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Transport Committee

Drink and drug driving law

First Report of Session 2010–11

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Report, together with formal minutes, oral and written evidence

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Report

Summary

The previous Government appointed Sir Peter North in December 2009 to conduct an independent review of the law on drink and drug driving in Great Britain. His report was published in June 2010 and we undertook an inquiry into his most high-profile recommendations.

Drink driving

While we agree that medical and statistical evidence supports a reduction in the current drink drive limit of 80mg alcohol per 100ml blood, we note that currently 2% of drivers killed in road accidents have a blood alcohol concentration (BAC) between 50mg/100ml and 80mg/100ml, while 18% have a BAC greater than 80mg. We recommend that the police should have an additional power to enable preliminary breath tests to be required and administered in the course of a designated drink drive enforcement operation.

We are concerned that a reduction in the limit to 50mg/100ml would send out a mixed message with the Government's official advice to not drink and drive at all, particularly in light of the strong evidence of public uncertainty about what constitutes a "legal drink". In the long term, we believe that the Government should aim for an "effectively zero" limit of 20mg/100ml but we acknowledge that is too great a step at this stage. Instead of an "interim" reduction to 50mg/100ml, the Government should concentrate on working with individual police forces to achieve a stricter enforcement of the current limit and beginning a public education campaign to help achieve public acceptance of a 20mg/100ml limit.

We support the retention of the current minimum penalty of 12-month mandatory disqualification.

Drug driving

The Government should adopt a five-year strategy to tackle drug driving, so that it is as important a road safety priority as combating drink driving. This should include a high-profile advertising campaign, in particular on the consequences of being caught and convicted of the crime.

The police currently lack the ability to enforce drug driving legislation effectively, which accounts for the low conviction rate. We welcome the Government's commitment to install drug screening devices in every police station by 2012; the medium-term aim should be to develop and type-approve a drug screening device for use at the roadside.

Unlike with drink driving, there is no objective test for impaired driving due to drugs, no legal definition of impairment in the Road Traffic Act, and no offence of driving in breach of prescribed limits of specific drugs. We favour the adoption of a "zero-tolerance" offence for illegal drugs which are known to impair driving, which are widely misused, including among drivers, and which represent a substantial part of the drug driving problem.

1 Introduction

Background

1. The introduction of a legal limit on the level of alcohol in a driver's blood supply in 1967 was a milestone in the history of road safety policy. The legislation also gave police officers the ability to enforce the new law through the introduction of the preliminary breath test (more commonly known as the 'breathalyser'). That year there were 1,640 deaths associated with drink-driving, nearly a quarter (22%) of the total of 7,319 road deaths. Since then, social attitudes and cultural norms about drinking and driving have changed markedly. High-profile advertising campaigns, combined with measures by the pub, restaurant and hospitality industries, have raised public awareness about the risks of drink driving. Police enforcement strategies, developments in technology and effective enforcement of heavy penalties helped increase the number of successful drink driving prosecutions. There has been a reduction in the number of drink-driving deaths since the late 1960s. In 2008 there were 400 drink driving deaths (16% of the total of 2,538 road deaths), less than a quarter of the number in 1967.[1] Given that motor vehicle traffic has trebled during this period, the drink driving regime—and road safety generally—can be considered as areas of public policy success.

2. Yet drink driving is a preventable activity and the number of deaths it causes on our roads remains high. On average, at least one person dies every day when a driver of a vehicle has consumed more alcohol than legally permitted. In many cases the drunk-driver is killed, a sad and avoidable waste of life in itself. But drink driving also causes untold sadness for families and loved ones. Too often, we hear tragic news of innocent people—other road users, accompanying passengers, pedestrians—killed or seriously injured in an accident involving somebody driving a motor vehicle whilst over the limit. Almost half (46%) of fatal drink drive accidents involve other vehicles and drivers who, themselves, were not over the limit. The Department for Transport has estimated that the prevention of those drink drive accidents which resulted in reported injuries in 2008 would have saved around £1.2 billion,[2] taking no account of those accidents that resulted in damage alone.

3. Whereas the development of drink driving policy has been helped by the considerable wealth of evidence accumulated on the subject over the past 50 years, the position with drug driving is very different. Indeed, in some ways, the current situation with drug driving mirrors that of drink driving in the mid-1960s. The evidence remains incomplete and inconclusive, partly because possessing and supplying controlled drugs is a criminal offence and partly because of a lack of domestic research on the issue. Enforcement of the law is difficult because police lack the ability to screen drivers for drug use. There have been few high-profile drug driving education or publicity campaigns. The number of successful prosecutions remains low.

