a risk which can be completely eliminated in the case of new lines, which can either be routed at least 400m away from housing, or failing that, undergrounded. Despite this, public health has not even been a consideration in the current Beauty to Denny proposals, with the line threatening c.1000 homes in the Stirling area alone.

Macdonald states that no definitive causal link is made by the authors - yet they clearly state there is an association - this should not be a debate about semantics, but one which puts public health protection to the fore. 100% scientific proof is rarely achieved. For example, it took 40 years before the link between smoking and lung cancer was universally accepted as causal, despite the initial very powerful epidemiological evidence. There is controversy among scientists on the causal
mechanisms involved with powerline EMFs and leukaemia, but this is no reason to ignore the evidence and fail to introduce precautions. Interestingly, no one is disputing the epidemiology - the evidence, which extends far beyond a doubled incidence of childhood leukaemia, with significant increases (fourfold in some cases) in certain adult cancers, motor neurone disease, depression, suicide and miscarriage. To dismiss the epidemiology on absence of "proof" or "no proven biological mechanism" (Scottish & Southern Energy (SSE) and Institute of Civil Engineers (ICE)) reveals an alarming disregard for public health, and makes a mockery of SSE's public consultations. Many of the 18,000 objection letters received by the Executive raise the health threat as their main concern, and Stirling Council regard it as a major material planning consideration. "Proof" of association may be decades away, but let us not make the same mistakes that are only now being rectified in the area of smoking - and compound the problem by building yet more extra high voltage power lines through populated areas.

Prof Denis Henshaw's letter to the Petitions Committee
Macdonald has little to say on the content of Prof. Henshaw's letter, which summarises the overwhelming scientific evidence for wide-ranging, adverse health effects associated with powerline EMFs. Macdonald does refer to AGNIR's (Advisory Group on Non-ionizing Radiation) dismissal of the corona ion theory, a theory also referred to in the Draper Report as a possible explanation for EMF effects being monitored at large distances. The AGNIR report published in 2004, presents the corona ion model (powerlines create corona ions, which attach to air pollutants which when inhaled are more likely to be trapped in the lung because of their added electrical charge). However, a subsequent addendum to AGNIR's report dismisses the health effects and makes no reference to Henshaw's Medical Hypotheses paper (2002) where the risk of lung cancer near powerlines was discussed in detail.

Finally, Henshaw is accused of being "pre-emptive" in advising that no new lines should be sited near housing or the converse. This is extraordinary, given that the Petitions Committee sought Prof. Henshaw's advice on this very issue, in the full knowledge that it related to the proposed construction of a new 400KV powerline.

If no one is brave enough to draw conclusions and give practical recommendations when asked, then lines will continue to be built in the face of compelling scientific evidence from around the world that their EMFs are responsible for a range of serious conditions, and children and adults alike will continue to pay the price with their health and lives.

Undergrounding
The question of undergrounding as a possible solution to the health issue was raised at the first consideration of PE812. Some of the responses on the advantages of undergrounding for public health are confusing (ICE & Dept. of Health - Kerr). The electrical field is entirely eliminated and the magnetic field reduces sharply to either side of the trench. This makes the health risks almost negligible, as no property could overlie such a trench and access would be restricted, yet the proposed overhead powerlines pass almost over some properties and overlie garden space with a considerable range of influence.
The capital costs of undergrounding are higher than those for overhead lines, though the estimates and data provided by ICE are exaggerated. In 2005 Highland Council, Scottish Natural Heritage (SNH) and Cairngorm National Park (CNP) commissioned Jacob Babbie to produce a report into undergrounding. Jacob Babbie took much of their information on trust from the power companies, and were unable to get information from the cabling companies who were involved in the tendering process with the developers for Beauly to Denny. As a result this report is seriously flawed. Moreover, nobody has factored in the costs in terms of loss of amenity and tourism should an overhead Beauly to Denny line pass over the Ochils, through Sheriffmuir and down passed the Wallace Monument. Neither has the impairment and loss of human life been costed into the equation. No mention is made by any of the respondents to the successful undergrounding of 400kV lines within the UK, including a 6km stretch in Yorkshire (completely healed in) and at Torness power station. Technology has moved on considerably since these projects, with excavation being reduced to a small trench and costs significantly reduced.

Were undergrounding to be recommended, it would not be the Utility companies (as suggested by ICE) that would have to pay the additional costs. These would be passed on to the consumer through the auspices of Ofgem. However, undergrounding would preclude the addition of telecom systems to the proposed overhead line, and SSE Telecom has applied for way leaves to add such masts. It may be that SSE have a vested interest in ensuring that Beauly to Denny is an overhead line for much, if not all of its route, and particularly in populated areas such as Stirling. Once a line is up, there are planning (& financial) advantages in using existing structures, but no one appears to have considered what the combined health effects of 400kV EMFs and telecommunication masts would have on the many hundreds of people living in close proximity.

From the ICE response (and issues raised in respect of Scottish Power at the first consideration of PE812) there is an assumption that 400kV lines should not pass through populated areas. Yet Stirling Before Pylon’s recent survey of SSE’s Beauly to Denny proposals reveals that nearly 1000 homes could be within 600m (zone with increased risk of childhood leukaemia) of the line in the Stirling area alone. Indeed in several areas the line has actually been brought closer to homes from an intiial position in which the power companies attempted to keep a nominal 100m clearance. ICE places emphasis on landscape issues as opposed to health (which it flippantly dismisses) and recommends that SNH’s advice be adopted in the siting of overhead powerlines. In the case of the Beauly to Denny application it should be noted that SNH recommend that in the Stirling area the route over Sheriffmuir is unacceptable and routes (both overhead and underground) to the west of Stirling should be investigated ((Beauly to Denny final response, 7). Such a route would avoid the rocky escarpment of the Ochils and take the line through sparsely populated farmland, eliminating many of the technical difficulties associated with undergrounding, and saving lives by avoiding tight corridors with clustered dwellings and whole villages such as Fallin.
Conclusion
Most of the industrial respondents state their willingness to comply with
government regulations, which are currently acknowledged to be insufficient. The
now disbanded National Radiological Protection Board (NRPB) recognised the
need for further precautions in 2004, as reported in the responses from the Dept.
of Health. I submitted PE812 in Dec 2004 in the knowledge that no further
precautions had been introduced, and my family, along with thousands are others
had our health and lives threatened by the Beauly to Denny proposals. I too am
looking to government to provide basic protection of our health. Such protection
should indeed be proportionate, and the health risks posed by living in close
proximity to powerlines are higher than the risks posed by passive smoking, which
although unavoidable in certain circumstances, do not represent the same
imposed threat as that posed by a powerline being built alongside hundreds of
homes, where young children live and sleep c.24hrs a day.

The responses received by the Petitions Committee do nothing to allay the fears
initially expressed in PE812. Indeed the only expert consulted in the field of EMF
health effects emphasises the need for such high-voltage lines to avoid coming
into close proximity with housing. Industry quote the ICNIRP guidelines, (which the
Dept. of Health acknowledges to be insufficient), and bring financial implications to
the fore. Attempts to discredit precautionary advice are weak and ill informed, and
totally disregard the large body of international scientific research (25 years) that
has led other countries in the developed world to introduce meaningful
precautions. These include Sweden (over ten years ago), and more recently,
Australia, some US states and Italian regions, Holland and Switzerland. It is time
that Scotland followed suit, particularly if it wants its Renewable Energy
Programme to forge ahead with public support. A grid infrastructure that seriously
(and unnecessarily) threatens lives is unacceptable and far from sustainable.

Caroline Paterson
Stirling Before Pylons

March 24th 2006
Stirling Before Pylon's official response to chapter 32 of the Environmental Statement

5. HEALTH ISSUES

5.1 CRITIQUE OF CHAPTER 32 OF THE ENVIRONMENTAL STATEMENT,

Chapter 32 of the Environmental Statement contains out of date, inaccurate and misleading information. A large amount of important and relevant information has been omitted. The overall effect is to give a false assurance that the proposed development poses no threat to the health of children and adults. Many questions have not been addressed and no proper risk assessment has been carried out.

Some considerations, including health, fall into the political and public domain and cannot be left to the judgment of private companies whose expertise is in engineering, and who are answerable first and foremost to their shareholders. The power companies are not competent at consulting the public on health issues or reviewing medical science.

This is a matter of utmost public concern and importance and needs to be fully explored in a Public Inquiry.

The following comments comment on particular sections of the ES.

5.1.1 Introduction: Section 32.1

It is very clear that the UK public do not share the power companies' view that the guidelines, recommended more than 7 years ago by ICNIRP, the International Commission on Non ionising Radiation Protection, "give the appropriate level of protection for the public from electromagnetic fields (EMFs)". Nor do a number of other countries in the European Union and elsewhere, who have introduced far more stringent precautions. The UK stakeholder group SAGE (Stakeholder Advisory Group on EMFs) is currently considering further precautions.

There is a widely held belief that the consultation process conducted by the developers was a not genuine exercise and this has been echoed by our MSPs. At the many public meetings that have taken place since the proposal was first made public, health risks have always been raised as a major concern and numerous articles and letters in the press have emphasised how seriously communities take this issue.

At least 1,100 letters from the Stirling area alone were sent to the power company in the summer of 2004. The majority of these cited health impacts as the first concern. SSE claim on their website to have analysed only 500 or so of these. No explanation has been given for this and no proper analysis of the second public consultation has been made public.

Many people received only standard replies to their concerns. Specific questions on health impacts were simply ignored despite repeated written requests for answers. This is not an acceptable response to such a serious issue.

Despite the huge and obvious level of public concern about the serious health risks from their proposed development, no mention of this material planning consideration is made in the ES.

Also missing from the Statement is any acknowledgment of the long term consequences of altering the environment of those communities affected by the proposed pylons. There is no health without mental health. Factors which considerably alter our quality of life, and fall outside our ability to control, will invariably impact on our mental wellbeing; this in turn has major social and financial costs.

We can find no mention in the ES of plans by the developers to put telecoms equipment on top of the pylons, but this intention has been confirmed in writing to Dr Sylvie Jackson MSP following a question from her. This also has potentially serious health implications.

5.1.2 Field Magnitudes – Section 32.2

Fields produced by the proposed overhead transmission line
Paragraph 32.2.1 – 32.2.3

The National Grid Transco’s computer calculations of EMF levels at varying distances from the proposed power line are not accepted as “acceptably accurate.”

Magnetic field levels quoted in the ES are disputed by government officials form other European countries. This is very important as it affects the avoidance distance from dwellings, schools etc, adopted by these countries when new lines are being planned. Such precautions are almost certain to be adopted by the UK eventually. The magnetic field levels quoted in the ES are a considerable underestimate compared to those quoted by officials from Holland, Sweden, and Switzerland (the only countries we have data from so far). This would result in an underestimate of a prudent avoidance distance.

Paragraphs 32.2.2.7 & 32.2.2.8

Inadequate balancing of circuits can increase magnetic field levels greatly. This is not explained in the ES and has important implications for a prudent avoidance distance.

Paragraph 32.2.2.9

Not mentioned are the number of properties within 100, 200, 400, and 600 metres of the deviation corridor. This could easily have been done by the developers. We have conducted a survey on the ground and found much greater numbers of houses at risk – see section 5.

Fields from other sources – section 32.2.4

The comparison between power line magnetic fields and those from household appliances was repeatedly made by the power company at public meetings in an attempt to reassure the public. This was done despite it being pointed out that the magnetic field from, for example, a radio alarm clock drops off very quickly to zero within a short distance. It is the long term exposure, particularly at night, to relatively low level magnetic fields which has been shown to disrupt the brain hormone melatonin. This in turn has implications for many illnesses including cancer. Unlike magnetic fields from appliances which are largely transient and within our control, power line EMF’s are continuous, imposed, and outwith our control. This should have been understood by the developers and communicated to the public. The misleading information was repeated many times, and still is not explained in the ES.

Misinformation was given on undergrounding. Dr Maclean of SSE repeatedly informed the public that underground cables did not reduce EMF exposures for people living nearby. This is not true. Undergrounding eliminates the electric field and the magnetic field drops off very rapidly to the side of a buried cable.

