

Smoking in Public Places Investigative Committee

Scrutiny of Smoking in Public Places in London

March 2002



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**Greater London Authority
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Chair's Foreword



Over the last twenty years we have seen a huge shift in public attitudes to smoking and in particular the issue of passive smoking, or breathing in other people's smoke. Many cities around the world have either placed restrictions on smoking in public places or have banned smoking in public places altogether.

There is now irrefutable evidence of the health risks of smoking and a growing body of work on the dangers of passive smoking. The GLA has a statutory role to improve the health of Londoners and it is under this remit that the London Assembly has carried out this investigation.

London is a world city, which is home to millions of people and welcomes many more millions of visitors every year. Making London a more attractive city to live in and visit is a priority for the GLA. The aim of this investigation has been to examine whether the current regulations regarding smoking in public places are fit for purpose and whether there is any scope for improvement. Throughout the Committee has endeavoured to balance the rights of smokers to enjoy a legal pastime, with the rights of others not to be exposed to harmful material in tobacco smoke.

The Committee would like to thank all those who gave evidence, both written and at our lively oral evidence sessions. We hope this report will add to the debate surrounding smoking in public places and provide a clear picture of the priority issues for London.

Jennette Arnold

The Smoking in Public Places Investigative Committee

The Smoking in Public Places Investigative Committee was established by the London Assembly in 2001. The following membership was agreed for the year 2001/02:

Jennette Arnold (Chair)	Labour
Angie Bray	Conservative
Louise Bloom	Liberal Democrat

The terms of reference of the Committee are as follows:

- To revisit existing scientific work on the damage to health from passive smoking and how it applies to public places in London, indoors, outdoors and in taxicabs.
- To review existing regulations (currently based on safety and hygiene) regarding smoking in public places, having regard to any current initiatives for change, and to consider the potential improvements for London.

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Executive Summary

This is the Report of the London Assembly's investigative committee on smoking in public places.

Our principal findings

The health risks of passive smoking

There has been much scientific research on the health risks of active smoking. More recent research on the effects of passive smoking has shown a link to lung cancer, heart disease and other illnesses. Many of these studies have concentrated on non-smokers who live with smokers. There has been, however, relatively little research into the effects of short term exposure to passive smoke, for example on people who go to a smoky pub or restaurant a couple of times per week. We believe that there is a need for more research into occasional exposure to environmental tobacco smoke (ETS).

We found that there is enough evidence for it to be understandable that some non-smokers are concerned about the dangers of exposure to environmental tobacco smoke. They should be free to make the necessary choices to protect their health. We do not argue that this means a ban on smoking in every public place. Policies will vary according to the function of place in question. We do, however, argue for the provision of choice. Where there are not to be total bans, non-smoking areas must be introduced wherever possible.

The health risks to children

We learned of the particular vulnerability of children to the health risks of passive smoking. Exposure to environmental tobacco smoke can lead to an increased risk of cot death, middle ear infection and asthma. We believe that there is a need for a public health education campaign to explain the dangers of passive smoking to the health of children.

Public awareness

There has been an increase in the number of smoke free public places over the past two decades. This has been coupled with an increase in awareness amongst the public of the dangers of passive smoking. However, there is still much to be done in informing and educating the public, especially the smoking public, on the dangers of environmental tobacco smoke. We found that people were more aware of the link between passive smoking and lung cancer than of the risks of heart disease. This is of concern as the risk of heart disease from passive smoking is higher than the risk of lung cancer. We recommend a public education campaign to increase awareness of the dangers of passive smoking.

Smoke free public places

The concept of smoke free public places is not a new one. Since the 1970s smoking has been restricted in aircraft, trains, buses, and more recently in some restaurants and pubs. We heard from the taxi associations who want the right to control smoking in their taxicabs. We agree. We believe that taxi drivers should have the right to prohibit smoking in their taxicabs if they so desire.

We also heard from the restaurant and pub trade associations who are encouraging their members to install superior ventilation equipment in their premises. There has been a rise in the number of restaurants and pubs that offer non-smoking areas. This has not been due to Government legislation, but rather consumer demand for more smoke free provisions. We call for all restaurants and pubs to have designated non-smoking areas, preferably with ventilation.

It is not only consumers who are concerned about exposure to environmental tobacco smoke. The people who work in smoky pubs and restaurants are exposed to high levels of ETS for long periods of time. This is of concern to the Committee and more research into this kind of passive smoking needs to be done.

In this report we discuss our views in full, explain our concerns, and make 16 detailed recommendations to the Government, the Mayor, the London Health Observatory, the London Health Commission, the Strategic Rail Authority and the hospitality industry.

1. Introduction

- 1.1 In a number of cities around the world there has in recent years been intense debate over the right to smoke in enclosed public spaces, and in many cases laws have been introduced to restrict or totally ban smoking in such places as bars and restaurants. Policies on smoking in public places are at the moment various and inconsistent across London. The establishment of the Greater London Authority with a duty to promote the health of Londoners is an opportunity to consider on a London-wide basis the public health issues involved.
- 1.2 The London Assembly agreed to set up an Investigative Committee to examine the scientific work on the damage to health from passive smoking and the potential benefits to London from an increase in the number of smoke free public places. We held five evidence sessions, hearing from health professionals and academics, representatives of the hospitality industry and of the tobacco industry, trade unions, as well as ASH and FOREST. We also received a considerable amount of written evidence. We are grateful to all those who gave evidence during this investigation.
- 1.3 In the subsequent chapters of this Report we discuss:
- The health risks of passive smoking
 - The health risks to children
 - Public awareness of the health risks of passive smoking
 - The provision of smoke free public places in London.

2. The health risks of passive smoking

- 2.1 Various arguments have been put forward to restrict smoking in public places. Some argue for restrictions to reduce the opportunities to smoke and thus, it is hoped, over time reduce the number of smokers. Another argument is simply the irritation and discomfort caused to some non-smokers from the inhalation of other people's cigarette smoke. In our investigation and in this Report, however, we concentrate on what we believe to be by far the most important consideration. Is there a significant health risk to non-smokers from passive smoking? In this section we examine the evidence put to us on the various health risks claimed to be related to passive smoking.

Cancer

- 2.2 The link between smoking and cancer was first mooted by scientists as far back as the 1920s, but was denied by the tobacco industry. However, during the 1950s and 1960s the link became irrefutable as an increasing number of scientific studies showed that smoking was a cause of cancer.¹ Government health warnings and public health campaigns have meant that smokers in the United Kingdom are for the most part aware that smoking is harmful to health.
- 2.3 The health risks of passive smoking have been studied more recently. In particular many scientific studies have measured the level of environmental tobacco smoke (ETS) that people are exposed to and the resultant increase in the risk of lung cancer. Tobacco smoke contains over 4,000 identified chemicals, some 60 of which are either known to be or are suspected of being carcinogenic.² In the late 1980s a number of reports were published by eminent scientific bodies that concluded that exposure to environmental tobacco smoke was a cause of lung cancer.³ Since then there has been further epidemiological research of the risk of lung cancer from passive smoking.
- 2.4 In particular, a paper published in the British Medical Journal in 1997 analysed 37 studies of lung cancer from passive smoking. The studies between them considered a total of 4,626 cases. This study looked at the relative risk of lung cancer in lifelong non-smokers according to whether the spouse currently smoked or had never smoked. This paper found that the "excess risk of lung

¹ Doll R. Tobacco: A Medical History, Journal of Urban Health. Bulletin of the New York Academy of Medicine, Vol 76, Issue 3. 1997.