1 Provisional estimates for 2009 show drink drive fatalities fell by 5% to 380. Department for Transport, *Reported Road Casualties in Great Britain: 2009 provisional estimates for accidents involving illegal alcohol levels*, August 2010.

2 For example, through loss of output due to injury and NHS costs. Based on provisional drink drive estimates in 2008.

4. The available casualty data suggests that there were 56 fatal accidents in 2008 in which impairment by legal or illegal drugs was judged by the police to be a contributory factor. Yet one in ten 16–59 year olds admitted to using illicit drugs in 2008–09 and the limited evidence available suggests that 11% of the driving population may have driven at some time whilst under the influence of illicit drugs. It is reasonable to suspect that the official data on drug driving tell only part of the story.

The North Report

5. In December 2009 the previous Government appointed Sir Peter North CBE QC to conduct an independent review of the law on drink and drug driving in Great Britain.[3] As part of this, Sir Peter was asked to consider the case for changing the prescribed alcohol limit for driving either by reducing the current limit, or adding a new lower limit with an associated revised penalty regime. He was also asked to consider the case for new drug driving legislation. His final report, published in June 2010, contained 28 recommendations relating to drink driving and 23 to drug driving. The Government will publish its response by the end of 2010.

Our inquiry

6. We announced our inquiry into drink and drug driving law on 22 July 2010. Our inquiry focussed on the North Review's more high-profile, and controversial, recommendations, including the proposals:

- to reduce the current prescribed blood alcohol limit from 80mg of alcohol in 100ml of blood to 50mg of alcohol in 100ml of blood;
- to retain the current penalty of 12-month mandatory disqualification at the new lower blood alcohol limit;
- to provide the police with a general and unrestricted power to require anyone who is driving a motor vehicle to cooperate with a preliminary breath test;
- to take steps for the earliest practicable type approval and supply to police stations of preliminary drug screening devices, to be achieved within two years;
- for the Government actively to pursue research to determine the levels of active and impairing metabolites of eight categories of controlled drugs[4] in order to set prescribed levels for such drugs in legislation and to introduce a new offence to make it unlawful to drive with any of the listed drugs in the body in excess of the prescribed level, and
- to allow nurses to take on the role currently fulfilled by forensic physicians in determining whether a drug driving suspect has 'a condition which might be due to a drug'.

3 Great Britain is the jurisdiction to which the relevant law on drink driving and drug driving currently applies. Road safety in Northern Ireland is a devolved matter.

4 Opiates; amphetamines; methamphetamines; cocaine; benzodiazepines; cannabinoids; methadone; ecstasy (MDMA).

7. The Committee received 42 memoranda in response to the announcement of the inquiry. We also took oral evidence on 14 September and 12 October from a wide range of individuals and groups, including road user and road safety groups, police representatives, medical and academic experts, pub, restaurant and hospitality industry representatives, drug testing companies, and Sir Peter North himself. We are grateful to all those who submitted evidence, whether oral or written. We decided not to take oral evidence from the relevant Government minister because the Department for Transport was preparing its formal response to the North Review. However, we wrote to the Department on 19 October seeking further information on issues raised by witnesses during the inquiry and we are grateful for the Department's response.[5]

2 Drink driving law

The drink drive limit

8. The Road Safety Act 1967 made it an offence to drive a vehicle with a blood alcohol concentration (BAC) in excess of 80mg of alcohol per 100ml of blood and obliged drivers to submit to a screening, breathalyser test at the roadside in certain circumstances. This limit remains in place today. The North Review's most high-profile recommendation is that the Government reduce the drink drive limit to 50mg per 100ml of blood.

9. As with the current 80mg/100ml limit, it is very difficult to provide an accurate estimate of how much alcohol the average person can consume and remain within the 50mg/100ml limit, given the range of alcoholic products available, the different amounts and measurements in which drinks are served, and the fact that a person's ability to absorb alcohol into the bloodstream can be affected by so many variables such as the physical build of the drinker, the strength of the drink and when it is consumed. During the publicity campaign to launch his report, however, Sir Peter emphasised that his proposal for a 50mg/100ml limit would still mean a driver could have "a drink" without infringing the limit.[6] Nevertheless, we note that other witnesses alluded to the greater likely uncertainty in the public's mind about what could constitute a 'legal drink' within a 50mg/100ml limit.[7]

10. We examine below the main arguments for, and against, a reduction in the legal drink-drive limit. We consider the evidence used by the North Review and reactions to the proposal by witnesses to our inquiry.

5 Ev 99

6 "Time to give the public what they want: North proposes crack down on drink and drug driving", North Review press release, 16 June 2010.