5.1.3 Compliance with Exposure Guidelines – section 32.3

The power companies state that their policy in planning the proposed project was to comply with Government policy on EMFs and in particular with the Government’s EMF exposure guidelines. What they fail to mention in this section is that the new guidelines (which had been adopted in other EU countries 6 years previously) were almost immediately under review. This is mentioned later in section 32.4.6.1 to 32.4.6.6. which makes it clear that further precautions are being actively considered by Government: “the government are committed to taking forward the issue of building near power lines (and vice versa) in consultation with all the relevant stakeholder groups.”

The public expect a socially responsible developer to be similarly committed, but SHETL and SPT have opted to emphasise their policy was to comply with “in limbo” guidelines which they should have been aware are considered unsafe in a number of other countries. This does not appear to the public to be the action of companies taking public safety seriously. It is telling that no mention of wishing protect public health is made in their stated policy in planning the project.

Numerical values of exposure guidelines – section 32.3.3

Little attempt is made in this section to explain who drew these guidelines up, how they were arrived at and
therefore what relevance they have to public health. They come from the International Commission of Non-Ionising Radiation Protection (ICNIRP). There are, however, international concerns over how this European organisation is funded and who it may actually represent (i.e. how truly independent it is from the power industry).

The guidelines for maximum public exposure to magnetic fields were arrived at by looking at one criteria, the thermal effects caused by induced currents of very high magnetic fields on the body. Other observed biological effects, and epidemiological studies showing associations with serious adverse health outcomes, were not considered at all. With many multifactorial diseases, timing of exposure to a risk factor is more important than dose of exposure. The ICNIRP guideline for maximum public exposure to magnetic fields is 100 microteslas (μT).

The following biological effects have been observed well below this level:

Around 40 μT: DNA strands break (recent studies)
Around 1.2 μT: Anti-proliferative action on melanin on breast cancer cells inhibited.
Around 1.2 μT: Anti-cancer action of the breast cancer drug Tamoxifen is inhibited.
Around 0.2-0.4 μT: Association with increased risk of childhood leukaemia
Around 0.2 μT: Reduced production of the brain hormone melatonin, especially at night.
Around 0.04 μT: Changes in calcium ion transport across cell walls.

Compliance of this Project with Exposure Guidelines — section 32.3.4

The calculated figures contradict literature produced by the developers in 2004 which quoted maximum magnetic field under a 400 kV power line as 100 microteslas.

5.1.4 Effects on People — section 32.4

The current scientific position — section 32.4.1

Paragraph 32.4.15

It has not just been “suggested” that power frequency EMF’s could be linked to various health problems. Scores of peer reviewed studies conducted over the last 26 years have shown an association between a number of very specific and some very serious adverse health impacts. The language used in this paragraph of the ES appears to be a deliberate attempt to misrepresent and diminish the true facts. Also “childhood cancers” is inaccurate, only an increased risk of childhood leukaemia is seen in association with living in proximity to power lines. No increase in other childhood cancers has been observed.

Paragraph 32.4.1.6

The developers assert in this paragraph and later in 32.4.3.6 that the UK study published in 1999 (United Kingdom Childhood Cancer Study, UKCCS) found no evidence that exposure to magnetic fields associated with proximity to power lines in the UK increases risks for childhood cancer. This is not true.

There was evidence that was thought to not be statistically significant at the time, but when the results were included in the pooled international analysis, an association was apparent. This study is referred to in the Draper report “…a previous UK study showed a relative risk of 1.42 for acute lymphocytic leukaemia within 400 m of 275 and 400 kV lines.” The power companies misleadingly refer to the UKCCS as the world’s largest ever study of its type whilst failing to note that in fact the Draper report is a much larger one.

Parents learning of these important inaccuracies are very concerned that they may be being deliberately misled in an attempt to allay their fears.

Reviews of the science by NRPB and IARC — section 32.4.2

Until shortly before the National Radiological Protection Board (NRPB) was subsumed by the Health Protection Agency (HPA) in 2004, the language used by the Board with regard to any possible health impacts from power lines was very dismissive and dogmatic. “Health scares” were often immediately countered by knee
jerk denials. One such criticism of the work of US scientists showing a link between miscarriage and magnetic fields had to be formally retracted.

It was believed by many that the NRPB was heavily influenced by Government and industry and not a genuinely independent organisation. The old NRPB was certainly generous with its ammunition in terms of quotes useful to industry wishing to put off the day they have to take precaution seriously. A few of those quotes are reproduced in this section of Chapter 32 of the ES. Most of them date from 2001 and the NRPB (now the HPA-RPD) is now moving slowly towards a precautionary approach. A comprehensive rebuttal of the conclusions drawn by the NRPB on the 2002 Californian Health Department study by Prof Denis Henshaw is attached at Appendix 1.

Some Governments, including the UK's, have been very reluctant to admit there could be a health problem from the electricity supply. They have feared it could result in expensive re-routing of power lines. Other countries have faced the problem and taken action. Switzerland, Sweden, Holland, Italian regions, Australia and some US States acknowledge the health risk and take proportionate precautions for new power installations.

This has not resulted in huge expense or public unrest, but rather increased public confidence and greater certainty of the legal position for the developers.

These countries report very positively on the actions they have taken. There is now every moral and pragmatic reason for the UK to follow suit. Precaution need not be expensive and is often extremely cost effective. An ounce of prevention is very often worth a pound of cure. Undergrounding often has a major visual cost benefit as well as health one.

Recent Studies of Childhood Cancer in the UK – section 32.4.3

The developers fail to point out the size of the study that is the subject of the Draper Report, which is by far the largest of its kind ever conducted. This major report, published in the British Medical Journal as its lead article on 2005, studied data from 29,000 children recorded as being diagnosed with cancer over a 33 year period.

The following conclusions were drawn by the authors of the study, but not mentioned or made clear in this ES:

- There is an association between childhood leukaemia and proximity to home address at birth to high voltage power lines.

- The most obvious explanation for the association with distance from a line is that it is indeed a consequence of exposure to magnetic fields.

- There is no obvious source of bias in the in the choice of cases or controls.

- Population mixing (which has been associated with childhood leukaemia) and socioeconomic status were ruled out as possible confounding factors.

- Previous pooled international studies showed a similar doubling of childhood leukaemia for children living in proximity to power lines in the 3 to 6 months prior to a cancer diagnosis.

Instead the power companies have chosen to selectively quote comments that would lessen the significance of the report to the reader. No mention either is made of the possibility, raised by the authors of the study, that the effect seen between 200 and 600 metres could be due to the "corona ion effect" caused by the electric field.

The authors did say the relation may be due to chance or confounding. This is true, in the same way that if someone smoked heavily for 20 years and then developed lung cancer, it may be due to chance and nothing to do with the cigarettes. It is now accepted by many scientists internationally that living close to high voltage power lines is a significant risk factor for childhood leukaemia on a par with the increased risk of lung cancer associated with passive smoking.

More focused studies, in Germany, looking at night time exposure to EMFs, showed a five fold increase in childhood leukaemia.

The Draper Study looked at data from children born near high voltage power lines. The pooled international studies looked at data from children living near high voltage power lines in the 3-6 months prior to a cancer diagnosis. No studies have looked at the subgroup of children that were conceived, born, and reared near power lines. This group could have a 20 fold increase risk of childhood leukaemia.
One of my colleagues has spoken to Dr Gerald Draper, and he told her that he would not live near high voltage power lines, nor would he have his family doing so. I have spoken to one of the other authors of the Draper report, Dr John Swanson, who is an employee of National Grid Transco. He was keen to down play the significance of the results, but did say “no one in their right mind would want to live near them.”

A large number of people have lost their minds doing just that - at least twelve epidemiological studies show increased risk of depression and suicide from magnetic fields. For example a study in Finland looked at depression in 12,000 same sex twins. This found that the risk of severe depression was nearly 5 times greater, for those living within 100 metres of a HV power line, than in those living more than 500 metres away. Professor Denis Henshaw of Bristol University estimates that as many as 9,000 cases of depression and 60 suicides may be attributable to exposure to power line EMFs annually in the UK.

The Californian Health Department EMF report of 2002 produced substantial evidence of increased risk of adult brain cancer, adult leukaemia, miscarriage and a type of motor neurone disease associated with magnetic field exposures.

All of the above wide range of adverse health outcomes could be explained by the disruption of the night time production of the brain hormone melatonin. Melatonin is a powerful antioxidant and natural anti-cancer agent. Reduced levels of melatonin are associated with depression and are also likely to have a bearing on miscarriage. There is now a body of studies showing that long term exposure to very low level magnetic fields are capable of significant disruption of nocturnal melatonin.

There is also evidence for a number of other causal mechanisms, through which living in close proximity to power lines may lead to ill health. For example it is known that the electric field of power lines produces so-called corona ions and that these particles attach to pollutants to create increased risk of respiratory and other diseases including cancer. These particles can be carried kilometres downwind of high voltage power lines and may cause thousands of cases of respiratory disease annually.

Paragraph 32.4.3.4

The fairly balanced response by the HPA-RPD to the Draper report acknowledges the association found between increased risk of childhood leukaemia and proximity to high voltage power lines. The power companies have only quoted part of this response.

Paragraph 32.4.3.5

Childhood leukaemia has a complex aetiology (the way in which the disease is caused) likely to involve a number of different environmental and inherited factors. Different charities receive funding to investigate particular risk factors. There is competition for this funding. Some become blinkered to factors other than the one they are working on. As a result of complaints made to the Charities Commission, Cancer Research UK had to withdraw statements on its website diminishing the significance of living near high voltage power lines as a risk factor for childhood leukaemia.

Other Suggestions of Health Effects of EMFs – section 32.4.2

There are not just “suggestions” of other health effects but a significant number of peer reviewed studies showing serious adverse health outcomes associated with living near high voltage power lines.

Paragraph 32.4.4.1

On 14 February 1996 the NRPP reacted to Prof’ Henshaw’s first paper on corona ions with a press release embargoed for the same day Henshaw announced his experimental results. This knee jerk reaction from the NRPP turned out to be a “school boy howler” physics error which had to be retracted. There may not yet be enough evidence for IARC to classify electric fields as carcinogenic, but nor should the NRPP have said “...it seems unlikely that corona ions would have more than small effect on the long term health risks” and “Any health risks from the deposition of environmental particulate air pollutants on the skin appear to be negligible.” The NRPP has not disclosed evidence to support these statements, and there is growing evidence to the contrary including the work of Dr Preece referred to in the next paragraph in the ES.

Paragraph 32.4.4.4

The preliminary results are not mentioned by the developers. The public is likely to be interested in even
preliminary results. What is meant by ... “There are various methodological issues raised by such work.”?

Reviews of the Science by other organisations — section 32.4.5

Paragraph 32.4.5.1

Which “eminent independent scientists” made criticisms of the 2002 Californian Health Department study? Professor Henshaw of Bristol University made a comprehensive refutation of the NRPB’s response to the Californian Study. This is attached at Appendix 1.

Views of the UK Government — section 32.4.6

This section refers to the Government position in 2004 before the Draper report was published and is therefore out of date. The last paragraph refers to a decision taken more than four years’ ago.

Professor Henshaw, who is a member of SAGE, in a recent letter to The Scottish Parliament’s Petitions Committee said “I urge the Scottish Parliament to consider immediate strict precaution against the siting of power lines near houses or the converse. I would remind the Parliament that we are well behind some other countries in this regard.” His letter is attached at Appendix 2.

In 1996 Sweden introduced an exposure limit 500 times lower than the UK’s current guidelines, as did three Italian regions in 2000. Switzerland introduced a limit 250 times lower than ours in 1999.

Other Effects of fields — section 32.4

The power companies concede that electronic equipment such as computers are adversely affected by low level magnetic fields. Similar magnetic field levels are a risk factor for a wide range of illnesses and are well below the ICNIRP guidelines.

5.1.5 Effects on Livestock and Crops — section 32.5.3

The developers say “little evidence” has been found of any agriculturally significant consequences as a result of power line EMF exposure. The public should be made aware of this evidence. The effect on the honey production of bees is another demonstration of biological systems being affected by power line EMF’s.

