



## **Children's Environment and Health Strategy for the United Kingdom**

### **Consultation Questionnaire**

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## Instructions

Please complete the consultation questions below and return your response by Friday 13 June 2008, to:

**CEHAPE Consultation Officer**  
**Chemical Hazards and Poisons Division**  
**Health Protection Agency**  
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If you wish your response to be treated confidentially, please indicate this when sending us your response.

<b>Contact details</b>	
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Are you under 18 years of age? (please tick)	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
If responding on behalf of an organisation, please state who the organisation represents and, where applicable, how the views of members were assembled.	Children in Scotland is the national umbrella organisation for the children's sector in Scotland. It has more than 450 members, including nearly all the relevant voluntary sector groups and professional associations and 90% of Scotland's local authorities. Consultation has occurred through formal and informal contacts with member organisations, as well as through a survey of more than 500 children and young people on

	attitudes, knowledge and behaviours related to injuries.
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**Regional Priority Goal I: Water, Sanitation and Health**

- 1 Do you agree that the areas highlighted need to be addressed with regards to water, sanitation and children's health in the UK?

Yes, although we are concerned that Scottish realities, policies and practices are under-represented in the UK report. This should be corrected in the final report, so that the situation and intentions of all four nations and governments within the UK are accurately and adequately included in relation to each Regional Priority Goal.

- 2 Are there any additional areas concerning water, sanitation and children's health that you feel need to be addressed in the UK, but aren't highlighted in this strategy? If so, please explain.

a) To the best of our knowledge, the Scottish Government has not yet confirmed its commitment to: officially reducing the maximum level of lead in drinking water (from 25 to 10 units) as proposed in this consultation; engaging in more rigorous monitoring of lead in drinking water; or, taking action to eliminate the sources of lead exposure to children (once identified). We think that all three of these steps should be taken in all four nations within the UK.

b) There are on-going issues about the procedures used to test water for lead levels, as they may significantly underestimate the actual lead exposure of children. We encourage all the nations within the UK to supplement tests of water quality with tests of the blood lead levels of those young children who predictably are at greater than average risk of lead exposure because of problems in the environments of their homes, care settings or schools (e.g., the continuing existence of lead pipes or lead soldering somewhere in their drinking water sources).

We encourage a well-planned and carefully-implemented programme of testing for blood lead levels because, in the final analysis, what really matters is their actual exposure, not just the projected/suspected level of lead in children's bodies based upon water testing results. We also recommend treatment for children found to have high blood lead levels. Although this will reverse the damage done, it will prevent further harm. Finally, we suggest that reference be made to the policy statement/research summary on lead exposure in Pediatrics (<http://pediatrics.aappublications.org/cgi/content/full/116/4/1036>) by the Environmental Health Committee of the American Academy of Pediatrics.

c) The CEHAPE report's current focus on water quality in schools is commendable, but incomplete. It is vital that the final UK CEHAPE report give at least equal attention and priority to water quality, sanitation, hygiene in the diverse early years settings in which ever-increasing numbers of young children are placed. Given the mixed economy of early years care and provision, the CEHAPE report must take full account of where young children actually are day-to-day (e.g., with

childminders, at private centres, with grandparents or in other locations outside their homes). Then, the report must propose actions that will reach young children in these disparate and often unregulated environments.

- d) Children in Scotland suggests replacing sweetened or diet beverages in vending machines with good quality bottles of water (as one step toward obesity reduction). Similarly, in places/situation where the cost of eliminating the source of lead exposure in drinking water is deemed too high, the possibility of providing good quality bottled water should be considered as an alternative solution.

**3** What issues concerning water, sanitation and children's health, if any, do you feel are a priority for the UK over the next few years?

**4** Is there anything else you would like to add?

**Regional Priority Goal II: Accidents, Injuries, Obesity and Physical Activity**

- 5 Do you agree that the areas highlighted need to be addressed with regards to accidents and injuries, obesity and physical activity, and access to green spaces and children's health, in the UK?

Children in Scotland agrees that these areas need to be addressed.

- 6 Are there any additional areas concerning accidents and unintentional injuries, obesity and physical activity, and access to green spaces and children's health, that you feel need to be addressed in the UK, but aren't highlighted in this strategy? If so, please explain.

- a) Children in Scotland thinks that it is inadequate and artificial to limit the goals and activities under CEHAPE to "accidents and unintentional injuries". Instead, CiS recommends that the focus be on ALL injuries to children and young people. The crucial public health concern is preventing harm -- in this case, to prevent physical injuries -- no matter how those injuries occur or who bears what degree of responsibility for them occurring. There is a spectrum of causality and responsibility in the world of childhood and adolescent injuries; not a bright line separating 'unintentional' injuries from all other injuries.