7 For example, the British Beer and Pub Association (Q 165).

Evidence and opinions

Medical and statistical evidence

11. North based his findings in large part on a review of international literature conducted by the National Institute for Health and Clinical Excellence (NICE), commissioned by the Department for Transport, and other relevant studies. Two key pieces of evidence were particularly important for his Review.

12. First, NICE found that driving impairment and crash risk increases exponentially with increasing BAC levels. Drivers with a BAC between 50mg/100ml and 80mg/100ml are six times more likely to be involved in a fatal crash than drivers who have consumed no alcohol, whilst drivers with a BAC between 20mg/100ml and 50mg/100ml are three times more likely to be involved in such an incident.[8] Results from laboratory studies indicate that 94% of subjects reviewed report impairment by the time they reach 80mg/100ml.[9] The British Medical Association agreed that driving performance deteriorates significantly between 50mg/100ml and 80mg/100ml.[10]

13. Second, statistical researchers estimate that at least tens of deaths and hundreds of serious injuries could be prevented each year by reducing the drink drive limit to 50mg/100ml.[11] Figure 1 shows the different level of alcohol in the bloodstream of all *drivers* killed in road accidents[12] in 2007, based on coroners' data. It shows that approximately:

- 65% of all drivers killed have **no alcohol present** in their bloodstream. whilst 35% have some alcohol in their bloodstream;

- 17% of drivers killed have alcohol in their bloodstream but are **below the legal limit** (over 0mg/100ml but under 80mg/100ml), with 2% having a BAC between 50mg/100ml and 80mg/100ml.[13]

- 18% of drivers killed are **above the legal limit** (80mg/100ml and higher): 2% are so-called 'borderline' drinkers with a BAC of between 80mg/100ml and 100mg/100ml, over 5% have a BAC between 100mg/100ml and 159mg/100ml, and 11% are more than twice over the drink drive limit (160mg/100ml and above).

8 Ev 91 [NICE]

9 National Institute for Health and Clinical Excellence, *Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths*, March 2010, p 45

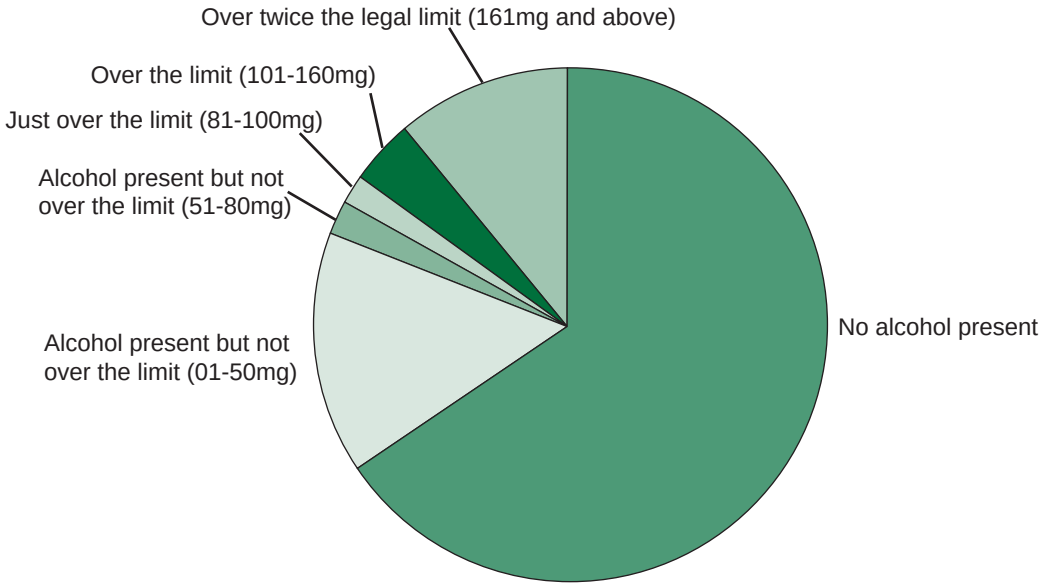
10 Q 118; Ev 80

11 Research undertaken by the University of Sheffield and Professor Allsop. See paragraphs 14–15.

12 Not including others killed by drivers. This is because coroners provide information about the BAC of (most, but not all) drivers killed. In the case of a driver who survives an accident in which somebody else is killed, the driver's precise BAC level may not be tested or recorded, particularly if he or she is under the limit or clearly not impaired.