² Memorandum – Action on Smoking and Health

³ (a) UK Department of Health and Social Security. Fourth report of the independent scientific committee on smoking and health. London: HMSO, 1988. (b) Australian National Health and Medical Research Council. Effects of passive smoking on health. Report of the NHMRC Working Party on the effects of passive smoking on health. Canberra: Australian Government Publishing Service, 1987. (c) US Department of Health and Human Services. The health consequences of involuntary smoking. A report of the surgeon general. Washington, DC: DHHS, 1986. (Publication No (PHS) 87-8398.). (d) US National Research Council. Environmental tobacco smoke: measuring exposures and assessing health effects. Washington, DC: National Academy Press, 1986

cancer was 24% in non-smokers who lived with a smoker.”⁴ This would mean that if the risk of getting lung cancer for a non-smoker in the general population was 10 per 100,000, an increase of 24% would equate to an extra 2.4 per 100,000. Therefore the risk of getting lung cancer for a non-smoker living with a smoker would be 12.4 per 100,000.⁵

- 2.5 The study concluded that the “epidemiological and biochemical evidence on exposure to environmental tobacco smoke, with the supporting evidence of tobacco specific carcinogens in the blood and urine of non-smokers exposed to environmental tobacco smoke, provides compelling confirmation that breathing other people’s tobacco smoke is a cause of lung cancer.”⁶
- 2.6 We heard evidence from Professor Konrad Jamrozik of Imperial College London, who considered that there was no doubt that compared to active smokers the individual non-smoker who was passively exposed had a much smaller extra risk of disease caused by smoking. Those who had never smoked but were exposed to passive smoke from their spouse had an increased risk of lung cancer of 25-30% compared to non-smokers who were not exposed to passive smoke, while smokers had an increased risk of 2,000%.⁷
- 2.7 We received a written submission from ASH where they stated: “Based on the findings of the SCOTH [UK Scientific Committee on Tobacco and Health] report and California EPA [Environmental Protection Agency] review ASH estimates that about 600 lung cancer deaths . . . in non-smokers can be attributed to passive smoking each year for the UK.”⁸
- 2.8 Professor Jamrozik advised the Committee that, when looking at public health policy it was important to consider the magnitude of the risk, the proportion of people exposed and the ethical issue of whether the risk was assumed involuntarily.⁹ We consider this to be a very useful formula in deciding what recommendations to make on smoking in public places.

Heart disease

- 2.9 We received a written submission from ASH, where they stated that studies in the early 1990s estimated that heart disease caused by passive smoking was the third leading preventable cause of death in the United States, ranking behind active smoking and alcohol abuse, and that non-smokers living with smokers had an increased risk of heart disease by around 30%.^{10 11 12}

⁴ Hackshaw AK, Law MR, Wald NJ. The accumulated evidence on lung cancer and environmental tobacco smoke. *British Medical Journal* 1997; 980-988

⁵ Memorandum – Professor Konrad Jamrozik

⁶ Hackshaw AK, Law MR, Wald NJ. The accumulated evidence on lung cancer and environmental tobacco smoke. *British Medical Journal* 1997; 980-988

⁷ Minutes of Evidence 21 November 2001 3.19

⁸ Memorandum – Action on Smoking and Health

⁹ Minutes of Evidence 21 November 2001 3.19

¹⁰ Memorandum – Action on Smoking and Health

¹¹ Glantz SA, Parmlev WW. Passive Smoking and heart disease epidemiology, physiology and biochemistry; *Circulation* 1991; 83: 1-12

¹² Glantz SA, Parmlev WW. Passive smoking and heart disease: mechanisms and risk; *JAMA* 1995; 273(13): 1047-1053

- 2.10 ASH went on to say that non-smokers exposed to passive smoke from their partners have around a 25% increased chance of contracting heart disease even though on average they inhale the equivalent of 1% of the smoke that a smoker does.¹³
- 2.11 A study published in the British Medical Journal found that: “people who have never smoked have an estimated 30% greater risk of ischaemic heart disease if they live with a smoker . . . This is surprisingly large – almost half the risk of smoking 20 cigarettes per day even though the exposure is only 1% of that of a smoker”.¹⁴
- 2.12 ASH said that this is a matter of concern. As over 40,000 active smokers die from heart related diseases each year in the UK as a result of smoking, the potential impact on non-smokers could be significant. This non-linear dose-response may be explained by the fact that small exposures to ETS cause the blood to thicken – a phenomenon known as platelet aggregation – and that the endothelium (the inner lining of arteries) seems to be particularly susceptible to tobacco smoke. Recent research has shown that even half an hour’s exposure to ETS by non-smokers is enough to adversely affect cells lining the coronary arteries. The dysfunction of these endothelial cells contributes towards the narrowing of the arteries and a reduction in blood flow.^{15 16}
- 2.13 ASH stated that an analysis of a large sample in the United States showed an elevated heart disease risk of around 20%. Given how widespread heart disease is in non-smokers, a 20% additional risk is very significant.¹⁷
- 2.14 ASH further stated that the London population is about 7.4 million compared to the US population of 262 million, so if there were the same per capita impact in London as in the United States, this study would suggest around 1,000 Londoners die of heart disease caused by passive smoking each year. The Californian Environmental Protection Agency gave substantially higher per capita figures, indicating that the 1,000 heart disease deaths attributable to ETS in London may be a conservative figure.¹⁸

Stroke

- 2.15 A stroke or brain attack occurs when a blood clot blocks a blood vessel or artery, or when a blood vessel breaks, interrupting blood flow to an area of the brain. When a brain attack occurs, it kills brain cells in the immediate area. This can result in paralysis, loss of speech or death.¹⁹

¹³ Law MR, Morris JK, Wald NJ. Environmental tobacco smoke exposure and ischaemic heart disease: an evaluation of the evidence. BMJ 1997; 315: 973-80

¹⁴ Law MR, Morris JK, Wald NJ. Environmental tobacco smoke exposure and ischaemic heart disease: an evaluation of the evidence. BMJ 1997; 315: 973-80

¹⁵ Callum C. The UK smoking epidemic: deaths in 1995; Health Education Authority; 1998

¹⁶ Otsuka R, Watanabe H, Hirata K et al. Acute effects of passive smoking on the coronary circulation in healthy young adults; JAMA 2001; 286(4):436-441

¹⁷ Steenland K, Thun M, Lally C, Heath C. Environmental Tobacco Smoke and Coronary Heart Disease in the American Cancer Society CPS-II Cohort, Circulation. 1996; 94: 622-628

¹⁸ Memorandum – Action on Smoking and Health

¹⁹ US National Stroke Association – <http://www.stroke.org/whats.cfm>

- 2.16 The Stroke Association stated in their submission that stroke was the nation's third biggest killer. Smoking is widely recognised as a significant risk factor for stroke.²⁰ The relative risk of stroke in heavy smokers was twice that of light smokers and the risk increased with the number of cigarettes smoked.²¹
- 2.17 They further stated that a link between passive smoking and stroke was established by researchers who found that exposure to environmental tobacco smoke significantly increases the risk of acute stroke among non-smokers or long-term ex-smokers in both men and women. The researchers concluded that "the major finding of an independent study of the increased risk of stroke associated with exposure to environmental tobacco smoke provides support for current efforts to reduce the prevalence of passive smoking and strengthens public health arguments against smoking."²²

Asthma

- 2.18 We received a written submission from the National Asthma Campaign. They explained that asthma is a long term condition that effects the respiratory system. People with asthma have airways that are almost always inflamed. Asthma symptoms include coughing, wheezing, a tight chest and getting short of breath. Several things, including tobacco smoke, can trigger these symptoms. In rare cases an asthma attack can be fatal.²³
- 2.19 The National Asthma Campaign went on to say, "The issue of second-hand smoke is a plain and simple one for Londoners with asthma. Whether it is in pubs or restaurants, at work, in shopping centres or in any other public place, if people with asthma are forced to breathe second-hand smoke the impact on their symptoms is clearly visible and often immediate."²⁴
- 2.20 Tobacco smoke is an extremely common trigger of asthma, causing difficulties for up to 80% of people with asthma. Indeed, the 1997 National Asthma Campaign members' survey found that almost 90% of those who responded wanted smoking banned in public places.²⁵

Exaggerated health risk?