5.1.6 Summary — section 32.6

Paragraph 32.6.1.2

This paragraph refers to NRPB advice from 2004. The NRPB was subsumed by the Health Protection Agency in April 2005 becoming the HPA-RPD. What advice has been taken by the developers from the HPA-RPD and when was this advice sought?

Old quotations gleaned from the NRPB such as “no convincing evidence” and “no biological mechanism has been established” are political spin and not based on the science which speaks for itself.

Paragraph 32.6.1.3

This paragraph again quotes out of date advice from the old NRPB.

The proposed power line passes unnecessarily close to a large number of dwellings. Safer alternatives exist that have not been adequately investigated. The developers do not say what recent advice they have taken from the HPA-RPD. In September 2004, after the second public consultation period, I spoke with Martin Wild, spokesman at the NRPB. He double checked his records and confirmed the NRPB had had no communication from SHEET or SFT and he had no knowledge of the proposed Beatty to Denny power line. He said that the NRPB did not have the resources to advise industry and that other expert bodies such as Bristol University should also be consulted.

The last sentence in this paragraph refers to decisions made by the Secretary of State for Trade and Industry, but no details of when or how these decisions were made is given. Did they predate the publication of the Draper report?
Precaution is not mentioned and appears never to have been seriously considered despite the huge amount of public concern and recognition by the World Health Organisation, the International Agency for Research on Cancer and the HPA-RPD, that magnetic fields are a "Type 2b Possible Carcinogen."

We have further comments to make on the Precautionary Principle, potential litigation and the position of the insurance industry; these will follow shortly.

1. References


California Health Department (2002) An evaluation of the possible risks from electric and magnetic fields (EMFs) from power lines, internal wiring, electrical occupations and appliances. California EMF program, Oakland, CA 94612, USA.

Prof Denis L Henshaw (2003): Comments on the NRPP Consultation Document "Proposals for Limiting Exposure to Electromagnetic Fields (0-300 GHz)", 1 May 2003

Prof D L Henshaw (11 April 2005): Evidence submitted by letter to the Scottish Parliament's Petitions Committee

5.2 Homes and Health

Since the publication of their proposals for the power line, SSE have made great play of their assertion that there are only 10 houses within 100 metres of the entire line proposed from Beauty to Denny. Dr MacLean of SSE stressed this point in his presentation to Stirling Council's Environment Committee on the 17th October 2005, in response to concerns raised about the potential health impacts.

In fact this is not an entirely satisfactory way to measure the impact. SSE are applying for permission to build the line anywhere within a corridor which is between 100-400 metres wide. The exact location of the line will be decided by the contractor on site, and the line could be at either edge of the deviation corridor. It is therefore more appropriate to count the number of homes which could be affected by the line, which is those within specified distances of the edge of the corridor, rather than of the notional line itself.

Stirling Before Pylons have surveyed the line through the Stirling area and have found no fewer than 50 houses that lie within 100 metres of the corridor in this area alone. The line also runs through Highland, Perth and Kinross and Falkirk Council areas. It seems that SSE have been rather selective with their information on the number of houses affected.

There are valid reasons to consider the health impacts on people living within 100, 200, 400 and 600 metres from the line, as referred to in section 5.1 above.

SSE acknowledge that this part of the line is the most populated. Stirling Before Pylons (SBP) were very sceptical of SSE's figures as a consequence of our local knowledge, and we therefore decided to carry out our own on-the-ground survey, which show significantly different results. These can be summarised as follows:
<table>
<thead>
<tr>
<th>Metres</th>
<th>SSE</th>
<th>SBP</th>
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<tr>
<td>0 – 100</td>
<td>3</td>
<td>50</td>
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<td>100 – 200</td>
<td>23</td>
<td>119</td>
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<td>200 – 600</td>
<td>333</td>
<td>709</td>
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<td>0 – 600</td>
<td>359</td>
<td>878</td>
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The major differences are to some extent explained by SBP using the corridor and SSE the line. However, we know that Ordnance Survey map data is often deficient and severely out of date in the more rural areas, and assume that SSE relied solely on these rather than conducting on-the-ground surveys. Also, we note that they only estimated the number of homes affected in Fallin.

The differences clearly indicate the importance of knowing the exact location of the line before the full health implications can be established, and then carrying out accurate on-the-ground surveys.

Other results from the SBP survey can be summarised as follows:

- There are 50 houses within 100 metres of the corridor, two directly beneath the proposed line, both occupied by recently widowed ladies.

- There are 878 homes within 600 metres of the corridor, with approximately 2,000 people living in them.

- In the ex-mining village of Fallin there are 578 houses affected, with a primary school on the 600 metre line. By not bothering to accurately count the homes affected in Fallin, SSE have shown scant regard to this socially excluded community and the Scottish Executive’s Social Inclusion Agenda.

- There are 20 houses within 100 metres in Logie Community Council area alone, which SSE acknowledges to be a ‘pinch point’ along the whole route. At the foot of the Ochils, this is an area where landscape, history and woodland are all dramatically affected. This area also includes a caravan park with 60 spaces and 6 permanent homes.

- Nearby, there is also the Alexander Hall of Residence at the University of Stirling, within 200m of the corridor. The 48 flats house 332 students. The University’s Medical Centre is 600m from the corridor.

- The William Simpson Home for the elderly in Plean houses 46 residents and is within 300 metres.

- A Forth Housing Association scheme in Plean has 28 homes.

- The village of Kinbuck with 50 houses and Cromlix House Hotel ‘amongst the best in the UK’ (according to the well known publication Scotland the Best) are within 600m of the corridor.

- Landlords such as the Council, Housing Associations, the University and Private Landlords could be subject to significant claims in the future if they have knowingly let homes to people who later develop major health problems as a result of proximity to the power line.

It is clear from this analysis that SSE have been very selective with the information that they have released about the impacts of their proposals. This applies to all aspects of their application, where they have minimised the potential impacts and not carried out an impartial, objective analysis. This is at its most obvious in relation to the minimising of impacts on the socially deprived ex-mining village of Fallin.
Michael McMahon  
Convener to the Public Petitions Committee  
The Scottish Parliament  
EDINBURGH  
EH99 1SP

Dear Michael

PE 812: ELECTROMAGNETIC FREQUENCY FROM HIGH VOLTAGE TRANSMISSION LINES

Thank you for your letter of 24th February requesting an update on developments in relation to the recommendations of the Stakeholder Advisory Group on EMF/ELF (SAGE)

As you are aware, SAGE first met in March 2004. Its agreed aim is "To bring together the range of stakeholders to identify and explore the implications for a precautionary approach to ELF EMF (electric and magnetic fields) and make practical recommendations for precautionary measures". Approximately 40 stakeholders are represented on the group, including the Scottish Executive Health Department.

Two SAGE working groups have been established. These are:

i) The ‘Electrical Equipment and Installations Working Group’ which is looking at all Magnetic and Electric Fields which originate from wiring and equipment within the home, which will go on to see if any lessons can also be applied to schools, hospitals, care homes etc. Its intended outputs will include advice to householders, guidance to electricians, recommendations for British Standards and Wiring Regulations, ways to influence appliance manufacturers, and identification of opportunities for innovation and research.

ii) The ‘Power Lines and Property Working Group’ which is considering issues related to new and existing homes near to new and existing power lines. This group’s main output will be to propose draft planning guidance covering all such situations.
Each of these Working Groups has met ten times since early in 2005 and their meeting schedules extend currently to April 2006. It is anticipated that the working groups will make recommendations for consideration by the main SAGE group in late summer or autumn of 2006. The main SAGE Group will then make policy recommendations to Government.

It remains the proposal that two new working groups will be established early in 2006, dealing respectively with (i) issues related to elements of the power distribution system operating below 11 kilovolts and (b) railways and other issues. These new groups will adopt similar reporting provisions.

I hope that the Committee finds this information helpful.

LEWIS MACDONALD
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 Smith

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 Helen Smith calling for the Scottish Parliament to urge the Scottish Executive to commit further resources to the provision of NHS dentistry, in particular for the recruitment of NHS salaried dentists to provide emergency and comprehensive care and for the provision of dedicated NHS dentistry facilities.

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.

Helen Eadie MSP

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 22 December 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
Public Petitions Committee – a template for e-petitions

Should you wish to submit an e-petition allowing signatures to be gathered online on the Public Petitions Committee e-petitioner web pages please complete the template below. Before submitting your e-petition please consult the Guidance on submission of public petitions for advice on what is and is not admissible. 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.

Peter Thomson BDS MIQA, Largie Tarff, Twynholm, Kirkcudbright, DG6 4NF

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 requests that the Scottish Parliament looks at implementing a different model to the current plan to ensure that NHS dentistry is available in remote and rural areas in the medium to long term.

Period for gathering signatures:
Please enter the closing date for gathering signatures on your petition, which we would usually recommend is a period of between 4-6 weeks

Closing date: 30 December 2005
Additional information:

Please enter any other information relating to the issues raised in your e-petition, including the reasons why the action requested is necessary. The text entered in this field should not exceed 2 pages. However, you may wish to provide further sources/links to background information.

1. The road to ineffectiveness:

The root of the collapse of NHS dentistry is hard to pin down to an exact policy. The decline in dentists’ confidence in government intentions for NHS dentistry go back as far as the ‘Winter of Discontent’ and were not enhanced when opticians were ‘privatised’ in the early 80’s; for the rest of the 80’s most dentists were waiting for a similar axe to fall on NHS dentistry. The ‘consultations’ in 1986 created an awareness amongst the rank and file that the contract discussions between the BDA and government were clearly about government trying to squeeze more from less; many dentists saw this as pressure to privatise NHS dentistry by the back door. The more thoughtful dentists saw that trying to retain a ‘universal service’ on a capped budget was a non-starter.

The financial assessment of the 1990 contract indicated that treating children to the proper standard would cost the average practice in North and West Dorset (at that time) around £250 per surgery per week. The vote on the proposed 1990 contract, run by the Electoral Commission, saw dentists registering a 3:1 vote against acceptance. The BDA caved in to Government pressure and accepted the contract against the wishes of the profession.

In 1991 I, colleagues from Dorset and our Conservative MP’s met with the Minister with responsibility for dentistry, Baroness Hooper. In the face of our detailed argument the Minister was left flapping like a recently landed puffin. The inability of her or her staff to answer our questions left our MPs – Nicholas Baker, Sir James Spicer and Malcolm Bruce – embarrassed. The gist of our argument was: you can not get a Rolls Royce for Lada prices; there is nothing wrong with a Lada but you have to understand it’s a Lada and accept its limitations.

Our core ‘Lada’ principle was that NHS dental funding should be targeted on children, those with low income and not used to subsidise middle class voters for expensive bridgework, crowns and the like. This was clearly sensible in terms of long term health benefit but unacceptable in terms of the short term Conservative target vote. The political imperative then left my colleagues and me with only one option, to take action and ‘privatise’ our practices. We did this in-line with our core ‘Lada’ principle which is still the model that many practices privatising still follow – subsidising NHS work from private income to retain standards of care. As you may imagine this method of cross funding essential NHS care causes many private dentists much ire when we are told we are ‘greedy dentists’ by ignorant politicians.

The chance was there this time round to create effective change in the main burden still affecting NHS dentists – excessive case load. The PDS trial in England saw NHS dental case load being reduced by 30% giving dentists in the trial time to set out effective treatment planning and target funding where required rather than being lead by the scale of fees. Now that the PDS roll out is happening across England it is estimated that the maximum case level reduction will be 5%.

Once again NHS dentists have been lied to and Mr Kerr’s suggestion that the SEHD will now introduce the PDS contract in Scotland (as a sop to Integrated Dental Holdings (IDH) – an English dental company) will give the remaining NHS dentists little comfort. The importation of dentists into Scotland clearly has more to do with the weakness of the Labour vote in key marginal seats than the actual needs for NHS dental provision in remote and rural areas. My opinion, given the EU employment rules, is that as soon as the Polish dentists are able, they will leave salaried employment for more lucrative private practice – I know I would – and the NHS dental access problem will return.