13 Department for Transport, *Reported Road Casualties Great Britain: 2008*, 2009; Ev 99

Figure 1: Level of alcohol in the bloodstream of drivers killed in road accidents (2007)



Source: Coroners and procurators fiscal

14. Sheffield University researchers devised for NICE a model to estimate reduced casualties in England and Wales based on the experiences of other countries (primarily Australia and 15 European countries) that reduced their limit from 80mg/100ml to 50mg/100ml. This study estimated that 77 to 168 deaths—including drivers, passengers, pedestrians and other road users—could be avoided in the first year of implementation (see Table 1). In 2008, this would have amounted to 3% to 7% of all road fatalities. A separate study by Professor Allsop produced more conservative estimates based on British drink drive casualty data. Allsop estimates that a 50mg/100ml BAC limit would prevent about 43 deaths on the roads.[14] In 2008 this amounted to 2% of all road fatalities.[15] NICE said that the evidence that reducing the drink drive limit reduces the number of accidents and fatalities was "practically plausible and scientifically robust".[16]

Table 1: Estimates of reduced casualties (per year) with a 50mg BAC limit

	NICE (England and Wales figures only)		Professor Allsop (GB)
	Based on European experience	Based on Australian experience	
Reduced fatalities	77-168	144	43
Reduced serious injuries	N/A	708	280

14 Again, including drivers, passengers, pedestrians and other road users.

15 Both the Sheffield University and Professor Allsop's study assume that the distribution of deaths in road accidents (i.e. including other road users) with respect to the BACs of involved drivers is estimated by the distribution with respect to the BAC of killed drivers. See Ev 46 [Professor Allsop].

16 Q 162

15. Critics argue that a reduction in the drink drive limit to 50mg/100ml would do little to change the behaviour of those people who drink and drive well in excess of 80mg/100ml. As shown in Figure 1, drivers with a BAC over 100mg/100ml represent about 16% of all drivers killed and almost half of drivers killed with at least some alcohol in their bloodstream. The Sheffield University and Allsop studies make different assumptions about the effect of lowering the limit on the behaviour of drivers who drink well in excess of the limit, which partly explains their different estimates. Allsop assumes that reducing the limit to 50mg/100ml would not, in itself, substantially change the behaviour of drivers with a BAC over 110mg/100ml; and thus does not include this group of drivers in his model. NICE, on the other hand, argue that the evidence is "sufficiently strong" that lowering the drink drive limit changes the behaviour of drivers at all BAC levels.[17]

16. There is broad agreement that lowering the limit from 80mg/100ml to 50mg/100ml would change the behaviour of (i) drivers who drink alcohol but stay within the current 80mg/100ml limit or (ii) "borderline" drink-drivers just over the limit. Figure 1 shows that these two groups account for 19% of all drivers killed and about 34% of drivers killed with a BAC over 10mg/100ml. North argues that the potential to influence about a third of the number of these driver fatalities is "very persuasive", particularly when associated deaths and serious injuries of passengers, pedestrians and other road users are taken into account.[18]

International comparison

17. Great Britain is one of only two countries in Europe with a BAC limit above 50mg/100ml, the other being Malta. The NICE review found that there was a clear trend, especially in Europe, towards introducing a 50mg/100ml limit. North says that Britain's 80mg/100ml limit is "now inconsistent with the more recently implemented trend worldwide towards a lower limit". In addition, he says there are obvious benefits in reducing the difference between Great Britain and its European neighbours, both for British drivers travelling abroad and for incoming drivers.[19]

18. North recognises, however, that is unhelpful to draw direct comparisons between Great Britain and other European nations because the penalty regime in Britain is considerably tougher than the regimes of many other countries with a lower limit. For example, Great Britain, the Netherlands and Sweden have the lowest number of road traffic fatalities per head of population, yet the BAC limits, enforcement, penalty regimes and cultural and ethical attitudes regarding drink driving vary considerably between these countries.

Public opinion

19. Surveys show there is considerable public support for strong drink drive legislation. The 2009 British Social Attitudes Survey found that 83% of respondents agreed with the

17 Ev 91

18 Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 94 [see revised version of the report on the North Review website].

19 Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 93

statement that "If someone has drunk any alcohol they should not drive", with 58% agreeing strongly.[20] A 2008 AA poll of its members (17,481 response) found that 66% were in favour of a lower blood alcohol limit.[21]

20. Opponents of a lower limit, such as the British Beer and Pub Association and the Association of British Drivers, argued that lowering the limit to 50mg/100ml could result in the loss of public respect for the law.[22]

Resource implications of a lower limit

21. Opponents of a reduced drink drive limit argued that enforcement of a lower limit would place additional pressure on limited police resources that should instead be targeted on those drivers well in excess of the limit.[23] Some witnesses in favour of a lower limit also identified police resources as a practical obstacle. The AA supported a 50mg/100ml limit but warned that there may be fewer resources for the police in the future: "if this is the case there may be little scope for changing the existing law while maintaining pressure on the most high risk group".[24]