To cite one of myriad examples, a child who is hit and injured by an intoxicated parent is excluded from consideration by CEHAPE because that harm is not considered 'unintentional'. However, if that same child is a wee bit quicker and escapes being hit by that same parent only to fall down the stairs a minute later while being chased, then it counts under CEHAPE as an 'unintentional' fall/injury. The plethora and diversity of cases where 'intentionality' is an open question (albeit often a conveniently ignored question) undermines the integrity and value of this distinction.

In an entirely different way, CEHAPE's limited focus on 'unintentional' injury makes it too easy to ignore some key environmental health issues. Again, to cite only one example, the perceived threat of intentional injury by bullies, gangs or malevolent adults does dramatically limit some children and young people's effective access to green space and safe play areas, especially in urban areas characterized by deprivation. Framed positively, the physical environment can be shaped to play a major role in protecting children from intentional injury, e.g., through adequate lighting, accessible pedestrian paths and supervised play areas.

- b) There should be direct connections made in the UK CEHAPE response -- in terms of goals, policies and practices -- among the main topics covered by RPG II. For instance, Children in Scotland favours a joined-up goal of simulatenously increasing physical activity by a certain percentage over the next ten years and decreasing injuries by a certain percentage over the same period. Explicitly linking these goals would go a long way toward ending the 'debate' (and often false choice) between more activity and less injury.

There are numerous practical examples, such as encouraging children to ride bicycles more often and for longer periods, while simultaneously building more safe bike routes and encouraging/requiring helmet use by children. Such a combination increases the health benefits of greater physical activity and outdoor play AND also decreases the likelihood of serious injury. The UK CEHAPE report should accord much stronger priority to all the ways in which children's environments can be structured toward responsible risk-taking -- rather than succumbing to the tendency toward excessive (and ultimately unhealthy and developmentally inappropriate) risk aversion. Giving children permission and opportunities to take risks -- but guaranteeing (as much as possible) that, when they make an error in judging their own ability to handle a given risk, they will not be seriously injured -- should be a recurrent theme within the UK CEHAPE report. Falling off a bicycle on a bike path while wearing a helmet is far different and far safer than the same child without a helmet falling off the same bike in the middle of a busy street.

c) There needs to be a serious, comprehensive injury surveillance and reporting system within each of the four UK nations, as well as sharing of the resulting data across the UK as a whole. This surveillance and reporting system should encompass all injuries of all kinds from all causes that require attention from health professionals. Thus, it should include GP and A&E visits for physical injuries, not just injury-related hospital admissions.

Data collection should include data from the environments where children spend the most time; namely, home(s), schools, daycares/nurseries and roads. Something is needed to not only take the place of HASS/LASS, but also to go beyond the limits of the previous system. Road traffic crash data need to be collected from police reports, just as sports injury data need to be collected from schools and clubs. Doing so will generate the currently-missing solid knowledge base from which to develop ever-better prevention and treatment strategies specific to children and young people.

Children and young people themselves should be encouraged and assisted to become directly engaged in monitoring and data collection activities. They will benefit in a variety of ways (from better academic skills to heightened safety) by being regarded and treated as partners in the surveillance process, not just the passive subjects of this system.

d) Too little attention is paid in the UK CEHAPE report to the role (actual and potential) of the voluntary sector in the planning, implementation and assessment of RPG II goals. From single issue community groups to large, national organisations, the voluntary sector already has innumerable connections with, and responsibilities for, children and young people in Scotland (and the rest of the UK). There is much to gain in meeting RPG II goals by engaging with the voluntary children's sector around issues of injury prevention, physical activity and obesity -- and much to lose by ignoring or marginalising these prospective key partners.

e) The CEHAPE consultation document under-represents the amount and quality of

work across Scotland in relation to both increasing physical activity and decreasing obesity by the Scottish Government, NHS Scotland and numerous other partners (including Children in Scotland). From the pilot scheme to provide universal free primary school meals in some local authorities to the growing interest in nature kindergartens, forest schools and other innovations promoting 'nurture through nature' in the early years, Scotland offers helpful examples and models of a positive direction of travel for CEHAPE RPG II.

f) The current UK CEHAPE consultation document provides only one graphic image concerning injury -- and that features mortality data. Children in Scotland suggests a much different balance, with far more emphasis given to morbidity data. The one compelling chart on child deaths can be found in Scotland's Child Safety Strategy. It reveals that children residing in the most deprived area are three times more likely to die due to a road injury than those residing in Scotland's least deprived communities. It is a grim reminder of the human cost of income inequalities.