The problem NHS dentistry faces is that politicians think dentists leaving the NHS are only concerned about money. Dentists will, in part, admit to some extent this is true as many see NHS dentistry as a second rate service for a third rate fee. A more important reason is the excessive case load that NHS dentists face on a daily basis and the physical, psychological and emotional strain this puts on dentists, their spouses and families which is reflected in the profession’s high levels of suicide, ill health retirement and divorce rates. The best way for dentists to prevent or reduce these risks is to privatise their practice. I consider that IDH taking on NHS provision in remote and rural areas may lead to a further round of NHS practices in these areas privatising, as these practices may feel they no longer need to defend NHS access and will seek to reduce their case loads.

The argument that, ‘What we need to do is train more dentists!’ is both specious and fanciful. The extra 20 dental undergraduates at Dundee will cost £4.5 million over the next five years. A recent survey of UK undergraduates has revealed that only 3% of undergraduates are considering a full time NHS career. The idea of opening Edinburgh Dental Institute as an undergraduate teaching centre, to solve the lack of NHS dentists, has serious cost implications on the University and FE funding budget (£2.7 million minimum net amount to be found, not including inflation and start up costs) and
that is if you can get the academic staff of sufficient quality to get the course ratified by the GDC as of adequate standard. If the plan to develop a dental school at Aberdeen is included then Government will have to find an additional £5.4 million from the University and FE budget annually. The effective spend for Government for this annual investment as far as NHS dentistry is concerned - £166,000 or 6 extra NHS dentists per annum. You do not need to be a wizard with figures to see that this approach is not very cost effective for a Government trying to increase the numbers of NHS dentists.

The final time bomb that is ticking is many of the remaining NHS dentists in remote and rural Scotland will retire within the next ten years. Many will be unable to sell their practices as going concerns given the low level of investment in equipment and materials which is common to rural NHS practices. Graduates will continue to focus on the areas of Scotland where the main population centres are, the need to look good is important and the money is available to pay for cosmetic treatment.

To solve the problems of access to public dental health, especially in remote and rural areas, there is a desperate need to think laterally rather than simply doing the same thing differently.

2. Thinking laterally

There is a way to solve the problem but it requires both government and the dental profession to think in a different way when delivering public dental health. The idea is not new and is in action in Canada's remote and rural communities. It accepts the fact that dentists, for historical and commercial reasons, will tend to congregate in major population centres and only a small percentage will be interested in a life in the 'wilde'.

Remote and rural areas' public dental service is provided mainly by therapists, hygienists, prosthetic technicians and dental health educators in Canada. Patients still see a dentist for their exam and treatment plan but all the routine work is carried out by therapists. They only see the dentist for complex treatments. The advantage for the remote and rural community is that the therapists are local people, locally trained and want to stay in the area. This proposal creates jobs for those bright young people that are remote and rural areas biggest export.

3. Summary

I believe that this proposal is reasonably well argued and as a model has already been tried not only in Canada but in the Khumbu in Nepal with great benefit to the remote communities it serves.

To put the model in place will require the challenging of many vested interests within the SEHD, British Dental Association, NES and Dental Practice Board.

It will also require defeating the argument that what it creates is a two-tier system of dental provision. This is a silly argument, made by academics and politicians with little knowledge that within dentistry there has been a two-tier system as long as private has existed alongside NHS dentistry and that is as long as NHS dentistry had existed. The NHS is not willing to make the funding available to compete with private dentistry, never has and never should. Its responsibility is to provide a core service to ensure dental health for all and especially the most vulnerable.

The NHS dental contract in 1990 failed to protect the most vulnerable and as a result saw children being sent for multiple extractions, under general anaesthetic in numbers not seen since the 1960's. The rise in GA's also meant that for the first time in a decade children were dying in dental surgeries. Government policies on funding lead to sharp practice by the likes of the infamous 'Pogo GA Clinics' which climaxed in the avoidable death of a child in their practice at Peffermill through negligence.

That is why it is essential for politicians to dwell a marching pace before deciding that importing dentists from a country with a different language, culture and qualifying requirements is actually as clever as it appears. Only time will tell and one thing is for sure, it will not stand still.

Ken MacDonald runs the only NHS dental practice on Lewis in Stornoway, he can not get dentists to join his practice, is threatening to withdraw from his NHS dental contract as he can no longer cope, no one will purchase his practice and is due to retire in five years - then there will be no dentist available on Lewis or Harris. There is a clear need to act fast, effectively and differently before it is too late.
Action taken to resolve issues of concern before submitting an e-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 MSPs. Details of those approached should be entered.

I am in contact with my MSP Alex Fergusson and other South of Scotland MSPs on this issue but they have advised me that the SEHD is not interested and claims that importing dentists and bringing in IDH will solve all the problems even though the Scottish BDA has informed them that the policy will do nothing to attract dentists back into the NHS.

I have E-mailed Mr Kerr for a response to a detailed argument and received a standard, word processed response which avoids all the issues raised. I am awaiting a reply to my second request for information.

Comments to stimulate on-line discussion:

Please provide at least one comment to set the scene for an on-line discussion on the petition, not exceeding 10 lines of text.

There are insufficient dentists employed or subcontracted to meet the needs of NHS Dentistry in Scotland and that NHS Dentistry can only be effectively delivered to remote and rural areas using a model that uses highly trained local people to deliver core dentistry as happens in Canada’s northern territories.

The SEHD’s current policy is trying to hide its long term failure to deal with the lack of access to NHS dentistry behind a smoke screen of greedy dentists and relies on the ignorance of the population on how NHS dentistry is actually funded so it can appear it is in the right.

The SEHD’s current policy does not engage the key problems that NHS dentists in remote and rural areas face with excessive case lists, inability to attract new dentists and impact this excessive stress has on them and their families.

That the fee paid to an NHS dentist to provide a full set of dentures is a third, in real terms, of the fee paid in 1952.

Why is there not a greater public out cry given that in Dumfries and Galloway only 35% of patients have regular access to any form of dentistry and the Health Board currently has a waiting list of 9,000 adults looking for a dentist. If this reflected a failure of GP services all hell would break loose.
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 11/11/05

Peter Thomson BDS MIQA

For advice on the content and wording of your e-petition please contact:
The Clerk to the Public Petitions Committee
The Scottish Parliament
Edinburgh
EH99 1SP
Tel: 0131 346 5186 Fax: 0131 346 5088
e-mail: petitions@scottish.parliament.uk

Note
Completed e-petition forms should also be sent to petitions@scottish.parliament.uk
Written Evidence from British Dental Association Scotland

Public Petitions Committee Inquiry: consideration of Petition PE920 and Petition PE922

1. The British Dental Association (BDA) is the trade union and professional association for dentists practicing in the UK, representing 22,000 members working in all aspects of dentistry, including general practice, salaried services, the armed forces, hospitals, academia and research. BDA Scotland represents all those members who practice or work in Scotland.

2. The BDA welcomes the chance to input into this inquiry and aims to cover three main areas of contention:
   1. Improving access for patients, in the context of workload pressures.
   2. Increased funding for NHS dentistry.
   3. Improved incentives for dentists to be recruited to and be retained in the NHS, with specific reference to salaried dentists and rural and remote areas.

Overview:
3. The BDA is concerned that until the Scottish Executive engages in constructive dialogue with the profession, and addresses many of the concerns currently faced, in particular, by general dental practitioners, NHS dentistry will continue to suffer, not only in rural and remote areas, but in suburban and city areas as well.

Improving access for patients in the context of workload pressures:
4. The difficulty in accessing NHS dentistry is an increasing problem in many areas of the country, as illustrated by both petitioners Ms Helen Smith (PE920) and Mr Peter Thomson (PE922). This is due to a combination of poor workforce planning – more dentists and other dental team members need to be trained – and dentists having to reduce their NHS commitment to keep their practices financially viable.

Shift towards private work:
5. The value of the private market has grown rapidly over the last ten years, though in terms of numbers of consultations, NHS dental care still far outstrips private care. The majority of family dentists now work in a mixed economy, offering both NHS and private treatment. This move towards private care is prompted by lack of investment in NHS dentistry and frustrations with the current NHS system, including the lack of time dentists can spend with patients offering preventative advice and the type of materials they are allowed to use. This was ably illustrated by Mr Thomson (PE922). The most frequently reported reason for the shift towards private work is for dentists to spend more time with their patients.

6. Mr Thomson mentioned excessive workload for NHS dentists and the BDA would agree – we have estimated that an NHS-committed dentist has to see, on average, 40 patients a day to meet demand. This neither gives dentists the time they would like to spend with each patient, with an emphasis on prevention and oral health advice, nor particular job satisfaction having to keep up with the treadmill of seeing a high pressured demand of 40 patients a day.

7. Research from the Scottish Parliament Information Centre for the Health Committee published on 1 February 2005, found that dentists’ intentions towards NHS work was not favourable. “Only 3.5 per cent of primary care dentists stated they intended to increase the amount of time spent treating NHS Scotland patients over the next two years.
Sixty-two per cent of retired dentists could see no incentive to induce them to return to providing NHS Scotland dental services and thus plans to increase provision of services by encouraging retired dentists to return to practice are unlikely to be successful.\footnote{Access to Dental Health Services in Scotland by Professor Tim Newson, Professor Alison Williams and Dr Elizabeth Bowen, Department of Oral Health Services Research and Dental Public Health, GKT Dental Institute, London. Section 5.12.1 and Section 5.12.3}

**Funding:**

8. The BDA believes that if NHS dental services are to be truly modernised, then financial provision needs to be made to facilitate a preventive approach to dental care. The squeeze in fee levels by successive governments over the last ten years has led to under-investment in dental practices.

9. The Scottish Executive's *Action Plan for Improving Oral Health and NHS Dental Services in Scotland* in March 2005 announced an additional £150m will be provided over three years. According to the Scottish Dental Practice Board (SDPB), the current spend for 2004-2005 was £173m per year. The BDA would argue that an increase to £520m per year is required in the non-salaried GDS (high street dentists) spend to tackle the diverse problems faced by Scottish dentistry. The BDA believes that to cover costs and to ensure take home pay, a dentist would require at least £100-£120 per hour to run a fully staffed and equipped surgery. An increase in funding is needed to ensure investment in training, infrastructure and information that will make the service better for patients. It would allow general dental practitioners (GDPs) to spend more time with patients discussing their oral health, their general health and agreeing individual management regimes.

**Funding for commitment to the NHS:**

10. In the questioning of Ms Smith (PE920), Sandra White MSP made the salient point of practice allowances and the minimum number of registered patients required in order to qualify for this payment – 500 patients per dentist per practice. The qualification criteria is something which the BDA had been meeting with the Scottish Executive to discuss as part of the implementation of the *Action Plan*. The Scottish Executive's measurement of NHS commitment means that dentists must also treat a minimum number of adult fee-paying patients to qualify – 100 patients per dentist per practice. Furthermore, a reduction in the number of NHS patients being treated by a practice since 1 October 2005 can also lead to a practice being deemed to be uncommitted.

11. The BDA supports some form of gradual banding or a sliding scale to be employed to determine commitment to the NHS similar to the measure of commitment used for the current General Dental Practice Allowance. For example, if a dentist is seeing children and exempt adults only on the NHS and using private fee-paying adults to subsidise this service, they should still be eligible for a proportion of the new NHS allowances.

12. The conditions for commitment appear to be flawed as they are not equitable and Ms White was correct in saying that this arbitrary figure of 500 could be a particular issue in rural and remote areas, especially for single handed practitioners. The following examples demonstrate this:

- Dentist A has 501 patients with 100 NHS paying adults. Dentist B has 1000 NHS patients but only exempt adults. In addition, they are both likely to have some private patients. Dentist A satisfies the conditions and receives the grant but Dentist B does not despite the fact they are treating twice as many NHS patients as Dentist A.

- Dentist C has 1700 NHS patients with 20 paying patients. The dentist works in an area where there are very few fee-paying adults. It is not possible therefore to satisfy the criteria to see 100 fee paying adults. The practice has no other source of income. The patient profile means they cannot raise any private income. They do not satisfy the conditions and get no grant.

13. Almost three hundred practices which provide NHS dental care have not qualified for the new allowances. This equates to one third of the total number of listed NHS practices in Scotland. The combined number of children and exempt adults these practices are seeing will be substantial. These practices have to operate as businesses as well as providing a service.