22. The response of police representatives to these arguments was clear. The Association of Chief Police Officers said that, operationally, a 50mg/100ml BAC limit would not in itself change police procedures because officers would continue to stop and breathalyse people suspected of being impaired or involved in a collision. Whilst ACPO accepted that the number of drink driving arrests may increase—thus resulting in more police officers taken off the streets to escort suspects to the station—it said that this could be counter-balanced by a reduction in drink drive casualties and fatalities as a whole, which were a significant strain on police resources.[25]

23. When pressed further, ACPO accepted that a lower limit would present financial challenges for the police but stressed that the priority should be to set the law correctly. Police forces would then target and prioritise resources accordingly: "we will enforce the change in the law if the law changes". ACPO's view was that the drink drive limit should be reduced to 50mg/100ml.[26]

The "morning-after" effect

24. Critics argued that a lower limit would increase the number of "morning-after" convictions, whereby people driving the morning after an evening drinking alcohol are found to be over the limit. The Association of British Drivers suggested that people were less impaired when blood alcohol levels were falling rather than rising—the "Mellanby

20 British Social Attitudes survey, 2009

21 Ev 77 [AA]

22 Ev 59; Ev 71.

23 For example, the British Beer and Pub Association Ev 59. Mike Rawson, a retired policeman, makes a similar point [Ev w3]. *[Note: references to 'Ev wXX' are references to written evidence published in the volume of additional written evidence published on the Committee's website.]*

24 Ev 77

25 Qq 79–80

26 Q 91

effect"—so somebody driving the next morning after a drinking session with the same amount of alcohol in their bloodstream as during the previous evening was less impaired. This risked creating public resentment and bringing the law into disrepute.[27]

25. Medical expert witnesses were not persuaded by this argument. The British Medical Association said the degree of impairment was "the same, whether [the blood alcohol limit] is going up or coming down", although one's state of impairment obviously improved over time as blood alcohol levels fell.[28] Dr Brutus, Medical Advisor to the North Review, argued that evidence on this issue was "inconclusive" because there was so much variation between individuals.[29] Sir Peter North was "utterly unsympathetic" to the "morning-after" argument because somebody that was driving impaired the morning after an evening of drinking still presented a major risk.[30]

Impact on pub, restaurant and hospitality industries

26. Representatives of the pub, restaurant and hospitality industries (including individual landlords) warned that a 50mg/100ml BAC limit could have serious consequences for their businesses, particularly in rural and semi-rural locations. The British Beer and Pub Association (BBPA) estimated that 1.5 million people drive to the pub in a vehicle each week, amounting to 10% of all pub visitors.[31] When including accompanying passengers, this increases to 2.5 million people, or 17% of all pub visitors. The BBPA argued that a lower 50mg/100ml limit could lead to the closure of 1,500 pubs and the loss of 9,000 jobs.[32]

27. North was not persuaded by these arguments. A 50mg/100ml limit, he said, would still allow the responsible driver who wishes to enjoy a drink to accompany their pub meal or have a glass of wine or a pint of beer to do so without being in danger of breaking the law—although he questioned the wisdom of doing so, given the evidence of impairment at even low levels of blood alcohol. North was not convinced that reducing the blood alcohol limit to 50mg/100ml would, in itself, have a "widespread detrimental impact" on the sector, although he accepted some individual businesses might be affected.[33]

28. A criticism made of the North Review is that it did not include an impact assessment of the effects on the pub, restaurant and hospitality sectors. Indeed, the Department for Transport's written evidence said that North's terms of reference required an examination of the impacts of any change in the blood alcohol limit on "health outcomes, businesses and on the economy more widely" but his report only had "limited coverage" of these questions and did "not include an impact assessment, or consideration of the public sector resource and enforcement implications of his proposals". The Department said it was conducting "further work" to this end, to inform the Government's decision.[34]

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27 Ev 71

28 Q 143

29 Q 27

30 Q 26

31 The BBPA estimates that approximately 15 million people visit the pub each week (Ev 59).

32 Ev 59

33 Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, pp 7, 96

34 Ev 99

The case for a 20mg/100ml BAC limit

29. A minority of witnesses, including the road safety group Brake and the pedestrian charity Living Streets, supported a 20mg/100ml BAC limit, effectively a "zero tolerance" level that allows for residual and naturally occurring alcohol in the body,[35] as operates in Sweden and Poland. BRAKE argued that a 20mg/100ml limit would be consistent with the longstanding Department for Transport advice on drink driving: "Don't drink and drive". A 50mg/100ml limit, on the other hand, would send mixed messages to the public.[36]