- 2.21 The Committee heard from British American Tobacco (BAT), who stated that active smoking was a cause of various diseases, including lung cancer, coronary heart disease, emphysema and chronic bronchitis. BAT went on to say that there

²⁰ Memorandum – The Stroke Association

²¹ Wolf PA, D'Agostino RB, Kannel WB, Bonita R, Belanger AJ. Cigarette smoking as a risk factor for stroke. The Framingham Study. JAMA 1988; 259: 1025-9

²² Bonito R, Duncan J, Truelsen T, Jackson, RT, Beaglehole. Passive smoking as well as active smoking increases the risk of acute stroke. Tobacco Control 1999; 8: 156-160

²³ Memorandum – National Asthma Campaign

²⁴ Memorandum – National Asthma Campaign

²⁵ Memorandum – National Asthma Campaign

was “a dose response relationship, where the more smoke a person was exposed to the greater the risk”.²⁶

- 2.22 Chris Proctor of BAT said that, “the big scientific question was if what was known about active smoking could be extrapolated to passive smoking” and he advised that in their opinion early studies concluded that this was not the case. Chris Proctor explained that, “although the smoke active and passive smokers were exposed to was coming from the same place, the chemistry was varied in terms of the way the various substances in the smoke had their concentrations relative to one another”, and that, “non-smokers were exposed to a much lower amount of smoke than active smokers”.²⁷
- 2.23 BAT further stated that “the number of non-smokers who got lung cancer was very small compared to smokers and added that virtually all lung cancer cases were smokers”.²⁸ BAT stated that studies suggested that exposure to environmental tobacco smoke was greater in the home than in some work or leisure places. They said that a relative risk of 10 to 30 %, with a non-smoker lung cancer rate of 10 in 100,000, would mean an increase in incidence from 10 to 11 to 13 per 100,000. BAT went on to say that in their opinion any link between chronic diseases and ETS is too small to measure with any confidence. However BAT did say that data on young children is more suggestive of a variety of increased risks, such as childhood respiratory symptoms, sudden infant death syndrome and middle ear infections.²⁹
- 2.24 Dr Mark Britton of the British Lung Foundation reminded the Committee that it had taken some time to come to the conclusion that smoking caused lung cancer. He added that there was currently no absolute proof that passive smoking caused lung cancer that he was aware of. In his personal opinion there was a statistically increased risk from lung cancer if exposed to passive smoking.³⁰ Dr Britton later clarified that the British Lung Foundation was of the view that “careful assessment of the evidence indicates that passive smoking can cause lung cancer in non-smokers”.³¹
- 2.25 We heard from FOREST, a lobbying group that defends the interests of smokers, who stated that they did not agree that passive smoking was a significant health risk.³²

The health risks of passive smoking – some conclusions

- 2.26 The Committee has considered the arguments put forward by a number of health organisations and also the response of a major tobacco manufacturer. The Committee notes that it is not easy to prove the link between passive smoking and lung cancer. But the evidence suggests that there is a link. The Department of Health concluded that “long term exposure to environmental

²⁶ Minutes of Evidence 21 November 2001 3.2

²⁷ Minutes of Evidence 21 November 2001 3.3

²⁸ Minutes of Evidence 21 November 2001 3.3

²⁹ Memorandum – British American Tobacco

³⁰ Minutes of Evidence 14 November 2001 4.7

³¹ Memorandum – British Lung Foundation

³² Minutes of Evidence 5 December 2001 4.2

tobacco smoke is a cause of lung cancer".³³ The Committee also acknowledges that there is a risk of heart disease from ETS and that this risk could be higher.³⁴ The studies that these figures have been extrapolated from are based on ETS exposure in the home, where a non-smoker has been living with a smoker. This level of exposure is much higher than the occasional visit to a smoky pub or restaurant and that this should be borne in mind when considering any public policy recommendations.

- 2.27 The Committee considers that further scientific research needs to be done to examine the health risks to non-smokers who are only occasionally exposed to environmental tobacco smoke. For example non-smokers who do not cohabit with smokers, but perhaps visit smoky pubs and restaurants twice per week. Such research would provide a better estimate of the health risks of passive smoking to the general population.

Recommendation 1

The Committee recommends that the Government prioritise scientific research into the health risks of passive smoking from occasional exposure, in addition to passive smoking in the home.

- 2.28 It is clear that passive smoking affects the health of Londoners. It is therefore vital that such health bodies in London as the London Health Commission and the London Health Observatory establish a strategy on this issue, define targets and monitor progress against those targets.

Recommendation 2

The Committee recommends that the London Health Commission adopt a strategy to reduce levels of passive smoking in London and the London Health Observatory monitor developments against agreed objectives.

Recommendation 3

Although it is clear that more research is needed into the health impacts of passive smoking, there is enough evidence available for it to be understandable that some non-smokers are concerned at the dangers of exposure to environmental tobacco smoke. They should be free to make the necessary choices to protect their health. We do not argue that this means a ban on smoking in every public place. Policies will vary according to the function of place in question. We do argue, however, for the provision of choice. Where there are not to be total bans, non-smoking areas must be introduced wherever possible.

³³ Department of Health. Report of the Scientific Committee on Tobacco and Health. HMSO 1998

³⁴ Memorandum – Action on Smoking and Health

3. Health risks to children

- 3.1 ASH pointed out that young children are particularly vulnerable to the health impact of passive smoking. In a 1992 report the Royal College of Physicians estimated that 17,000 children under the age of five are admitted to hospital every year in the UK as a result of illnesses resulting from passive smoking.³⁵ This equated to over 2,000 children in London alone. During the last 25 years, numerous studies have concluded that environmental tobacco smoke increases the risk of various adverse health effects in children.³⁶

Cot death

- 3.2 ASH stated in their submission that there is a significant cause and effect relationship between passive smoking and cot death:³⁷ “Exposure of babies to tobacco smoke from other members of the household . . . after birth increases the risk of death: the greater the exposure the higher the risk”.³⁸ It is estimated that 80 cot deaths a year could be attributed to maternal smoking.³⁹ A report in the British Medical Journal suggested that the link between the two was so serious that “An appropriate public health message might be that smoking in the same environment as a pregnant mother or child is as unacceptable as drinking and driving”.⁴⁰

Middle ear infection

- 3.3 ASH stated that passive smoking increases the risk of Otitis Media and Recurrent Otitis Media (middle ear infection) in children aged under 7 by between 20-40%, especially in those children whose mothers smoked.⁴¹

Asthma

- 3.4 ASH stated in their submission that parental smoking in the presence of children is associated with an increased prevalence of asthma in school children and is a

³⁵ Royal College of Physicians. Smoking and the young: a report of a working party of the Royal College of Physicians; 1992

³⁶ Memorandum – Action on Smoking and Health

³⁷ (a) Department of Health. The Confidential Enquiry into Stillbirths and Deaths in Infancy. Third Annual Report for 1st January to December 1994; HMSO; 1996. (b) Blair PS, Fleming PJ, Bensley D, et al. Smoking and Sudden Infant Death Syndrome: results from 1993 – 5 case control study for confidential inquiry into still births and deaths in infancy; BMJ 1996; 313: 195-8