\footnote{Access to Dental Health Services in Scotland by Professor Tim Newson, Professor Alison Williams and Dr Elizabeth Bowen, Department of Oral Health Services Research and Dental Public Health, GKT Dental Institute, London. Section 5.12.1 and Section 5.12.3}
14. The Scottish Executive’s continued intransigence on having an all or nothing settlement, coupled with the Deputy Health Minister’s recent comments that the principle of treating all categories of patients is not negotiable, is exhausting the goodwill of dentists in Scotland.

**Improved incentives for dentists to be recruited to and be retained in the NHS, with specific reference to salaried dentists and rural and remote areas:**

**Current workforce shortages:**


16. In 2000, a recommendation was made by the Scottish Advisory Committee on the Dental Workforce (SACDW) to standardize the output of the two dental schools in Scotland by setting an output target of 120 dental graduates (70 from Glasgow and 50 from Dundee), over the five year period 2000-2005. The Scottish Executive Health Department has set a revised output target of 134, which is reflected by an intake target in 2004/2005 of 151. However, given the difficulties of accessing NHS dental services in Scotland it is unfortunate that SACDW has not met for two years. Also, the BDA believes that without significant investment in the two dental schools in Scotland, this increase in intake will be difficult to support.

17. Ms Smith (PE920) raised the issue of the large number of dental students leaving Scotland on graduation. A recent parliamentary answer would support this argument. It showed that, of those dental students who graduated in 2004, only 71 per cent were continuing to work in Scotland. 23 per cent were employed in the rest of the UK. The BDA has long argued that the long-term solution to that shortage is train more of our own dentists. It is also important that the reasons why some graduates choose to move elsewhere are better understood.

18. At the other end of the workforce numbers, retirements of dentists in Scotland are a pressing issue. According to the findings of the Toothousand Project, a survey of General and Community Dental Practitioners carried out by the Scottish Council for Postgraduate Medical and Dental Education, two-thirds of General Dental Practitioners (GDPs) planned to retire early. Half of this group planned to reduce their clinical hours in the years before retirement. The “piecework” nature of the General Dental Service (GDS) was cited as one of the main reasons; furthermore, a third of GDPs identified stress as a reason for early retirement. While the BDA recognises that it might not be appropriate to have an upper age limit for removal from a dental list, we do believe that greater emphasis must be placed on developing a service structure that does not encourage dentists to seek early retirement.

19. The Scottish Executive announced in October 2005 the recruitment of 32 Polish dentists. While the BDA welcomes qualified dentists from overseas to ease the shortage of practitioners, this is only a short term measure. More needs to be done to encourage dentists trained in Scotland to remain here.

**Specific issues on the salaried general dental service:**

20. Ms Smith in her oral evidence to the committee on 30 January 2006 called for an increase in the NHS salaried general dental service to “provide emergency and comprehensive care” at more dental access centres (DACs). On a general point about dental access centres - while the BDA recognises the service salaried GDPs provide at DACs, we remain concerned about the continuity of care aspects. If this is an emergency one off service it is difficult for patients and dentists to form a care relationship, with an emphasis on prevention and oral health advice. The high street NHS GDP, with a registered patient list is more able to offer that.

21. In the evidence of 30 January 2006, Helen Eadie MSP cited the Scottish Executive’s announcement of the allocation of £30m to Local Health Boards (LHBs) for funding dental premises, including ten new dental access centres.

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The aim was to improve outreach facilities, in particular, in rural and remote areas. While the allocation of funding for dental premises is a welcome boost for the clinics, hospitals and access centres whose bids were successful, the British Dental Association nonetheless believes that further investment in high street dentistry remains necessary if the service is to fulfil its potential. High street dentists provide more than 80 per cent of the nation’s dental care.

Specific issues regarding rural and remote dental provision:

22. Mr Thomson pursued the argument that rural and remote dental provision could be modelled on the Canadian public dental service - being mainly provided by therapists, hygienists, technicians and dental health educators. Patients would see a dentist for a treatment plan and for more complex treatments. The BDA cannot comment on the specific example of the 'Canadian model' as we have not conducted any in depth research into this type of modelling.

23. However, as a result of the changes to the Dentists’ Act 1984, through a Section 60 Order, the term Dental Care Professionals (DCPs) has been created and expands the scope of regulation. For the first time dental nurses, clinical dental technicians and orthodontic therapists will be registered with the UK-wide regulator, the General Dental Council (GDC). Previously only dental therapists and hygienists were registered. From July 2006, DCPs will be regulated through educational curricula and ethical guidance (Standards for Dental Professionals), rather than through prescriptive lists of permitted duties. In undertaking work amounting to the practice of dentistry, hygienists and therapists will still be required to work under the authority of a dentist. DCP educational curricula will define the knowledge, skills and aptitudes that a DCP must have on first registration. There will be no barriers to DCPs expanding their range of skills through recognised training and experience.

24. On a general point about current incentives to recruit and retain dentists to rural and remote areas, the Scottish Executive have allocated a number of remote area allowances to independent GDPs and salaried dentists. The BDA has been supportive of this move and is encouraged the funding is in place. However, proper analysis needs to be undertaken to establish whether these recruitment initiatives are actually achieving their objectives.
Dear Dr Johnston,

PUBLIC PETITIONS COMMITTEE PE920

As requested in your letter of 16 February, I attach a response from NHS Fife on the points raised in Petition PE920.

I hope this is helpful.

Yours sincerely

GEORGE J BRECHIN
Chief Executive

Enc
Defining the problem

NHS Fife has recorded a marked rise in the number of local people seeking help to register with an NHS dentist although there were limited access problems observed prior to 2003. Contacts are made either through calls to the Primary Care department or to the Fife Dental Helpline — typically about 100 calls a day.

Although 14,135 patient de-registrations were made by General Dental Practitioners (GDPs) in the period January 2004 – February 2006, these were largely from one multiple dental practice in Lochgelly which chose to de-register all its NHS patients and to move to a largely private base. It is worth noting that where practices do this, a significant proportion of the de-registered patients may be subsequently re-registered as practices often continue to offer care to patients who are in receipt of income support or to other priority groups.

In Fife it has been more common for dental practices who choose to move to a largely private base to do so incrementally as existing patients come to the end of their 15 month registration period. It is therefore more accurate to use the total number (or proportion) of registered patients rather than the number of de-registrations as an indicator of trends in NHS dental access. On this basis, the total number of adults and children registered to GDPs in Fife (as a proportion of the total Fife population) was at 45.9% and 60% respectively at 31 December 2006 — a drop of 5.1% and 4% when compared with registrations at 31 March 2002.

Thus, although there has been a downward shift in the proportion of registered NHS dental patients over the past 2 years, it is worth making the point that a very large number of people remain in NHS registration with Fife practices and the vast majority of dental treatments carried out are still provided by GDPs. Indeed the NHS dental service across the UK has only ever operated with about half of the adult population registered at any one time. We are aware however, that in some other NHS Board areas, the proportion of registered NHS patients has fallen much further and that this trend may continue in Fife.

This raises a further point which concerns the issue of planning for change. NHS Boards have a duty to provide access to NHS dental services for their local populations. What constitutes access in this case is undefined and it is complicated significantly by the fact that GDPs as independent contractors are largely free to make changes to their access arrangements and patient base without any consultation or prior notice to the NHS Board with whom they are in contract. This leaves NHS Boards in a constantly reactive position and unable to do much more than 'second guess' what local GDPs will do next.
Understanding changes in registration levels on a population basis would be a helpful approach to modelling trends in dental access but unfortunately all the registration data held in Scotland is currently only available by dental practice rather than patient residence.

Planning to meet the fluctuating demands

Given these challenges, the approach we have taken to planning dental service development in response to patient need/demand has been to undertake some modelling of registrations by post code of dental practice combined with area of residence of callers to the Fife Dental Helpline and the Primary Care Department.

Defining the problem is only the first step. The range of options open to Boards to put NHS dental services into place is largely limited to creating new salaried NHS dental posts in existing or new dental premises. The Dental Action Plan has been very helpful in devolving the decision-making to create such posts to NHS Boards – with the result that new services can be put in place more rapidly. There is also a welcome range of salaried dental posts available, including the introduction of senior and specialist grades which has made the salaried NHS dental service more attractive to work in. However, the issues of premises and recruitment are major hurdles:

- Premises

In Fife, there has been a reduction in NHS dental estate over the last 10 years as attendance at a family dentist was encouraged, in line with national policy. The Community Dental Service has focussed on providing mobile dental services to deliver modern clinical care to rural areas, closing outdated facilities and concentrating resources on delivering care in more central locations to patients with special needs.

The recent expansion of new salaried NHS dental services has thus brought a major shift and has meant that new dental surgeries have had to be constructed which meet modern clinical practice principles – a process which has a long lead time and requires new capital investment. The recent Scottish Executive announcement of £3.6m capital funding for dental surgery development in Fife (from a total fund of some £30m) has therefore been very welcome.

- Recruitment

Ongoing work on dental workforce planning (NHS Education Scotland) has recently begun to be able to quantify the need for additional primary care dentists by NHS Board area. Interestingly the work has confirmed a picture that has been raised anecdotally in Fife for some time – that Fife has one of
the largest gaps in the primary dental care workforce across all the central belt Boards. Recruitment problems were first experienced by Fife GDP colleagues trying to fill vacant associate posts in their practices. Subsequent difficulties in recruitment have been experienced by the salaried dental service – the recent work (sponsored by the Scottish Executive) to bring EU dentists into Scotland has therefore been opportune. The logistics of bringing EU dentists and their families into Scotland is not without its challenges nor is it the complete answer to the dental workforce problem. It is however an important component of our efforts to meet the staffing requirements of the expanding salaried dental service.

- Registration arrangements

Largely because of the pressure on NHS dental access, NHS Fife has chosen not to offer full NHS dental registration in its salaried dental service. If full registration were to be offered, the available salaried dental capacity would be rapidly used up and still leave an access crisis for those patients who had not managed to register (although registration is offered to priority groups, including children and the elderly and those with medical conditions who might be at greater risk).
It is our view that NHS dental registration is not well suited to the salaried dental service model since most of these services are established to meet shorter term needs rather than long term care. It is conceivable that if there was considerably more salaried dental service capacity available, that full registration could be offered. It is not clear at this stage whether this degree of expansion of the salaried dental service in Scotland is a viable strategic aim. In the meantime, patients in Fife who use the salaried dental service are offered an intermediate range of treatments which do not include more complex restorative procedures.

- Creating the right working conditions

NHS Fife has taken the view that if the salaried dental service is to expand and the right staff are to be recruited then the working conditions have to be attractive. State of the art premises is a prerequisite (see above) but there is an increasing awareness that the jobs clinicians are asked to do have to be professionally satisfying too. In practice this has meant that clinicians are not necessarily asked to work in one clinic location for a full week but rotate through various services (treatment of the elderly; treatment of children; treatment under relative analgesia etc) in order to maintain skills, learn new skills and improve job variety. In addition, the creation of three teaching chairs in Fife has enabled outreach teaching for final year dental students from Dundee to commence in 2006. This brings enhanced roles for staff involved in student supervision and exposes potential job applicants of the future to the high quality working environment offered in Fife.
Conclusions

The range of issues outlined offer an approach to managing the current problems with NHS dental access which relies on the creation of salaried primary care dental services to replace reduced capacity in GDP services.

One possible way of addressing these complex issues in the future may be guided by the two national oral health demonstration projects funded through the Dental Action Plan. One of these projects is managed by NHS Fife and is aimed at delivering effective preventive treatments for children in nursery and school settings who are at higher risk of developing dental disease. This will pilot the role of dental nurses in delivering simple preventive treatments for which they have been trained. The key to this is the move by the General Dental Council towards competency based roles for Dental Care Professionals. It is our view that there is a significant and still relatively untapped role for DCPs which could potentially be harnessed in helping to meet the challenge of providing NHS dental care in the future.

Graham Ball
Consultant in Dental Public Health
NHS Fife

3 March 2006
9 March 2006

Dr James Johnston  
Clerk to the Public Petitions Committee  
The Scottish Parliament  
TG.01  
Parliamentary Headquarters  
EDINBURGH  
EH99 1SP

Dear Dr Johnston

Consideration of Petition PE 920 and Petition PE922

Thank you for your letter of 7 February 2006. My comments in relation to the Public Petitions are provided in the document attached to this letter. I have also emailed you an electronic copy.