30. The North Review rejected lowering the alcohol limit to 20mg/100ml for three main reasons: (i) there was a lack of evidence that drivers with a BAC of between 20mg/100ml and 50mg/100ml were a problem group in terms of casualties; (ii) it would risk alienating public support for drink drive legislation, and (iii) milder penalties than the current minimum 12 month mandatory disqualification would have to be in place at this level, which could "dilute the effectiveness of the current regime".[37]

31. When questioned in person, however, Sir Peter stated that "in a wholly hypothetical ideal world" he would support a 20mg/100ml limit but he had "no confidence that this is deliverable in the real world for a decade or more". He confirmed his Review's "pragmatic" findings that a 50mg/100ml limit was the most politically acceptable measure; the public might be ready for a 20mg/100ml limit, he said, in "10 or 20 years time".[38]

32. The majority of witnesses shared this view. Most felt that a reduction to 20mg/100ml would be too great a change for the public to accept.[39] Medical experts also said that the impairing effects of alcohol between 20mg/100ml and 50mg/100ml were much less substantial than between 50mg/100ml and 80mg/100ml.[40]

Penalties

33. The UK has more stringent penalties for drink driving than most other countries, with a minimum 12-month mandatory disqualification for anyone caught over the limit. Most witnesses (including some critics of a lower drink drive limit) agreed with North that the current penalty should be retained in the event of a new 50mg/100ml limit—even though this would be the most severe penalty in Europe at that level. It was argued that this would avoid unnecessary complications and sending mixed messages to the public. An AA survey found that the largest group of respondents (49%) preferred the same disqualification period of 12 months for a lower drink drive limit with only 13% in favour of a lesser penalty.[41]

35 When taking into account alcohol in common substances such as syrups and mouthwashes and natural alcohol production in the body.

36 Ev 67, Q 109

37 Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 92

38 Qq 33, 36

39 For example, the Association of Chief Police Officers [Q 111].

40 British Medical Association [Q 140]

41 Ev 77. 20,129 respondents.

34. Some witnesses argued that a 12-month mandatory ban was too severe at 50mg/100ml BAC. The Magistrates' Association supported a 50mg/100ml limit but argued that it was a general principle that punishment "should be proportionate to the severity of the offence": mandatory disqualification, it argued, should be for a lower level such as six months.[42] Some witnesses, including the Association of Chief Police Officers, RoadPeace and Professor Allsop, ideally preferred to retain a 12-month disqualification penalty but would support a more lenient penalty for somebody with a BAC of between 50 mg/100ml and 80mg/100ml if the former option proved politically or publicly too difficult to introduce.[43]

Conclusions

35. We have considered the evidence for and against a reduction in the drink drive limit from the current 80mg per 100ml of blood. We note the medical and statistical evidence that the risk of accident, or death, increases substantially when blood alcohol levels exceed 20mg/100ml of blood. Such evidence makes a strong case for reducing the legal blood alcohol limit.

36. However, we also accept that there are valid criticisms against such an immediate and unilateral reduction, which warrant further examination. The first relates to the potential resource implications for the police. In the current economic climate police forces are under increased pressure to use their limited resources in the most effective and appropriate way possible, and it is reasonable to explore whether such a legal change might place unmanageable pressures on their resources. **We recommend that individual police forces should be consulted to assess the respective cost-benefit implications of more effectively enforcing the current drink drive limit against any proposed reduction.** We further note that this is an area of policy which may fall within the remit of the Government's proposed directly-elected Police Commissioners.

37. The second concern relates to public awareness and acceptance of the legal alcohol limit. We note the evidence that suggests a lack of public understanding about the current BAC limit and what it means in terms of drinks that may be "legally" consumed before driving. The introduction of a 50mg/100ml limit is likely to increase such public confusion, given that the amounts and measurements in which drinks are served and consumed are not easily converted by the average drinker into units of alcohol, let alone into microgrammes of alcohol in blood. It is also complicated by the fact that a person's ability to absorb alcohol into the bloodstream can be affected by many different variables such as the physical build of the drinker, the strength of the drink and when it is consumed. We agree with the Government's official advice that a driver should not drink at all and are concerned that a reduction to 50mg/100ml risks sending out a mixed message.

38. **In the long term, the Government should aim for an "effectively zero" limit of 20mg/100ml but we acknowledge that this is too great a step at this stage.** There is little evidence to suggest the public would support such a drastic, immediate, change in the law.