³⁸ Blair PS, Fleming PJ, Bensley D, et al. Smoking and Sudden Infant Death Syndrome: results from 1993 – 5 case control study for confidential inquiry into still births and deaths in infancy; BMJ 1996; 313: 195-8

³⁹ Dybing E, Sanner T. Passive smoking, sudden infant death syndrome (SIDS) and childhood infections; Hum Exp Toxicol 1999; 18(4): 202-205

⁴⁰ Blair PS, Fleming PJ, Bensley D, et al. Smoking and Sudden Infant Death Syndrome: results from 1993 – 5 case control study for confidential inquiry into still births and deaths in infancy; BMJ 1996; 313: 195-8

⁴¹ Memorandum – Action on Smoking and Health

significant risk factor for new cases in children who had never previously displayed asthmatic symptoms.⁴²

Public education

- 3.5 We heard evidence from British American Tobacco who said that the data available did not suggest that ETS was a cause of childhood asthma but acknowledged it could exacerbate the condition. The data on the effect of ETS on the respiratory system in children, with symptoms such as coughs, wheezes, bronchitis and middle ear syndrome, was conclusive enough to warrant public health education not to smoke around children, in particular young children. The data available indicated an increase in risk of sudden infant death syndrome from ETS, but that it had not been concluded if this was due to maternal smoking during pregnancy or exposure to ETS following the birth. British American Tobacco stated that the public health education message should be not to smoke when pregnant or around young children and to show courtesy to asthmatics.⁴³

Recommendation 4

The Committee recommends that the Department of Health through the NHS London Regional Office carry out a public education campaign to increase awareness of the dangers of passive smoking to the health of children.

⁴² Barber K, Mussin E, Taylor DK. Fetal exposure to involuntary maternal smoking and childhood respiratory disease; *Ann Allergy Asthma Immunol* 1996; 76(5); 427-430

⁴³ Minutes of Evidence 21 November 2001 3.6-3.7

4. Public awareness

Knowledge of the health risks

- 4.1 There is a growing public awareness that passive smoking is a health risk. The Office for National Statistics found that 80% of people surveyed thought that passive smoking would increase the risk of a non-smoker having lung cancer, bronchitis and asthma. An even greater percentage of people were aware of the health risks to children. 90% thought that a child's risk of getting chest infections was increased by passive smoking.⁴⁴
- 4.2 We heard evidence from the Consumers Association, who had carried out research on people's views and understanding of passive smoking. During the course of the research 927 face to face interviews were carried out, of these 33% were cigarette smokers, 41% had never smoked and 26% were ex-smokers. Of the respondents 75% considered that they were exposed to other people's smoke, 33% felt that they were regularly exposed to smoke at home and 20% considered that they were exposed to smoke at work.⁴⁵
- 4.3 Clara MacKay from the Consumers' Association said that, "62% of respondents were more worried about the health risks of passive smoking than the smell of smoke. 63% agreed that people shouldn't smoke round others. 68% believed that passive smoking was a serious health risk. 75% believed passive smoking increased the risk of lung cancer. 50% believed that passive smoking increased the risk of heart disease."⁴⁶

Behavioural attitudes

- 4.4 With an increasing knowledge of the risks of passive smoking there comes a change in behaviour. Even amongst smokers themselves, there has been a greater awareness that passive smoking poses a risk to others, especially children, and this affects smoking patterns. The Office for National Statistics found that 50% of smokers said that they would not smoke in the company of non-smokers and 34% said that they would smoke fewer cigarettes. Furthermore, 67% of smokers said that they would not smoke in front of a child and 25% said that they would smoke fewer cigarettes in the presence of a child.⁴⁷
- 4.5 The same survey showed that an increasing number of people want smoking restrictions in restaurants and pubs. In 1996, 85% of people wanted smoking restrictions in restaurants. By 2000, this figure had risen to 88%. The percentage of people who wanted smoking restrictions in pubs rose from 48% to 53%, and in other public places such as banks and post offices 82% to 86%.⁴⁸

⁴⁴ Smoking Related Behaviour and Attitudes, 2000. Office for National Statistics

⁴⁵ Minutes of Evidence 14 November 2001 4.28

⁴⁶ Minutes of Evidence 14 November 2001 4.28

⁴⁷ Smoking Related Behaviour and Attitudes, 2000. Office for National Statistics

⁴⁸ Smoking Related Behaviour and Attitudes, 2000. Office for National Statistics

- 4.6 The Consumers' Association found in their survey that 33% of respondents felt that it was acceptable to smoke around others. 93% believed it was irresponsible to smoke around children. 67% agreed with more government action to discourage smoking. 20% of smokers agreed on the need to ban smoking in all public places. 66% of non-smokers agreed on a ban on smoking in all public places. From their research the Consumers' Association concluded that some restrictions on smoking in public places might receive broad public support, particularly where children might be exposed to tobacco smoke.⁴⁹

Policy implications

- 4.7 We need to increase the public's awareness of the health risks of passive smoking. This is the most effective way to change behaviour. In particular we need to make smokers more aware of the effects their smoke can have on non-smokers in their vicinity. By educating smokers to make them more aware of the link between passive smoke and ill health, in particular children's illnesses, we could expect more self policing by responsible smokers.
- 4.8 It is clear that there is greater awareness of the dangers of passive smoking, but the Committee believes that more must be done. For example, there is inadequate understanding of the links to heart disease. The Committee considers that there needs to be more Government funded public health education on the risks of passive smoking. The risks of active smoking have been publicised over the years by various Government campaigns to encourage smokers to give up smoking.
- 4.9 The current Government is committed to a three year campaign costing almost £50m aimed at persuading smokers to quit and non-smokers, particularly children, not to start.⁵⁰ The only current Government smoking related health promotion is the "Don't give up giving up" campaign. The Committee welcomes this campaign as a step in the right direction. However this campaign is mainly focused on smokers giving up smoking for the sake of their own personal health. Passive smoking is only briefly mentioned on the "Giving up smoking" web site, where the health risks to smokers' families and friends are mentioned.⁵¹

Recommendation 5

The Committee recommends that the Department of Health through the NHS London Region Office fund a public education campaign to increase awareness of the dangers of passive smoking.

⁴⁹ Minutes of Evidence 14 November 2001 4.28

⁵⁰ Memorandum by the Department of Health. Tobacco industry and the health risks of smoking (TB1). House of Commons, Select Committee on Health, Minutes of Evidence. HMSO 14 January 2000

⁵¹ www.givingupsmoking.co.uk/employers/tec.htm

Recommendation 6

The Committee proposes that the London Health Commission, as part of its public health promotion in London, host a conference to disseminate the conclusions of this Report.

Recommendation 7

The Committee recommends that the London Assembly review the actions arising from this Report in 12 months time.