Nevertheless, the bigger story emerging from Scotland for the UK CEHAPE report is about the tens of thousands of children and young people who are admitted to hospital each year as a result of injuries -- and the even larger number who are treated and released from A&E Departments annually. The CEHAPE report should underscore the reality that the cost of serious injuries is not limited to the NHS and direct treatment expenditures. Injury-caused disabilities bring with them long-term (sometimes lifelong) extra costs for society and for multiple government agencies.

The additional costs also are measured in human terms -- lost dreams, compromised lives and diminished life chances for these young people. These, too, create calculable economic costs (from lower educational attainment to lost productivity) that are significant, but often ignored. These costs are particularly worth remembering in a political/societal context that too often views 'doing nothing' as the inexpensive (if not cost-free) option. The UK CEHAPE report could begin to counter this misperception by bringing forward persuasive, reasonable estimates of the real (high) costs of 'doing nothing' about injury prevention.

g) Explicit attention should be given to the physical activity needs and aspirations of children having disabilities, chronic medical conditions or who are otherwise medically-fragile. Most play areas, child care settings and schools are ill-equipped and inadequately prepared to deal fairly and effectively with children having additional support needs. As a recent report on 'moving and handling' from Scotland's Commissioner for Children and Young People pointed out, children with disabilities both want and can benefit from increased physical activity and play. The UK CEHAPE report should encourage policies and strategies that respond positively to the environmental health issues of children with additional support needs.

- 7 What issues concerning to accidents and injuries, obesity and physical activity, and access to green spaces and children's health, if any, do you feel are a priority for the UK over the next few years?

The missing ingredient in Scotland -- and to an extent in the rest of the UK -- is the absence of leadership, political will and media attention accorded to injury prevention. All the specific points made elsewhere only become meaningful in the context of a society and government that: genuinely care about children and young people being injured; believe that injuries could and should be prevented; and, are willing to accord priority and resources to this task.

This need not mean massive new expenditures. The required resources largely can come from the reallocation of existing resources and/or more creative, cost-effective ways of achieving the desired objectives. One positive step is to stay focused on, and tie funding to, outcomes -- i.e., fewer children being injured and those injured harmed less seriously -- rather than simply pouring more resources into more activities or materials that may not have any real efficacy.

- 8 Is there anything else you would like to add?

a) Scotland's Child Safety Strategy deserves to be highlighted within the UK CEHAPE response. Scotland was the first of the four nations within the UK to become actively involved with this aspect of CEHAPE -- and has represented the UK in this arena at the European level for the past few years. This fact merits a more visible place within the UK CEHAPE report. Similarly, Professor David Stone's pioneering report on childhood injuries in Scotland (cited in Scotland's Strategy) should be featured in the final UK report.

b) Although not without limitations, the survey of 500 children and young people conducted by Children in Scotland (and commissioned as part of Scotland's Child Safety Strategy) also merits more attention in the UK report. This survey of attitudes, knowledge and behaviour in relation to injury prevention is indicative of the type of research that should be undertaken more extensively, and in greater depth, across the UK. Understanding what a broad spectrum of children and young people -- not just a select handful -- actually think, know and do ought to be central in the formulation, implementation and assessment of governmental policies, programmes and practices in the field of injury prevention. However, such direct consultation and active engagement of children and young people has been conspicuous by its absence. Among other helpful findings, this children in Scotland survey revealed key gender and age differences in injury-related perceptions and behaviour.

Children in Scotland also recommends a stronger emphasis within the UK CEHAPE report on getting children directly and meaningfully involved in the development and implementation of injury prevention work. The results predictably will be far better if the strategies employed are based on partnerships with children, young

people and the organisations working with them. In other words, injury prevention is best done with and by children and young people -- not to and for them.

- c) RPG II (as is the case throughout the consultation document) neither gives adequate attention to, nor builds its case around, the rights of children, generally, and the UN Convention on the Rights of the Child, specifically. There are several Articles within the UNCRC (ratified by the UK years ago) that could and should inform and influence the UK CEHAPE report. The CEHAPE consultation response of Scotland's Commissioner for Children and Young People makes explicit the ways in the UNCRC and a rights-based approach can be used to strengthen the case for, and enhance elements within, CEHAPE.

**Regional Priority Goal III: Respiratory Health, Indoor and Outdoor Air Pollution**

- 9** Do you agree that the areas highlighted need to be addressed with regards to outdoor air pollution and indoor air pollution and children's health in the UK?
  