42 Ev W25

43 Ev 54, Ev W14, Ev 46

39. **We believe that any reduction in the legal drink drive limit should only occur after an extensive Government education campaign, run in conjunction with the pub, restaurant and hospitality industries, about drink strengths and their effect on the body. In doing so, the Government should look to learn from experiences in other countries which have successfully implemented a reduction in the drink drive limit to either 50mg/100ml or 20mg/100ml.**

40. We also considered concerns expressed by pub, restaurant and hospitality representatives, who argued that the effects of a 50mg/100ml BAC limit would put hundreds of outlets out of business. Whilst we accept that some individual businesses might be affected, we are not convinced that there would be widespread closures of the kind feared by the pub and hospitality sector. Drink drive legislation had its most significant impact on the industry with the introduction of the legal blood alcohol limit in 1967 and the industry has diversified since then. A reduction to 50mg/100ml BAC would not, in our view, have a significant economic effect on the sector.

41. The weight of the evidence supports retaining the current minimum penalty of 12-month mandatory disqualification for somebody driving with a BAC level in excess of 80mg/100ml. **The success of Great Britain's drink driving policy has been largely attributable to the deterrent effect of the current 12-month mandatory disqualification penalty and we believe that it should remain even after a reduction in the legal BAC limit.**

Police enforcement of drink drive law

42. The police have a general power under section 163 of the Traffic Act to stop any vehicle at any time. There is no similar general power to require a person to cooperate with a preliminary test for the presence of alcohol (or drugs). Police may only request a preliminary alcohol breath-test when they reasonably suspect that the driver has either:

- alcohol in their body;
- been involved in an accident, or
- committed a traffic offence.

43. North recommends that the Road Traffic Act 1988 should be amended to give police a general and unrestricted power to stop and breath-test drivers: in effect, to allow "random" breath testing. This, he says, would "contribute greatly to improving enforcement and awareness of the law".[44]

44 Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 116

Evidence and opinions

44. NICE's evidence review found "sufficiently strong evidence" from other countries that visible, rapid enforcement was necessary if drink driving legislation was to be effective.[45] The impact of the reduction in the legal limit from 80mg/100ml to 50mg/100ml in Austria (where alcohol-related crashes reduced by 9%) and the Netherlands (where the proportion of drivers with an illegal BAC level reduced from 15% to 5%) was attributed in part to enforcement measures.[46] A 2003 European review of enforcement measures found that the countries with the lowest drink drive figures were those with long traditions in drink driving enforcement, relatively high risk of detection (as measured by proportion of drivers tested) and a mass media supporting enforcement.[47]

45. The North Review found that there may be benefits in Great Britain from the police performing a greater number of roadside breath tests, similar to the positive benefits witnessed in other countries such as Australia.[48] The number of breath tests conducted by police in Great Britain is low compared to other European countries. A 2004 study showed that only 3% of drivers[49] had been stopped and tested for alcohol in the previous three years, in contrast to the European average of 16%.[50] Table 2 shows that the UK carries out the lowest number of breath tests per driver in Western Europe, apart from Italy, with fewer than 2% of drivers being tested in 2006 compared to 57% in Norway and 30% in France. Drivers in the UK are twice as likely as drivers where testing is common to think they will never be checked.[51]

45 National Institute for Health and Clinical Excellence, *Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths*, March 2010, p 164

46 G Bartl and R Esperger, *Effects of lowering the legal limit in Austria*, 2000, Proceedings of 15th Conference on Alcohol Drugs and Traffic Safety Stockholm, International Council on Alcohol, Drugs and Traffic Safety; Mathijssen, MP, "Drink driving policy and road safety in the Netherlands: a retrospective analysis", *Logistics and Transportation Review*, 2005, 41(5), pp 395–408.

47 T Makinen, DM Zaidel, *Traffic enforcement in Europe: effects, measures, needs and future*, 2003, Final report of the ESCAPE consortium.

48 In Queensland it was estimated that every increase of 1,000 in the number of daily breath tests corresponded to a decline of 6% in all serious crashes, and of 19% in single-vehicle night-time crashes. J Henstridge, R Homel & P Mackay. *The Long-Term Effects of Random Breath Testing in Four Australian States: A Time Series Analysis*. Canberra: Federal Office of Road Safety, 1997. Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 62.

49 In the United Kingdom.

50 SARTRE, *European drivers and road risk*, 2004, SARTRE 3 reports, Part 1

51 46% compared to 22%. National Institute for Health and Clinical Excellence, *Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths*, March 2010, p 140.