5. Smoke free public places

- 5.1 Public places were defined in evidence as places where people gather for leisure and social activities, although many of them are also places of work. Such places include casinos, cinemas, concert halls, conference centres, libraries, museums, pubs, passenger terminals, restaurants, sports clubs and theatres.⁵² We have concentrated on indoor public places rather than outdoor public places such as parks, due to the higher levels of environmental tobacco smoke that can occur indoors. Professor Stanton Glantz told the Committee that, “the levels of pollution were higher in indoor smoking areas than outside, even at locations next to busy roads”.⁵³
- 5.2 The concept of smoke free places is not a new one. The House of Commons led the way by banning smoking in the main chamber in 1693. Over the past three decades we have seen smoking restricted and then eventually banned in cinema auditoriums. Many of us can still remember the days when smoke used to waft across the cinema screen from the smoking side to the non-smoking side.
- 5.3 Another example in recent years has been the increasing restriction on smoking in aeroplanes. In the 1970s segregated areas on the aircraft were introduced, where smoke would drift into the non-smoking area. The late 1980s saw smoking banned by many airlines on short haul flights. In the early 1990s more operators moved over to a total ban of smoking on all their flights, including long haul. This has been due to a combination of Government legislation, the threat of litigation from airline staff and increased public demand.⁵⁴ The provision of more smoke free places appears to be a matter of natural progression as the smoking population declines. At the end of the second world war 65% of men and 41% of women smoked cigarettes in the UK.⁵⁵ Now less than 33% of people in the UK smoke.⁵⁶

Public Transport

- 5.4 It was not that long ago that there were carriages for smokers on the underground. It was as recently as 1984 that smoking was banned on all London Underground trains. In 1985 this was extended to tube stations below the surface. Following the Kings Cross fire in 1987, the smoking ban on the London Underground was extended throughout the network, including overground tube stations.⁵⁷
- 5.5 In 1991 smoking was banned on all London Transport buses providing a cleaner and healthier environment for all passengers. National Express, Britain’s largest coach company, followed suit in 1992, banning smoking on all of their coaches. Network South East, one of the old British Rail regions, banned smoking in

⁵² Memorandum – London Fire & Emergency Planning Authority

⁵³ Minutes of Evidence 26 July 2001 p.4

⁵⁴ R Rabin, S Sugarman. Regulating Tobacco. Oxford University Press. 2001

⁵⁵ Memorandum by the Department of Health. Tobacco industry and the health risks of smoking (TB1). House of Commons, Select Committee on Health, Minutes of Evidence. HMSO 14 January 2000

⁵⁶ Consumers’ Association (1988), The Big Stink, Health Which? December 1998, pp 8-11

⁵⁷ Memorandum – Action on Smoking and Health

1993. In a follow up survey in 1994, 85% of their customers approved of the smoking ban.⁵⁸ This shows that smoke free public transport is popular with both non-smokers and smokers. Smoking on London commuter trains has not been an issue for over seven years.

- 5.6 However the privatisation of British Rail has led to a hotch potch of rules and regulations where smoking is permitted on a few carriages by some rail operators, but totally banned by others. Smoking is still permitted at many over ground rail stations. This is of particular importance to London as so much of the national rail network runs through the capital. The Committee considers that there needs to be some consistency on smoking policies on the national rail networks. This is an issue that the Government and the Strategic Rail Authority need to address.

Recommendation 8

We recommend that the Government and the Strategic Rail Authority establish a unified smoking policy on the national rail networks.

- 5.7 It is strange that whilst buses and tubes are smoke free, taxis are not. Many non-smoking taxi drivers have been placing "please do not smoke" signs in their taxi cabs for the past few years. However this is a request rather than mandatory. This is beneficial for the driver as well as the non-smoking passenger, who may otherwise get into a cab where smoke had lingered from a previous smoking passenger.
- 5.8 We heard evidence from Geof Kaley, of the Joint Radio Taxi Association who represent over a third of all London black taxicabs. The taxi association have proposed that cabs should have suitable exterior signage displaying whether they were smoking or non-smoking cabs and that when people telephoned for a radio cab they would have the choice of which type of cab they required. He said that "non-smoking customers often did not like getting into a cab if the previous customer had been smoking."⁵⁹
- 5.9 Geof Kaley thought "the policy of drivers deciding if their cabs were to be smoking or non-smoking made sense." He added that "of all the complicated arguments surrounding smoking restrictions this was the one area where a solution which would benefit all parties could be found quickly".⁶⁰
- 5.10 Geof Kaley added that "he was directly representing 9,000 taxi drivers and felt that he was also representing all the industry as there was no disagreement over the policy he was proposing". He went on to say that this policy "would benefit the customer as well as the driver".⁶¹ The Committee were advised by Geof Kaley that the Mayor was the regulator for London Taxis. However, a change in primary legislation would be required to allow taxi drivers to ban smoking in their taxicabs. The Committee considers that it is right and proper that taxi

⁵⁸ Memorandum – Action on Smoking and Health

⁵⁹ Minutes of Evidence 21 November 2001 3.41

⁶⁰ Minutes of Evidence 21 November 2001 3.41

⁶¹ Minutes of Evidence 21 November 2001 3.41

drivers should have the right to choose whether their taxi is smoking or non-smoking.

Recommendation 9

The Committee strongly believes that taxi drivers should if they wish be able to prohibit smoking in their taxicabs. We recommend that the Mayor seek legislative changes that would allow him to enable taxi drivers to ban smoking from their taxicabs.

Restaurants & Pubs

- 5.11 The demand for smoking restrictions in restaurants has grown. SmokeFree London, an alliance of London's health authorities and other agencies, commissioned a survey of nearly 10,000 Londoners views on smoking in public places. 97% of all those interviewed thought there should be restrictions on smoking in restaurants. Indeed 94% of the smokers interviewed thought there should be such restrictions.⁶² So there is strong public demand from both smokers and non-smokers for segregated non-smoking and smoking areas in restaurants.
- 5.12 The Consumers' Association carried out some research recently on smoke free dining. They found that it took two attempts on average to book a non-smoking table and that most restaurants did not ask whether customers would prefer a smoking or non-smoking table. Only 10% had signs outside and only 30% had signs inside to show their smoking policy.⁶³
- 5.13 Clearly there is some difference between what the public wants and what is being provided. There is great consumer demand for smoking restrictions in restaurants, but the restaurant industry is only slowly starting to cater for this need.
- 5.14 The Committee is aware that more restaurants are gradually responding to the growing public demand for smoke free environments.⁶⁴ Many people, including smokers, prefer to eat their meal in a smoke free environment.⁶⁵ This movement towards a higher number of smoke free restaurants is welcomed and should be encouraged. We would like to see the majority of London restaurants catering for both non-smokers and smokers by having segregated non-smoking and smoking areas. Ideally, new premises should have these areas separated physically by a wall.
- 5.15 The number of non-smoking sections in pubs has also grown considerably in the past decade. Once inconceivable that smoking should be restricted in the traditional British pub, it is now something that 22% of people consider when

⁶² BMRB International Ltd (2001). A survey of London residents. SmokeFree London (sflondon@doh.gsi.gov.uk)

⁶³ Consumers' Association. Smoke free dining. Health Which? June 2001

⁶⁴ Memorandum – The Restaurant Association

⁶⁵ BMRB International Ltd (2001). A survey of London residents. Smoke Free London (sflondon@doh.gsi.gov.uk)

choosing which pub to visit.⁶⁶ The Committee is also aware that increasing numbers of pubs in the London area, especially pub chains, have non-smoking areas. These types of pubs have become popular and have grown considerably during the past decade. They have catered for new niches in the market by offering meals in a non-smoking area and also tea and coffee. In 1993 the JD Wetherspoon pub chain created non-smoking areas in all their 50 pubs.⁶⁷ Since then their chain has grown to over 300 pubs. This is an indication of public demand for more non-smoking areas in pubs.