Kind regards

Yours sincerely

Jeremy Bagg

Enc
Consideration of Petition PE920 and Petition PE922

Comments by Professor Jeremy Bagg

Head of Glasgow Dental School

PE920

All those involved in managing the delivery of dental care services in Scotland are fully aware of the challenges around access to NHS dentistry in certain geographic areas. In response to the text of petition PE920, it is my view that the 'Action Plan for Improving Oral Health and Modernising NHS Dental Services', published in March 2005, both acknowledges the relevant issues and lays down a framework for identifying and implementing solutions. It has taken many years for the current, unsatisfactory situation to develop and it will take significant time for the measures now being put in place to reverse the situation. There is currently massive investment in enhancing NHS dental provision, including £150 million to support the Oral Health Action Plan and recent release of £30 million of capital money to allow development of NHS dental premises in a variety of locations where access to NHS dentistry is poor. New models of care delivery are also being developed, with significant expansion of salaried dental practitioner and dental therapist posts, the latter supported by increased student numbers. Increasing amounts of the training for both dentists and dental therapists are being undertaken in the outreach environment, an expansion which is being coordinated with the new capital projects outlined above. This should enhance NHS service provision, and is likely to improve recruitment of trained personnel to these areas. There are also plans for appropriate incentives to be made available to dental students to encourage them to remain in NHS dental practice in Scotland, following graduation.
It is also important to recognise that prevention of dental disease, rather than treatment of established disease, must be at the core of delivery of dental care. This forms an important element of the Oral Health Action Plan, with significant multi-agency working to enhance the outcomes.

Clearly there is always scope for making good use of any additional resource.

However, the Scottish Executive is currently investing heavily in NHS dental services and the responsibility which now rests with those who are managing the investment is to ensure that it is used to maximum advantage for the Scottish population. As a stakeholder, the University of Glasgow Dental School is committed to providing the necessary support, on the understanding that it will be appropriately resourced to do so.

**PE922**

Many of the comments made in my response to PE920 are relevant to PE922. The difficulties facing delivery of dental services in remote and rural areas are fully acknowledged by the Scottish Executive. The petitioner cites the example of the problems facing patients trying to access NHS dentistry in Dumfries. The Scottish Executive has recently agreed capital funding of approximately £2.4 million to support building of the Dumfries Dental Centre. This Centre provides a 14 chair facility, with six surgeries to be used for service provision for salaried dentists, six chairs for outreach training of dental undergraduates and four chairs for training of dental therapists. The intention is to recruit trainee therapists from the local area, but to deliver the training as a satellite course linked to the School for Dental Therapists within Glasgow Dental Hospital & School. Similar large-scale initiatives have been
funded in Inverness, Aberdeen and Coatbridge. There are also significant numbers of
'teach and treat' centres being funded and developed. The purpose of these initiatives
is to provide an appropriate infrastructure to stimulate the re-development of NHS
dentistry in Scotland, in a manner which addresses many of the points raised in
PE922. However, these initiatives will take time to bear fruit and in the interim there
is a shortage of manpower, hence the recruitment of a relatively small cohort of
dentists from overseas. The Scottish Dental Schools are working in close
collaboration with the Scottish Executive and NHS Education for Scotland to ensure
that we deliver sufficient high quality graduates to support the initiatives outlined in
the Oral Health Action Plan, but clearly the working environment within Scottish
primary care dentistry must be sufficiently attractive and the remuneration schemes
seen as appropriate by the practitioners. In particular, it will be essential that the
salaried posts within the new dental centres, many of which will have significant
training requirements for University undergraduate students, are attractive and
rewarding jobs. Through joint working, I believe that we can ensure this is the case.
However, it is also essential that the Dental Schools themselves, which are the
powerhouse for many of the Oral Health Action Plan initiatives, are resourced
properly. There has been a significant increase in student numbers, a concomitant
reduction in staffing levels and ongoing challenges with the fabric and infrastructure
of the undergraduate schools. It is a continuing concern to those of us engaged in the
delivery of dental education in Scotland that the funding provided to the Universities
of Glasgow and Dundee by SFC for the BDS programmes is considerably lower than
that provided by HEFCE to Dental Schools in the other home countries. This results
from a continuing reluctance on the part of SFC to fund fully the Second Year of the
BDS curriculum at the clinical rate. We believe that funding at the clinical rate is
justified by the course content, and it already applies in England and Wales. In
moving into line with England and Wales, the financial viability of the Scottish dental
undergraduate courses would be enhanced significantly. It is essential that the relevant
departments within the Scottish Executive take a positive and corporate view on
providing adequate funding to support the Dental Schools, if the latter are to continue
to provide the required underpinning for so many facets of the Oral Health Action
Plan.
Faculty of Medicine, Dentistry and Nursing

DENTAL SCHOOL

Head of Department and Dean of Dentistry
Professor W. P. Saunders BDS FDSRCS Edinburgh FDSRCPs Glasgow FDSRCS Edinburgh

Dr J Johnston
Clerk to the Public Petitions Committee
The Scottish Parliament
TG.01
Edinburgh EH99 1SP

WPS/JAG
14 March 2006

Dear Dr Johnston

Consideration of Petition PE920 and Petition PE922

Thank you for your letter of 7 February 2006. I enclose a submission in response to the above named Petitions that I hope will inform the Parliamentary debate.

Yours sincerely

Professor W. P. Saunders
Considerations of Petition PE920 and Petition PE922

It is clear that considerable additional resource has been allocated to NHS dentistry through the Action Plan. However, it seems that many general dental practitioners who worked previously within the NHS have decided to abandon this service and increase their private work. This has had an immense effect on the workload of Dundee Dental Hospital and School where attendances to Accident and Emergency have increased markedly. Many adult patients can now no longer gain access to an NHS dentist for routine dental care.

The recruitment of salaried dentists to work in health centres throughout Scotland is welcomed. In addition, the opportunity for our students to gain experience of dental care to the Scottish population within outreach centres in all parts of Scotland will be beneficial to both local populations and the students themselves. Purpose-built premises in Highland, Grampian, Tayside and Fife regions will allow patients to receive high quality dental care from our undergraduate dental and dental therapy students. These opportunities will also encourage students of the benefits of working in these parts of Scotland and hopefully will result in Vocational Training being undertaken in these regions. Monetary incentives have been introduced to persuade dental students that their future lies in the Scottish NHS.

Dental care continues to improve and expand. The importance of prevention cannot be overstated but operative intervention becomes ever more sophisticated and, inevitably, expensive. Patients are demanding rightly that they keep their teeth throughout their lives. We train students to perform independent practice to the highest standards based upon clinical and scientific evidence. It is important, therefore, that the NHS dental provision matches the advances in clinical practice. Dental health is linked to general health and patients must be in a position to allow adequate dental care to be provided to attain that goal.

The use of dental care professionals is essential to manage the need for dental treatment. Their expertise will allow dentists to be relieved of many operative procedures, allowing the latter to become more involved with more difficult and demanding clinical tasks.

There is no doubt that NHS dentistry is seen globally as a poor service providing low standard treatment of an unsophisticated nature. Personally I do not hold with this view. Most dentists are thoroughly professional and ethical and provide a very good quality service. There are certainly issues regarding remuneration; it cannot be expected that dentists will continue to see upwards of 30 or 40 patients a day to ensure a reasonable standard of living.

I am greatly irritated by the assertion that dentists are greedy. They are very highly qualified professionals who should be rewarded for their expertise. I hope this response is helpful and I would be delighted to discuss dental matters with any interested parties in the Scottish Parliament.
Consideration of Petition PE920 and Petition PE922

I am grateful for the opportunity to provide comments on petitions PE920 and PE922 from Helen Smith and Peter Thomson respectively.

PE920 calls for the Executive to commit further resources to the provision of NHS dentistry, in particular for the recruitment of NHS salaried dentists to provide emergency and comprehensive care and for the provision of dedicated NHS dentistry facilities.

Following publication of “An action plan to improve oral health and modernise NHS dental services in Scotland” on 17 March 2005, the Executive is investing an additional £295m in NHS Dentistry over the 3 years 2005-08. In addition, the Executive made available £30m of funding for dental premises through its primary and community care premises modernisation programme.

Responsibility for the overall provision of NHS dental services in an area rests with the NHS Board. Where a NHS Board considers that the existing NHS general dental service provision is insufficient to meet the demands of the local population, and no independent general dental practitioner is available to fill the gap, the Board can appoint additional salaried posts to address further gaps in provision. Dentists from Poland have been recruited to work in Scotland and the first group arrived in Scotland at the end of January.

In terms of emergency dental services, the Executive has also provided to NHS Boards in the current financial year £2m of additional support to improve such services.
The Executive’s main aim is to restore the balance so that patients who want to access NHS dental services can do so, wherever they live in Scotland. Building up the salaried dental service is one way in which we can achieve this.

Petition PE922 calls on the Parliament to look at a different model to the current plan to ensure that NHS dentistry is available in remote and rural areas in the medium to long term.

The “Action plan for improving oral health and modernising NHS dental services in Scotland” followed a comprehensive consultation across Scotland and subsequent independent analysis of consultation responses.

The Executive is aware of the problems with access to NHS dental services in parts of Scotland, particularly in remote and rural areas. It is indeed the case that a substantial number of patients across Scotland have been removed from NHS lists by high street dentists, without their consent and against their will. While we cannot prevent individual dentists from acting in this manner, we believe those decisions taken by dentists are denying patients access to NHS services. We want to end and indeed reverse the deregistration of patients by dental practitioners and that is why we have put in place a set of rewards and incentives to encourage dentists to remain with or return to the NHS.

Dentists should by now be aware of the Executive’s seriousness about improving their rewards if they renew their own commitment to the NHS. As mentioned above, we are investing £295m in NHS dentistry over the 3 years 2005-08, and 80% of that is going to high street dentists. I have also written to every principal dentist three times in the last few months, enclosing each time a newsletter setting out the details of our new investments.

For example, the general dental practice allowance has been increased for all general dental practices with NHS patients to 6% of NHS earnings, and doubled to 12% for all practices which meet the definition of commitment to the NHS. In January we paid out substantial amounts of new money—nearly £5m in GDPA and £3.2m in rent re-imbursement to the two-thirds of practices that qualify. Of course, we cannot force high street dentists who own their own practices to continue to treat patients on the NHS. They are independent contractors who are free to choose whether to join a NHS Board’s dental list and whether to provide NHS treatment to each individual patient. They are also at liberty to withdraw from individual arrangements with patients at any time provided they give 3 months notice of their intention to do so. Individual dentists will make individual business decisions which affect their patients; and while we cannot dictate what those decisions should be, we want to influence those decisions because we believe patients should be able to access NHS treatment if they so wish.

I do believe we have put in place very significant incentives for high street dentists, and I believe there is no excuse for those who choose to de-register their patients from the NHS. Where high street dentists have chosen to do this, it is for NHS Boards to secure provision of NHS dental services in their area, and I am delighted that NHS Dumfries and Galloway has shown considerable initiative in seeking to develop, with funding from the primary and community care premises modernisation programme, a state of the art dental facility in Dumfries which will also provide outreach training facilities for members of the dental team.

In this respect our action plan includes a number of measures aimed at increasing the dental workforce, including hygienists and therapists, along the lines proposed in the petition. Our current actions include:

- Expanding the intake of dental students by 15% to guarantee an output of 135 graduates per year from this year
- Setting an output target of 35 qualified hygienists and/or therapists per annum for the next 5 years extending Scotland’s dental hygiene schools in Glasgow and Dundee and by establishing a conversion course at Edinburgh dental School for existing hygienists.

- Supporting dental outreach training in Glasgow, Greenock and Dundee and expanding dental outreach training in Aberdeen, Inverness and Dumfries.

We have also introduced a remote areas allowance to address the specific circumstances of dentists working in these areas of Scotland.

By taking forward the measures in our Action Plan, the Executive is determined to secure the future of NHS dental services in Scotland.

LEWIS MACDONALD
Public Petitions Committee – a template for e-petitions

Should you wish to submit an e-petition allowing signatures to be gathered online on the Public Petitions Committee e-petitioner web pages please complete the template below. Before submitting your e-petition please consult the Guidance on submission of public petitions for advice on what is and is not admissible. 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.