- 10** Are there any additional areas concerning outdoor air pollution and indoor air pollution and children's health that you feel need to be addressed in the UK, but aren't highlighted in this strategy? If so, please explain.
  
- 11** What issues concerning outdoor air pollution and indoor air pollution and children's health, if any, do you feel are a priority for the UK over the next few years?
  
- 12** Is there anything else you would like to add?

**Regional Priority Goal IV: Chemical, Physical and Biological Hazards**

- 13** Do you agree that the areas highlighted need to be addressed with regards to chemicals, ionising and non-ionising radiation, noise, biological hazards and emergency preparedness and children's health in the UK?
- 14** Are there any additional areas concerning chemicals, ionising and non-ionising radiation, noise, biological hazards and emergency preparedness and children's health that you feel need to be addressed in the UK, but aren't highlighted in this strategy? If so, please explain.
- 15** What issues concerning chemicals, ionising and non-ionising radiation, noise, biological hazards and emergency preparedness and children's health, if any, do you feel are a priority for the UK over the next few years?
- 16** Is there anything else you would like to add?

The reminder that lead in paint (as well as in drinking water) still poses a significant environmental health risk for some young children across the UK is needed and appreciated.

### Overarching Issues and Priorities

**17** Are there any other overarching issues not highlighted that you feel should be taken into account in developing the Children's Environment and Health Strategy and action plans?

a) The areas highlighted via CEHAPE include both reserved and devolved competencies in the UK context. Scotland, in particular, has a significant say in the relevant CEHAPE policies and in the programmes financed to address them. The UK government must recognise and consult on those areas that are devolved. This consultation document has limited reference to Scottish specific policies and initiatives and, where references are made, they sometimes misrepresent the situation here. A UK response to these issues is pragmatic and has great merit. However, greater effort needs to be made to ensure that all of the devolved governments/structures are involved and fully consulted in preparing the final UK CEHAPE report.

b) Children in Scotland recommends that identifying and redressing environmental health inequalities in all four RPGs must be an over-arching priority within the final CEHAPE report. This applies powerfully and most obviously to socio-economic inequalities, i.e., those living in the most deprived UK communities are at greater risk for poor health outcomes from environmental sources than those residing in the least deprived areas. However, inequalities also exist and must be redressed in relation to gender, ethnicity and disability.

c) There is an emphasis throughout CEHAPE (stemming from the WHO) on the 'burden of disease'. This concept informs the approach taken and the strategies preferred. It should be noted and explicitly discussed in the final CEHAPE UK report that there are many important negative consequences of environmental health problems that do not fit the 'disease' category. An injury is not a disease, but its ill-effects upon a child's well-being and life chances can be just as severe. Perhaps more accurate terminology can be found and used in the final report.

d) The UK CEHAPE report explicitly (and correctly) includes the foetus in its definition of 'children'. It deals with some potential environmental hazards for pregnant women in RPG IV. This makes sense because for a foetus, the whole 'environment' -- and thus, all 'environmental health' issues and concerns -- exist within the pregnant mother's body.

The final report should also give priority to other pregnancy-related 'environmental' health problems. Specifically, Foetal Alcohol Syndrome (and Foetal Alcohol Spectrum Disorder) should be highlighted. The result for some babies exposed to alcohol during pregnancy is permanent brain and nervous system damage. This is not a disease, but it certainly is a very adverse health outcome directly attributable to that foetus' unhealthy environment. Being born with Foetal Alcohol Syndrome renders some later (post-birth) environmental protections less meaningful because serious harm already has occurred and cannot be reversed. Thus, Children in Scotland recommends that FAS/FASD -- as an environmental health issue -- be accorded prominence in the final UK CEHAPE report.

**Organising to Deliver**

**18** Do you agree with the proposed general approach for addressing the CEHAPE priorities in the UK?

**19** Do you consider the use of environment and health indicators a useful means of measuring environmental determinants of children's health and the overall impact of the Children's Environment and Health Strategy?

Yes

**20** Are there any other means of monitoring the impact of the Children's Environment and Health Strategy that should be considered?

Greater involvement of children and young people -- and of voluntary sector organisations -- as active partners in the planning, implementation, monitoring and assessment processes is recommended by Children in Scotland

**21** Over what timescales do you think the Children's Environment and Health Strategy should operate?

10 years

**Consultation Process**

**22** Are there any ways we could improve similar consultations in the future?

There should be a much larger scale, meaningful consultation process with children and young people themselves about environmental health issues.

**Anything Else?**

**23** Is there anything else you would like to add concerning the Children's Environment and Health Strategy?

Thank you for taking the time to consider this document