5.16 We heard evidence from the Charter Group, who represent the various pub and restaurant trade associations, on issues related to smoking in public places. The Charter Group recognised non-smoking as the national norm and had addressed the issue on this basis. The Charter Group stated to the Committee that they had looked at policy choices together with appropriate signage and ventilation. Nick Bish of the Charter Group explained that the Public Places Charter aimed for outlets to formalise and communicate their smoking policy through external signage.⁶⁸ The Charter Group is encouraging its members to tackle the issue of smoking at their leisure venues and comply with the industry's own voluntary Public Places Charter on smoking (the Charter).⁶⁹

5.17 The founder members of the Charter Group agreed the Public Places Charter on smoking with the Department of Health, following the Government "Smoking Kills" White Paper in 1998. The Charter laid down six objectives.⁷⁰ These are as follows:

- to produce a written policy on smoking, available to customers and staff [for each outlet].
- implementation of good practice through non-smoking areas, air cleaning and ventilation, as appropriate and whenever practicable.
- communication to customers through external signage to an agreed format and appropriate internal signs.
- implementation on a rolling basis over a number of years, informed by an initial assessment of the current position, internal monitoring and subsequent independent research to monitor progress.
- recognition of smoking policies as a management responsibility to be reflected in general training, qualification and supervision.
- support for shared expertise and guidance on commercial and technical benefits of smoking policies and air cleaning.

5.18 The Charter Group agreed to implement the following targets for the public house sector by January 2003:⁷¹

⁶⁶ Smoking Related Behaviour and Attitudes, 2000. Office for National Statistics

⁶⁷ Memorandum – Action on Smoking and Health

⁶⁸ Minutes of Evidence 17 October 2001 p.2

⁶⁹ Memorandum – The Charter Group

⁷⁰ Memorandum – The Charter Group

⁷¹ Minutes of Evidence 17 October 2001 p.2 & Memorandum – British Beer and Pub Association

- 100% of companies, and 90% of licensee will be aware of the Public Places Charter.
 - 50% of public houses will have written smoking policies available to both staff and customers.
 - 50% of public houses will display both external and internal signage on smoking.
 - 35% of public houses will provide designated smoking and no smoking areas and/or be ventilated to the minimum standards (as defined below).
- 5.19 “The aim of the Charter has been to provide customers with additional information to allow them to select venues to visit that have the facilities that they prefer – and specifically those with cleaner air delivered through smoking restrictions and/or superior ventilation. It was believed that customer pressure for better facilities would lead to a progressive upgrading of venues with poorer air quality in a flexible manner reflecting their own circumstances and conditions.”⁷²
- 5.20 The Charter provides standardised national signage for pubs and restaurants to show what kind of arrangements they have for smoking and non-smoking customers. This varies from smoking allowed throughout, to separate non-smoking and smoking areas with ventilation.⁷³
- 5.21 We heard from Rita King of the British Beer and Pub Association who represent over 35,000 of the UK’s 60,000 pubs. She said that they had conducted a survey of nearly 40,000 pubs, “the results showed that about 27% signed up to the Charter, and that of these 27%, around 30% had proper ventilated non-smoking areas.”⁷⁴ This means that around 9% of the pubs that are Charter signatories have non-smoking areas.
- 5.22 The Committee is concerned about two factors – the low standards embodied in the Charter, and the low levels of current compliance with the Charter within the industry. We deal with the issue of standards further on in this Report, at paragraph 5.27. On compliance, we are disappointed with the current low rates both of Charter membership and compliance. We would like to see a greater effort by the industry in both areas.

⁷² Memorandum – The Charter Group

⁷³ Memorandum – The Charter Group

⁷⁴ Minutes of Evidence 14 November 2001 4.21

Recommendation 10

The Committee welcomes the hospitality industry's voluntary Charter on smoking in public places. There are as yet, however, far too few signatories and low compliance. There must be a concerted campaign in London by the hospitality industry, supported by the Greater London Authority and the London Health Commission, to achieve 100% Charter membership and compliance. This is the only way the voluntary approach will retain credibility.

Ventilation and non-smoking areas

- 5.23 The Charter Group stated that they believed that there were solutions to environmental tobacco smoke other than banning smoking in public places and that the best of these solutions was ventilation.⁷⁵
- 5.24 Georgina Wald of the British Institute of Innkeeping said that, "the public wanted cleaner air and that the industry was taking steps to meet this, however people also wanted to go out in mixed groups of smokers and non-smokers and that ventilation provided a solution."⁷⁶
- 5.25 However, there was some disagreement over the effectiveness of ventilation systems. The Committee heard from Joanna Carrington a researcher from Manchester Metropolitan University, who had studied the effectiveness of non-smoking areas in 60 pubs in Manchester. Some of these pubs had ventilation systems fitted. She found that ventilation did not appear to reduce the environmental tobacco smoke compounds measured.⁷⁷
- 5.26 The Committee also heard from Vent-Axia Limited a leading manufacturer of ventilation equipment. Don Spearman, their Products Director, said that he was "confident to state that ventilation equipment removed the health risk from environmental tobacco smoke in separate areas but when there were smokers and non-smokers in the same area he could not say."⁷⁸ Don Spearman also suggested that in his opinion a standard should be introduced regarding ventilation equipment, as under the present Public Places Charter it was possible to put a fan in the window and comply.⁷⁹
- 5.27 The Committee heard that The Charter Group had agreed with the Department of Health to meet the following targets by January 2003: 50% of pubs with policies and signage, 35% of these ventilated and/or with smoking restrictions.⁸⁰

⁷⁵ Minutes of Evidence 17 October 2001 p.3

⁷⁶ Minutes of Evidence 17 October 2001 p.4

⁷⁷ Minutes of Evidence 17 October 2001 p.6

⁷⁸ Minutes of Evidence 5 December 2001 4.17

⁷⁹ Minutes of Evidence 5 December 2001 4.16

⁸⁰ Minutes of Evidence 17 October 2001 p.2

Recommendation 11

The Committee recommends that there should be an approved standard of ventilation in the Public Places Charter, to include the regular and independent checking of equipment.

Recommendation 12

The Committee recommends that the Government should fund further research into the effectiveness of ventilation in removing environmental tobacco smoke from pubs and restaurants.

Recommendation 13

The Committee recommends that the Government should consider granting tax incentives to encourage small businesses to install ventilation equipment if research demonstrates that ventilation is effective in removing the toxins in tobacco smoke.

- 5.28 The Charter requires hospitality venue operators to implement a formal smoking policy and to display appropriate signage on the outside of the premises. The policy options are “smoking allowed throughout”, “separate areas”, “no smoking”, “ventilated premises smoking allowed throughout” and “ventilated premises – separate areas”. The ventilation standard was set at a minimum rate of 30 cubic metres per occupant per hour.⁸¹ The current Charter target of 35% of pubs having non-smoking areas by January 2003 is in our view too unambitious. We would like to see all venues achieving at least non-smoking areas or ventilated non-smoking areas.

Recommendation 14

The Committee recommends that the Public Places Charter should be amended to require all Charter signatories’ premises to have non-smoking areas, preferably ventilated, within 12 months of joining.

Protection for workers

- 5.29 Most work places do not now permit smoking in them and some have a separate smoking room allocated for smokers to use when on breaks. However not all workers are employed in an office environment. Many people are employed in pubs and restaurants. These employees often have little escape from the tobacco smoke that engulfs them. So the issue of smoking restrictions in pubs and restaurants is not just one of consumer choice and customer health, but also the health of the employees who work in these establishments.
- 5.30 We heard evidence from Professor Martin Jarvis of University College London, who had conducted a recent study into the exposure of London bar staff to

⁸¹ Memorandum –Atmosphere Improves Results

environmental tobacco smoke (ETS). The researchers had visited pubs in central and inner-suburban London during the first week of September 2001. Those bar staff who stated that they were non-smokers or ex-smokers were invited to supply a saliva specimen by sucking on a cotton wool dental roll for a few minutes. These specimens were then frozen within 2 or 3 hours and tested for the presence of cotinine.⁸²