Mark McCabe

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 requests that the Scottish Parliament amend Scots criminal law relating to sex offences so that (a) there is a statutory offence of male rape in line with the rest of the United Kingdom and with Ireland; and (b) there are no offences that may be committed exclusively by gay men and all sex offences apply equally to everyone, whether man or woman, gay or straight. The criminal law (save some aspects, such as treason) is within the competence of the Scottish Parliament under Schedule 5 of the Scotland Act 1998 (c.46).

Period for gathering signatures:
Please enter the closing date for gathering signatures on your petition, which we would usually recommend is a period of between 4-6 weeks

Closing date: 30 September 2005

a template for e-petitions, July 2004
Additional information:

Please enter any other information relating to the issues raised in your e-petition, including the reasons why the action requested is necessary. The text entered in this field should not exceed 2 pages. However, you may wish to provide further sources/links to background information.

1. There is no offence of male rape in Scots law. Currently, a man who rapes another man would be charged with sodomy without consent or serious assault, neither of which carries sentences comparable to that of a man who has raped a woman. This seems unfair and unequal.

2. Although there is no crime of "shameless indecency" any longer in force in Scotland by virtue of a recent court case involving a teenaged boy, there do remain the crimes of "lewd and libidinous behaviour" and "gross indecency". As it is understood, "gross indecency" is held to be the same in Scotland as it is in England and exists in Scotland by virtue of section 13 of the Criminal Law (Consolidation)(Scotland) Act 1995; according to one source, "the meaning of "gross indecency" is not clear but the phrase clearly covers conduct such as mutual masturbation" [Asterley-Jones, P & Card, RIE. (1976). Introduction to the Criminal Law, 8th Ed. London: Butterworths. ISBN 0-408-57047-7]. The crime is defined by section 13 of the Sexual Offences Act 1956, where it says that, "it is an offence for a man to commit an act of gross indecency with another man, whether in public or in private, or to be a party to the commission by a man of an act of gross indecency with another man, or to procure the commission by a man of an act of gross indecency with another man". This is alarming because the crime clearly applies only to homosexual conduct; section 13(4) of the 1995 Act (mentioned above) makes what is commonly called "foreplay" legal. The fact that only men can commit this offence is discriminatory in itself. For example, if two men engage in sexual activity in a sheltered public place where they cannot be seen they can be charged with this crime, but a heterosexual couple who do the same are clearly not covered by the Act.

3. The offence of rape, even for women, relies solely on the common law, where it has been defined in clear and certain terms in English and Irish statute law for many years. This seems quite unacceptable and seems on the whole to suggest to some that sex offences are not regarded with the same seriousness or importance in Scotland as they are in England and Wales.

4. The measures announced on the Scottish Executive's website [http://www.scotland.gov.uk/News/Releases/2004/06/56055](28th July 2005) on sex offences reform do not mention if the law relating to gay sex offences will be looked at or if offences will be neutralised.

5. Most of the offences in Scots law rely solely on common law, leaving them open to judicial amendment and not solidified by a written statute; they are also open to police interpretation as to what constitutes such a common law crime when a written statute could clearly mark-out the boundaries.

6. The number of men raped in Scotland cannot be counted because there is no distinction between "male rape" and "assault", so I cannot offer any figures to suggest the number of men raped in Scotland in recent years.

7. The following newspapers may also help shed light on the current state of the law: (a) The Scotsman, [http://news.scotsman.com/topic.cfm?id=53&id=1105932006](28th July 2005) and (b) The Sunday Herald, [http://www.sundayherald.com/37282](28th July 2005).
Action taken to resolve issues of concern before submitting an e-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 MSPs. Details of those approached should be entered.

Mike Watson MSP was contacted by email and letter, and correspondence on the matter proceeded with the end result appearing to be that Mr Watson was satisfied that the Scottish Executive’s reliance on common law seemed sufficient. Patrick Harvie MSP was contacted by email but no response was received. Cathie Jamieson MSP was contacted by email but again no response was received.

Comments to stimulate on-line discussion:

Please provide at least one comment to set the scene for an on-line discussion on the petition, not exceeding 10 lines of text.

Article 1 of the UN Universal Declaration on Human Rights [http://www.un.org/Overview/rights.html](28th July 2005) states clearly that, “All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience, and should act towards one another in a spirit of brotherhood”. With this in mind, that everyone is equal before the law, the law should be changed to reflect this so that (a) there is a crime of rape (applying to men and women) defined firmly in statute and not open to judicial amendment or police interpretation, and (b) crimes applying only to men should be abolished so that all sex offences apply to, and can be committed by, men and women equally regardless of sexual orientation.

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 2005-09-07

For advice on the content and wording of your e-petition please contact:

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

Note
Completed e-petition forms should also be sent to petitions@scottish.parliament.uk
Mr McCabe

I have passed your response to the Clerk of the Committee for his attention.

Eileen

---Original Message---

From: Mark McCabe [mailto:freescotland92@hotmail.com]
Sent: Saturday, April 01, 2006 9:21 AM
To: Petitions
Cc: freescotland92@hotmail.com
Subject: Petition PE885

Dear Ms Martin:

SCOTTISH PARLIAMENT PUBLIC PETITIONS COMMITTEE – CONSIDERATION OF PE885

Thank you for your letter dated 10 March 2006 in which you enclose the Scottish Law Commission’s Discussion Paper on Rape and Other Sexual Offences.

In relation to the proposals of the Commission insofar as they relate to the petition I have raised, I would like to comment on the following points.

Guiding Principles.—I agree with the Commission’s proposal that “…the law on sex offences should not involve
functions based on sexual orientation or types of sexual practice”. No-one engaging in consensual sex, where all the parties fall outside the “protective principle”, should be penalised for their conduct; this principle, it is proposed, will protect those who (a) cannot consent, (b) are vulnerable because of their age or are under someone in a position of trust, or (c) lack the mental capacity to consent. As a supporter of John Stuart Mill’s "Harm Principle" (where one can do what one wishes provided it does not cause death or injury to anyone or their property), I can see no reason why the protective principle should not be followed in relation to sex offences.

Definition of rape.—I agree with the Commission’s proposal that rape should consist in “…penetration by a person with his penis of the vagina, anus or mouth without that person’s consent”. This is how rape is defined in England and Wales (by s.1, Sexual Offences Act 2003). In that Act, rape occurs when—

"A person (A) commits an offence if—

a. he intentionally penetrates the vagina, anus or mouth of another person (B) with his penis,
b. B does not consent to the penetration, and
c. A does not reasonably believe that B consents."

As can be seen by this definition, mens rea is required. The unlikely occurrence of accidental penetration is not included and the onus seems to be on the accused to show that he reasonably believed B consented to the penetration. The crucial point is then the question of what constitutes consent.
Definition of consent.—I agree with the Commission’s proposal that consent should be defined along the terms of the California Penal Code. Consent should be defined in terms of (a) what constitutes consent generally, and (b) specific circumstances where consent is not valid together with the types of person who cannot consent. If I might be so bold, I suggest the following to be a good model for consent — based on the California Penal Code, current Scots law, and the Commission’s proposals and observations—

"(1) In this Act,—

(a) "consent" means positive co-operation in act or attitude, pursuant to an exercise of free will. The person must act freely and voluntarily, and have knowledge of the nature of the act in question:

Provided always, that the circumstances where consent shall be null and void, and deemed to be invalid, include but are not limited to—

i. if one of the parties to the act in question is aged under sixteen years [Goddes v HMA 1996];

ii. where one of the parties is a mental defective [Chas Swinney 1858];

iii. if the victim is asleep or unconscious [Chas Swinney 1858];

iv. where the use or threat of force or violence is used against the victim to overcome the victim’s will [Barbour v HMA 1982];

v. where the accused knows or has reason to believe that the victim does not consent or is recklessly indifferent as to whether the victim consents or not [Meek & Ors v HMA 1982; Doris v HMA 1996; McPhail v HMA 1996];

vi. where the accused induced the victim to engage in the act in question by abusing a position of trust, power or authority;

vii. if, at any point during the act in question, the victim withdraws consent by express words or physical resistance or some other indication that a reasonable person would consider to be a withdrawal of consent;

viii. if the victim is deceived by the accused intentionally impersonating a person known personally to the victim [Wm Fraser 1847]; and

ix. where the accused supplies alcohol or drugs to make the victim insensible but this does not apply where the victim is voluntarily intoxicated by alcohol or drugs [HMA v Granger & Rae 1932];

(b) "mental defective" means a person suffering from a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning [s.45, Sexual Offences Act 1956 (s & 5 Etc, 2 e:69)]; and

(c) "sexual" includes but is not limited to anal or vaginal intercourse, fellatio or cunnilingus, masturbation, or any other act from which the accused derives sexual gratification.

"(2) It is not a defence to a charge of rape for the accused to lead evidence that he was engaged in a current marriage or dating relationship with the victim, or that he was formerly engaged in any such relationship.”.

Clarity of law principle.—I agree with the Commission’s "clarity of law" principle whereby the law that is phrased in clear language understandable to the layman (a) criminalises specific conduct, and (b) such crimes are comprehensive so that they are not "open-ended" (i.e., they are not so vague that the courts could declare the existence of other crimes arising from the statutory ones).

With this in mind, the "clarity of law" principle would satisfy the provisions of my petition where I claim that "...most sexual offences in Scots law rely solely on common law, leaving them open to judicial amendment and not solidified by a written statute; they are also open to police interpretation as to what constitutes such a common law crime when a written statute could clearly mark out the boundaries". In this respect, the Commission’s proposal to "publish a final report next year, which will include draft legislation" would also satisfy that part of my petition.
a. "any existing common law offence relating to homosexual conduct should be abolished";
b. "section 13 of the Criminal Law (Consolidation)(Scotland) Act 1995 should be repealed" (paragraph 64);
c. "the crime of lewd, indecent and libidinous practices and behaviour should be abolished" (paragraph 45); and

d. sexual offences "would be neutral as regards gender and sexual orientation", as shown by the definition of rape proposed by the Commission.

Sex offences against children.—I agree with the Commission’s proposals that there should be offences of (a) engaging in sexual activity in a child’s presence, and (b) causing a child to watch a sexual act (paragraphs 46-7).

If I might be so bold, please find attached a Sex Offences Bill I have drafted personally which, I feel, might convey my feelings on the Discussion Paper clearer than this email is. On the whole, I must commend the Commission for their work and will be responding to the Scottish Law Commission about their paper shortly.

I trust this is of assistance to you.

Kind regards

k McCabe
Draft Sex Offences Bill

A BILL

For

An Act of the Scottish Parliament to make fresh provision by enactment for rape and other sexual offences.

PART 1

General

1 Fundamental Principles

(1) The offences created by this Act are based on the following three fundamental guiding principles –

(a) the Harm Principle. A person's conduct is offensive if he, being an adult of sound mind, physically injures any other person;
(b) the Protective Principle. Following from the Harm Principle, it is the duty of the law and of all adults of sound mind to protect other adults of unsound mind and to protect children; and
(c) Consent. A person's conduct is offensive if he has sexual relations and thereby physically injures another person without his or her consent or if he has sexual relations with a person of unsound mind or with a child, being a direct breach of the Protective Principle and both being a direct breach of the Harm Principle.