- 5.31 The Committee heard from Professor Jarvis that cotinine in itself was inert, but was used as an indicator of nicotine, which in turn was an indicator of the presence of the other toxins present in tobacco smoke. The concentration of cotinine in the saliva of non-smokers provided an accurate quantitative guide to the extent of their exposure to nicotine from other people's tobacco smoke. Professor Jarvis stated that his findings confirmed that non-smokers working behind the bars in pubs were in an occupational group with extremely high exposure to other people's tobacco smoke and that the average exposure in this group was much higher than non-smokers in general or non-smokers with partners who smoked.⁸³
- 5.32 Many bar staff are non-smokers and yet are exposed to very high levels of environmental tobacco smoke, often for up to 8-10 hours per day. We heard evidence from the GMB who had conducted a survey of its 5,000 London members employed as bar staff and croupiers. We recognise that adults make informed choices of where they work. However, the results of this survey clearly showed that these people have real concerns about exposure to tobacco smoke, and that they were suffering from eye complaints, chest complaints and breathing difficulties. Paul Kenny of the GMB said that "Many staff had their work stations around 12 inches from customers who were smoking, many of the rooms they worked in had no natural ventilation and staff had to work in these conditions for 8-10 hours with small breaks".⁸⁴
- 5.33 The Committee asked Georgina Wald of the British Institute of Innkeeping what could be done to protect staff from the effects of environmental tobacco smoke. She said that the BII were happy to disperse information on environmental tobacco smoke to its members and to produce best practice notes.⁸⁵ We welcome this commitment and would like to see this happen in all pubs and restaurants.

Recommendation 15

The Committee recommends that the Charter Group distribute information on the health risks of passive smoking to bar and restaurant staff.

- 5.34 We also heard from Owen Tudor of the TUC who were concerned that the hospitality industry's own voluntary approach, as reflected in the Public Places Charter, would not deliver the changes necessary to protect workers in these industries. The number of pubs taking up the Charter, at under 30%, was not a good indicator of the success of the voluntary approach, particularly as, a

⁸² Minutes of Evidence 5 December 2001 4.19

⁸³ Minutes of Evidence 5 December 2001 4.19-4.20

⁸⁴ Minutes of Evidence 21 November 2001 3.27

⁸⁵ Minutes of Evidence 17 October 2001 p.4

minimum requirement, a pub only needed to put up a sign to say smoking was allowed throughout to comply with the Charter.⁸⁶

- 5.35 In 1999 the Health and Safety Executive (HSE) published the draft Approved Code of Practice on passive smoking at work (ACOP). This was part of a consultation process by the HSE on smoking in the work place. The Health and Safety Commission (HSC), a consultative body including business and trade union representatives, then reviewed this and approved a revised ACOP. The HSC then recommended it to the Government in 2000 for implementation.⁸⁷
- 5.36 The Health and Safety Commission also decided to recommend, in recognition of the particular challenges faced by parts of the hospitality industry, that where the Public Places Charter applies, compliance with this will count as complying with the ACOP for two years, after which compliance with the ACOP would be expected.⁸⁸
- 5.37 The Health and Safety Commission Chair Bill Callaghan commented, “I would stress that the code should not be viewed as a draconian measure, that will prevent smokers enjoying a cigarette in their local pub or club. We are not proposing a ban on smoking in workplaces. It is rather a recognition of the need to protect those workers exposed to environmental tobacco smoke and to build on existing good practice.”⁸⁹
- 5.38 The HSE stated that, “The ACOP would give authoritative guidance on employers’ obligations under health, safety, and welfare law regarding passive smoking at work. This Code would have special legal force, similar to that of the Highway Code. Failing to follow the Code would not be an offence in itself, but an employer will need to demonstrate that equally effective methods have been adopted to signal compliance with the law.”⁹⁰
- 5.39 The HSE state that “In the light of the code, employers should determine what is the most reasonably practical way of controlling environmental tobacco smoke. That will necessitate a number of responses: perhaps banning smoke in the workplace, either completely or partially; perhaps enabling the physical segregation of non smokers from tobacco smoke, providing adequate ventilation, or perhaps implementing a system of work that reduces the time an employee is exposed to environmental tobacco smoke”.⁹¹
- 5.40 The HSE offered further guidance, “Should a complete or partial ban not be viable, perhaps because there is a common area where clients or customers have been given leave to choose to smoke, employers should take one or more measures. They may physically segregate employees from environmental tobacco smoke for example. Where that is not reasonably practical they should ensure that the workplace is adequately ventilated. Where that is not practically

⁸⁶ Minutes of Evidence 21 November 2001 3.28

⁸⁷ Memorandum – Health and Safety Executive

⁸⁸ Memorandum – Health and Safety Executive

⁸⁹ Memorandum – Health and Safety Executive

⁹⁰ Memorandum – Health and Safety Executive

⁹¹ Memorandum – Health and Safety Executive

achievable they should implement a system of work that ensures that employee exposure to environmental tobacco smoke is reduced".⁹²

- 5.41 We asked the Secretary of State for Transport, Local Government and the Regions, Stephen Byers MP, what was the reason for the delay in the implementation of the ACOP. His response was that the Government was still considering further consultation on the ACOP.⁹³

Recommendation 16

We recommend that the Government re-examine the Approved Code of Practice without further delay. It is unacceptable that the Government has not yet implemented a code of practice. Workers need protection from excessive exposure to environmental tobacco smoke. The Government should ensure that any code of practice agreed is clear and practicable.

⁹² Memorandum – Health and Safety Executive

⁹³ Memorandum – Secretary of State, Department for Transport, Local Government, and the Regions

Annex A: Recommendations

The health risks of passive smoking

1. The Committee recommends that the Government prioritise scientific research into the health risks of passive smoking from occasional exposure, in addition to passive smoking in the home. (paragraph 2.27)
2. The Committee recommends that the London Health Commission adopt a strategy to reduce levels of passive smoking in London and the London Health Observatory monitor developments against agreed objectives. (paragraph 2.28)
3. Although it is clear that more research is needed into the health impacts of passive smoking, there is enough evidence available for it to be understandable that some non-smokers are concerned at the dangers of exposure to environmental tobacco smoke. They should be free to make the necessary choices to protect their health. We do not argue that this means a ban on smoking in every public place. Policies will vary according to the function of place in question. We do argue, however, for the provision of choice. Where there are not to be total bans, non-smoking areas must be introduced wherever possible. (paragraph 2.28)

The health risks to children

4. The Committee recommends that the Department of Health through the NHS London Regional Office carry out a public education campaign to increase awareness of the dangers of passive smoking to the health of children. (paragraph 3.5)

Public awareness

5. The Committee recommends that the Department of Health through the NHS London Region Office fund a public education campaign to increase awareness of the dangers of passive smoking. (paragraph 4.9)
6. The Committee proposes that the London Health Commission, as part of its public health promotion in London, host a conference to disseminate the conclusions of this Report. (paragraph 4.9)
7. The Committee recommends that the London Assembly review the actions arising from this Report in 12 months time. (paragraph 4.9)

Smoke free public places

8. We recommend that the Government and the Strategic Rail Authority establish a unified smoking policy on the national rail networks. (paragraph 5.6)
9. The Committee strongly believes that taxi drivers should if they wish be able to prohibit smoking in their taxicabs. We recommend that the Mayor seek legislative changes that would allow him to enable taxi drivers to ban smoking from their taxicabs. (paragraph 5.10)
10. The Committee welcomes the hospitality industry's voluntary Charter on smoking in public places. There are as yet, however, far too few signatories and low compliance. There must be a concerted campaign in London by the hospitality industry, supported by the Greater London Authority and the London Health Commission, to achieve 100% Charter membership and compliance. This is the only way the voluntary approach will retain credibility. (paragraph 5.22)
11. The Committee recommends that there should be an approved standard of ventilation in the Public Places Charter, to include the regular and independent checking of equipment. (paragraph 5.27)
12. The Committee recommends that the Government should fund further research into the effectiveness of ventilation in removing environmental tobacco smoke from pubs and restaurants. (paragraph 5.27)
13. The Committee recommends that the Government should consider granting tax incentives to encourage small businesses to install ventilation equipment if research demonstrates that ventilation is effective in removing the toxins in tobacco smoke. (paragraph 5.27)
14. The Committee recommends that the Public Places Charter should be amended to require that all Charter signatories' premises have non-smoking areas, preferably ventilated, within 12 months of joining. (paragraph 5.28)
15. The Committee recommends that the Charter Group distribute information on the health risks of passive smoking to bar and restaurant staff. (paragraph 5.33)
16. We recommend that the Government re-examine the Approved Code of Practice without further delay. It is unacceptable that the Government has not yet implemented a code of practice. Workers need protection from excessive exposure to environmental tobacco smoke. The Government should ensure that any code of practice agreed is clear and practicable. (paragraph 5.41)

Annex B: Evidentiary hearings and expert witnesses

The following expert witnesses appeared before the Committee:

Evidentiary Hearing 1, 26 July 2001

Witnesses:

Professor Stanton Glantz – University of California, School of Medicine

Evidentiary Hearing 2, 17 October 2001

Witnesses:

Nick Bish – Chairman of the Charter Group & Chief Executive of the Association of Licensed Multiple Retailers

Georgina Wald – Public Relations Manager, British Institute of Innkeeping

Clive Bates – Director of Action on Smoking and Health (ASH)

Joanna Carrington – Researcher, Manchester Metropolitan University, Department of Environmental and Geographical Sciences

Evidentiary Hearing 3, 14 November 2001

Witnesses:

Dr Mark Britton – Chairman of the British Lung Foundation

Michelle Di Leo – Head of Public Affairs, British Lung Foundation

Dr Martin Rawlings – Director of the British Beer & Pub Association

Rita King – Deputy Director of the British Beer & Pub Association

Clara MacKay – Principal Policy Advisor on Health, Consumers' Association

Evidentiary Hearing 4, 21 November 2001

Witnesses:

Chris Proctor – Head of Science and Regulation, British American Tobacco

Paul Kenny – Regional Secretary, London Region, GMB

Owen Tudor – Senior Policy Officer, Trade Union Congress

Professor Konrad Jamrozik – Imperial College London, Department of Epidemiology and Public Health

Geof Kaley – Chairman, Computer Cab and Member of the Joint Radio Taxi Association

Evidentiary Hearing 5, 5 December 2001

Witnesses:

Simon Clark – Director of the Freedom Organisation for the Right to Enjoy Smoking Tobacco (FOREST)

Don Spearman – Products Director, Vent-Axia Limited

Professor Martin Jarvis – University College London, Department of Epidemiology and Public Health

Jean King – Director of Education and Funding, Cancer Research Campaign

Annex C: Written evidence

Written evidence was received from the following organisations and individuals:

Action on Smoking and Health (ASH)
Atmosphere Improves Results (AIR)
Air Care 1 Ltd
Allen Carr's Easyway (International) Ltd
British American Tobacco
British Beer & Pub Association
British Heart Foundation
British Institute of Innkeeping
British Lung Foundation
British Medical Association
British Thoracic Society
Professor John Britton – University of Nottingham, Faculty of Medicine & Health Sciences
Restaurant Association
Business in Sport and Leisure Ltd
Cancer Research Campaign
Joanna Carrington - Manchester Metropolitan University, Dept of Environmental & Geographical Sciences
Charter Group
Computer Cab plc
Consumers' Association
Professor John Copas – University of Warwick, Department of Statistics
Cystic Fibrosis Trust
Department of Transport, Local Government and the Regions
Professor Richard Doll – University of Oxford, Nuffield Department of Clinical Medicine
Foundation for the Study of Infant Deaths (FSID)
Freedom Organisation for the Right to Enjoy Smoking Tobacco (FOREST)
Professor Stanton Glantz - University of California, School of Medicine
Glendola Leisure Limited
GMB
Guild of Master Victuallers
Health & Safety Executive
Joint Radio Taxi Association
Kleenair Group
London Borough of Hackney
London Borough of Harrow
London Borough of Lambeth
London Borough of Richmond
London Borough of Southwark
London Borough of Tower Hamlets
London Fire & Emergency Planning Authority (LFEPA)
London Health Commission
London Health Observatory
London School of Hygiene & Tropical Medicine, University of London
Musicians' Union
National Asthma Campaign

NHS London Regional Office
Royal Colleges of Physicians of the United Kingdom, Faculty of Public Health Medicine
Smoke Free London
Stroke Association
Thorley Taverns Ltd
Tobacco Manufacturers' Association
Tobacco Workers' Alliance
Transport & General Workers Union (TGWU)
Unique Pub Co
Vent Axia Ltd
Young & Co's Brewery Plc

Annex D: Orders and translations

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यदि आप या किसी आपके ज्ञान में हैं, आप चाहें तो इस प्रतिवेदन के सारांश और मुख्य निष्कर्षों का बड़ा अक्षर या ब्रैल में प्रतिलिपि प्राप्त करना चाहें। यदि आप हमसे संपर्क करना चाहें तो हमें 020 7983 4100 पर फोन करें या ईमेल करें assembly.translations@london.gov.uk। हमें यह बताना होगा:

Si usted o algún conocido, quiere recibir copia del resumen ejecutivo y las recomendaciones relativas a este informe en forma de Braille, en su propia idioma, y gratis, no duden en ponerse en contacto con nosotros marcando 020 7983 4100 o por correo electrónico: assembly.translations@london.gov.uk

اگر آپ یا آپ کے کوئی جاننے والا اس رپورٹ کے خلاصہ اور اس کے سفارشات کی ایک بڑی پرنٹ میں یا بڑی پرنٹ یا اپنی زبان میں براہ معذرتہ عمل کرنا چاہیں تو براہ کرم ہم سے فون 020 7983 4100 پر رابطہ کریں یا assembly.translations@london.gov.uk پر ای میل کریں۔

Ta ba ri eniken ti o ba ni ife lati ni eda ewe nla ti igbimo awon asoju tabi papa julo ni ede ti abinibi won, ki o kansuwa lori ero ibanisoro. Nomba wa ni 020 7983 4100 tabi ki e kan si wa lori ero assembly.translations@london.gov.uk. Ako ni gbawa lowo yin fun eto yi.

Haddii adiga, ama qof aad taqanid, oo duqanayn xudu ku helu knohi ah warihiyinta oo knohat iyo talooyinka fari wariweyn ama farta qofka indidaha la' looga talagalay, ama luuqadoeda oo helaash u ah, fadlan tagala soo xiriir telefoonka 020 7983 4100 ama email-ka rinwaxan ku yabay assembly.translations@london.gov.uk.

Annex E: Scrutiny principles

The powers of the London Assembly include power to investigate and report on decisions and actions of the Mayor, or on matters relating to the principal purposes of the Greater London Authority, and on any other matters which the Assembly considers to be of importance to Londoners. In the conduct of scrutiny and investigation the Assembly abides by a number of principles.

Scrutinies:

- aim to recommend action to achieve improvements;
- are conducted with objectivity and independence;
- examine all aspects of the Mayor's strategies;
- consult widely, having regard to issues of timeliness and cost;
- are conducted in a constructive and positive manner; and
- are conducted with an awareness of the need to spend taxpayers money wisely and well.

More information about the scrutiny work of the London Assembly, including published reports, details of committee meetings and contact information, can be found on the GLA website at www.london.gov.uk/assembly

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