(2) In this Act, –

(a) “adult” means a person aged fourteen years or older;
(b) “child” means a person aged under fourteen years;
(c) “consent” means positive co-operation in act or attitude, pursuant to an exercise of free will. The person must act freely and voluntarily, and have knowledge of the nature of the act in question:

Provided always, that the circumstances where consent shall be null and void, and deemed to be invalid, include but are not limited to——

(i) if one of the parties to the act in question is aged under sixteen years [Geddes v HMA 1996];
(ii) where one of the parties is a mental defective [Chas Sweenie 1858];

(iii) if the victim is asleep or unconscious [Chas Sweenie 1858];

(iv) where the use or threat of force or violence is used against the victim to overcome the victim’s will [Barbour v HMA 1982];

(v) where the accused knows or has reason to believe that the victim does not consent or is recklessly indifferent as to whether the victim consents or not [Meek & Ors v HMA 1982; Doris v HMA 1996; McPhelin v HMA 1996];

(vi) where the accused induced the victim to engage in the act in question by abusing a position of trust, power or authority;

(vii) if, at any point during the act in question, the victim withdraws consent by express words or physical resistance or some other indication that a reasonable person would consider to be a withdrawal of consent;

(viii) if the victim is deceived by the accused intentionally impersonating a person known personally to the victim [Wm Fraser 1847]; and

(ix) where the accused supplies alcohol or drugs to make the victim insensible but this does not apply where the victim is voluntarily intoxicated by alcohol or drugs [HMA v Grainger & Rae 1932];

(d) “corroboration by distress” means evidence from a third party that the complainer was distressed shortly after the time of the alleged offence, but such evidence is only corroboration of the withholding of consent for a sexual act [Fox v HMA 1998; Smith v Lees 1997];

(e) “immediate family” means, in relation to an adult complainer, -

(i) his or her spouse or civil partner, or

(ii) his or her son or daughter; or

in relation to a child complainer, -

(iii) his or her mother or father, or

(iv) his or her brother or sister.

(f) “mental defective” means a person suffering from a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning [cf. s.45, Sexual Offences Act 1956 (4 & 5 Eliz. 2 c.69)];

(g) “Moorov doctrine” means where a person is charged with a series of similar offences –

(i) that are closely related by character, circumstances and time; and

(ii) the evidence of one credible, but different, witness to each offence,

affords mutual corroboration and can be used in relation to an offence under this Act;
Draft Sexual Offences Bill

(h) "public place" means any road or pavement or any other premises or place to which the public at any time have or are permitted to have access, whether on payment or otherwise, and includes a car park and any place where two or more members of the public can or are likely to witness conduct that is an offence under this Act;

(i) "severe injury" means physical injury falling short of death;

(j) "sexual act" includes but is not limited to anal or vaginal intercourse, fellatio or cunnilingus, masturbation, or any other act from which the accused derives sexual gratification;

(k) "similar fact evidence" means that evidence is admissible where it relates to the conduct of the accused, at some time other than the acts with which he is charged, which shows his propensity or disposition to engage in the misconduct alleged, that he has previously engaged in behaviour in a way that was strikingly similar to his behaviour at the time of the alleged offence; and

(l) "young person" means a person aged 14 years or older but aged under 16 years.

(3) It is not a defence to a charge of rape for the accused to lead evidence that he was engaged in a current marriage or dating relationship with the victim, or that he was formerly engaged in any such relationship.

(4) In this Act, where it is provided that "a person" commits an offence by engaging in specific conduct and there is no distinction as to age (for example, a child or an adult) this shall be construed as referring to a person of any age in relation to another person of any age.

PART 2

Sexual Offences

2

Rape and statutory rape

(1) A person (A) commits an offence of rape if –

(a) he intentionally penetrates the vagina, anus or mouth of another person (B) with his penis,

(b) B does not consent to the penetration, and

(c) A does not reasonably believe that B consents.

(2) A person (A) commits an offence of statutory rape if –

(a) he intentionally penetrates the vagina, anus or mouth of another person (B) with his penis;

(b) B is under the age of fourteen years; and

(c) A knows or ought to know that B is under the age of fourteen years or, at most, under the age of sixteen years.

(3) A person solemnly convicted of rape or statutory rape shall be liable to imprisonment for life.
3 Sexual assault by penetration

(1) A person (A) commits an offence of sexual assault by penetration if—
   (a) he intentionally penetrates the vagina or anus of another person (B) with any part of the body or any object other than his penis;
   (b) B does not consent to that penetration; and
   (c) A does not reasonably believe that B consents.

(2) A person solemnly convicted of sexual assault by penetration shall be liable to a term of imprisonment—
   (a) not exceeding ten years if B was aged fourteen years or older; or
   (b) not exceeding fifteen years if B was aged under fourteen years, at the material time.

4 Sexual assault

(1) A person (A) commits an offence of sexual assault if—
   (a) he intentionally—
      (i) does a sexual act to another person (B), or
      (ii) touches B in such a manner that it a reasonable person would regard as amounting to a sexual act, or
      (iii) compels or coerces another person to engage in a sexual act by the use or threat of force or violence to B or any member of B’s immediate family, or
      (iv) causes or incites a child to engage in a sexual act with A or to perform a sexual act on A, and the sexual act in question does not amount to rape, statutory rape or sexual assault by penetration;
   (b) B does not consent to that sexual act if B is an adult or, if B is a child, B is under the age of fourteen years; and
   (c) A does reasonably believe that B consents if B is an adult or, if B is a child, A knows or ought to know that B is under the age of fourteen years or, at most, under the age of sixteen years.

(2) A person solemnly convicted of sexual assault shall be liable to a term of imprisonment—
   (a) not exceeding two years if B was aged fourteen years or older; or
   (b) not exceeding five years if B was aged under fourteen years, at the material time.

(3) No-one is liable for sexual assault by penetration, sexual assault or aggravated sexual assault by reason only of doing any act reasonably and in good faith for medical reasons (for example, gynaecology).

(4) A person may consent to the infliction of violence upon himself for the purposes of his own sexual gratification and the infliction of such violence is not an offence and is lawful, but he may not consent to the infliction of such violence upon himself that he suffers severe injury and such infliction of such violence resulting in severe injury amounts to severe injury and is not lawful.
5 Provisions relating to sex offences against children and mental defective

(1) A person (A) commits an offence of child indecency if—
   (a) engages in a sexual act in the presence of a child; or
   (b) causes a child to watch a sexual act, -
   with intent that A gains sexual gratification therefrom.

(2) It is a defence to an offence under this Act committed by an adult against or involving a child that A believed on reasonable grounds that the child was aged 16 years or older.

(3) It is not a defence to an offence under this Act committed by an adult against or involving a child that—
   (a) the accused and the child were married or in a civil partnership with each other; or
   (b) the accused believed on reasonable grounds that he and the child were married or in a civil partnership with each other, -
   given that marriage or civil partnership under the law of Scotland is valid only between consenting persons aged 16 years or older.

(4) In any proceedings for an offence under this Act committed by an adult against or involving a child, if the accused relies on any defence to any such offence the evidential burden shall lie on him.

(5) Where an offence is committed under this Act against or involving a child, and one party to the offence is over 16 years of age and the other party is over 14 years of age but under 16 years of age, the Police may, in their absolute discretion, decide whether it is appropriate to charge the party involved who is over 16 years of age, but such party must be charged and proceeded against if he is ten or more years older than the other party.

(6) No offence is committed under this Act if both parties to the sexual act—
   (a) are under 16 years of age but over 14 years of age; and
   (b) consent to the sexual act in question, but if consent is withdrawn and the sexual act continues by the party other than the party who withdrew his consent, an offence provided for above is committed.

(7) Nothing in this Act affects, or shall be so construed to affect, the age of consent.

(8) No natural or artificial person shall be liable for—
   (a) an offence under this Act;
   (b) incitement to commit an offence under this Act; or
   (c) art and part involvement in relation to an offence under this Act, -
   by reason of providing counselling, support or treatment to children or young persons on sexual health matters.
(9) A person convicted of child indecency shall be liable to imprisonment for a term not exceeding one year.

(10) Save as otherwise provided by subsection (6) above, a girl or boy under the age of sixteen cannot in law give any consent which would prevent an act being an offence under this Act for the purposes of this Act.

(11) A woman or a man who is a defective cannot in law give any consent which would prevent an act being an offence under this Act for the purposes of this Act, but a person is only to be treated as guilty of an offence under this Act on a defective by reason of that incapacity to consent, if that person knew or had reason to suspect her to be a defective.

(12) Whoever, without lawful authority or excuse, with intent to engage in a sexual act with him or her, takes away and detains –
   (a) a man or woman against his will; or
   (b) a child aged sixteen years or younger out of the possession of his or her parent or guardian against that child’s will; or
   (c) a mental defective out of the possession of his or her parent or guardian against that person’s will,
   is guilty of abduction, and shall be liable to a term of imprisonment –
   (d) not exceeding five years for an offence under paragraph (a) above; or
   (e) not exceeding fifteen years for an offence under paragraphs (b) or (c) above.

(13) The common law crime of *plagium* is hereby abolished.

6 Aggravated sexual assault

(1) A person (A) commits an offence of aggravated sexual assault if he engages in a sexual act with another person (B) where –
   (a) A was in a position of trust in relation to B; and
   (b) B was under the age of 18 years or was a mental defective; and
   (c) The sexual act occurred as a result of a breach of trust.

(2) In this Act, “position of trust” includes but is not limited to cases where –
   (a) A is the teacher, instructor or religious advisor to B;
   (b) A provides care services to B professionally or on behalf of a voluntary organisation; and
   (c) A is actively engaged in the management of, works in, or is contracted to provide services to –
      (i) a hospital where B is being given treatment; or
      (ii) an establishment where B lives.

(3) A person solemnly convicted of aggravated sexual assault is liable to imprisonment for a term not exceeding three years.
7

Indecent exposure

(1) A person (A) commits an offence of indecent exposure if, with intent to commit rape or an offence under this Act, -
   (a) he exposes his genitals to another person (B) in a public or private place; and
   (b) B is in immediate fear that he or she will be the victim of rape or an offence under this Act by A, -

But no offence is committed under this subsection if -
   (c) there is no intent by A to commit rape or an offence under this Act; or
   (d) B does not fear that he or she will be the victim of rape or an offence under this Act by A; and
   (e) in any case, an offence under this subsection does not include nanurism.

(2) A person convicted of indecent exposure shall be liable to imprisonment for a term not exceeding one year, or to a fine, or to both.

8

Bestiality

If any person, with or without intent, engages in a sexual act with, or performs a sexual act on, any animal, he or she is guilty of bestiality and shall be liable to imprisonment for a term not exceeding two years.

9

Interfering with human remains

If any person, with or without intent, engages in a sexual act with, or performs a sexual act on, a dead human body, he or she is guilty of interfering with human remains and shall be liable to imprisonment for a term not exceeding two years.

10

Public indecency

(1) A person commits an offence of public indecency if -
   (a) he engages in a sexual act in a public place, either alone or with another person; and
   (b) the sexual act in which he is engaged is visible to other persons passing by, -

But no offence is committed under this subsection if the sexual act in which he is engaged is not visible to other persons passing by.

(2) A person convicted of public indecency shall be liable to a fine not exceeding the maximum amount that may be imposed by the District Court.

PART 3

Miscellaneous Provisions
11 Corroboration

(1) No person shall be convicted of an offence under this Act on the evidence of only one witness, unless the evidence of that witness is corroborated in a material particular by evidence that implicates the accused, but this shall not apply to an offence under—
   (a) section 2(1): (rape);
   (b) section 2(2): (statutory rape);
   (c) section 3(1): (sexual assault by penetration concerning a child);
   (d) section 4(1): (sexual assault concerning a child);
   (e) section 5(12)(b): (abducting a child); or
   (f) section 6(1): (aggravated sexual assault).

(2) For the avoidance of doubt, where an offence mentioned in subsection (1) above can be corroborated by sufficient and relevant admissible evidence, such evidence shall be so admitted in any proceedings, but the lack of any such evidence shall not affect subsection (1) above.

(3) Corroboration by distress shall be competent to establish evidence of the lack of consent to a sexual act.

(4) The following methods of corroborating the evidence of a witness pursuant to subsection (1) above shall be sufficient to establish corroboration, namely by using—
   (a) the Moorov doctrine; or
   (b) similar fact evidence.

12 Offences abolished

(1) The following offences are hereby abolished, namely—
   (a) lewd, indecent and libidinous practices and behaviour towards children;
   (b) any common law offence existing as part of the law of Scotland when this Act comes into operation relating to homosexual conduct;
   (c) section 13 of the Criminal Law (Consolidation) (Scotland) Act 1995;
   (d) incest; and
   (e) any remaining common law offence existing as part of the law of Scotland when this Act comes into operation relating to any kind of sexual conduct.

(2) Following from subsection (1)(b) and (e) above, no sexual act or sexual conduct shall be an offence and be unlawful unless, and only unless, such act or conduct is expressly defined and declared to be unlawful by an enactment.