Table 2: Proportion of drivers who have been breath tested for alcohol by country over a one year period (during 2005–2007)

Country	Legal BAC limit	Breath-tests (approx)	Proportion of drivers breath tested (%)
Norway	20	1.6 million	57
Sweden	20	2.5 million	45
France	50	11.4 million	30
Finland	50	696,000	22
Netherlands	50	2 million	20
Greece	50	1.3 million	19
Hungary	0	1.1 million	18
Portugal	50	1 million	17
Cyprus	50	71,000	15
Spain	50	3.6 million	14
Denmark	50	389,000	12
Belgium	50	625,000	10
Czech Republic	0	410,000	7
UK	**80**	**577,000**	**2**
Italy	50	189,000	1

Sources: EU Directorate-General for Energy and Transport, European Transport Safety Council, European Road Safety Observatory, European Traffic Police Network

46. One explanation for these differences is that approximately half of EU countries—and other countries globally—have introduced random breath testing to improve apprehension rates and strengthen the deterrent impact of their driving laws. Studies have shown that sobriety checkpoints (i.e. random and selective breath testing without the need for the police to have grounds for suspecting drink driving) can help reduce road traffic injuries and deaths.[52] In addition, random breath testing had an immediate, substantial and permanent impact on accidents in three out of the four states studies in an Australian study.[53] Several studies suggest that random breath testing is one of the most cost effective road safety measures: a 2004 World Health Organisation study, for example, reported that each dollar spent on random testing results in a cost saving of $19.[54]

52 C Peek-Asa, "The effect of random alcohol screening in reducing motor vehicle crash injuries", *American Journal of Preventive Medicine*, 1999, vol 16, pp 57–67; RA Schults, RW Elder, DA Sleet et al., "Reviews of evidence regarding interventions to reduce alcohol-impaired driving", *American Journal of Preventive Medicine*, 2001, vol. 21, pp 66–88.

53 J Henstridge, R Homel, P Mackay, "The long-term effects of random breath testing in Adelaide", in CN Kloeden and AJ McLean (editors), Proceedings of the 13th international conference on alcohol, drugs and traffic safety, 1995, Adelaide, Australia: International Council on Alcohol, Drugs and Traffic Safety.

54 M Peden, *World Report on Road Traffic Injury Prevention*, 2004. See Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 71 for other relevant studies.

47. The majority of contributors to our inquiry supported the introduction of a formal power to allow the police in Great Britain to conduct random breath tests.[55] Many respondents believed that with such a low expectation of being tested in Great Britain many drivers feel able to take a chance to drink and drive. Respondents shared Sir Peter North's view that the most appealing aspect was the deterrent effect: the "clear public message" it sent to drivers that they could be stopped and tested at any time.[56] 79% of AA members responding to a Populus Poll in 2010 were in favour of the police being able to breathalyse a driver at any time.[57] A survey conducted by the RAC Foundation also found that 71% of the public support random breath testing.[58]

48. A minority of organisations, such as the Association of British Drivers, did not support the proposal. They argued that random breath testing would waste police resources that should instead be targeted at those showing clear signs of impairment.[59] The Association of Chief Police Officers (ACPO), however, stressed that the police would breathalyse drivers in an intelligence-led targeted way, for example focussing on areas where there had been a high incidence of drink driving, similar to operations in other countries.[60] Sir Peter North stressed this point also; he commented that the term "random" may be misleading.[61]

49. A second criticism was that the police already possessed sufficient powers to stop and administer a breath test to whomsoever they wanted—so new powers were unnecessary.[62] This was also the point made by the Secretary of State, when he gave evidence to us in July 2010. He argued that there was a public misunderstanding about the police's powers in relation to breath testing, and that the police already had powers "where there is evidence of a localised problem" to target an area in a way which "many members of the public would call "random" breath testing".[63] Police representatives indicated that the current law allowed police to administer a breath test in the majority of cases because the driver had committed a traffic offence or the police were alerted to the manner of a person's driving.[64] The Association of Chief Police Officers (ACPO) also said that some police forces already carried out targeted testing at checkpoints for drink driving. However, these still required "an element of consent" because, whilst the police had the power randomly or arbitrarily to stop vehicles, officers did not have the power to administer breath tests unless there were grounds for suspicion.[65] Roadside checkpoints for drink driving, in which all drivers were *required* to provide a breath specimen, were said to be unlawful under current powers.[66]

55 Such as the Beer Pub and Beer Association [Ev 59, Gin and Vodka Association [Ev W8], BRAKE [Ev 67] and the Magistrates Association [Ev W25].

56 Q 14

57 Populus interviewed 20,417 AA members online.

58 Ev 57

59 Ev 46

60 Q 78

61 Q 14

62 Association of British Drivers [Ev71]

63 Oral evidence taken on 26 July 2010, HC (2010–11) 359, Q 89

64 Evidence to the North Review. Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 115.

65 Ev 54; Q 87

66 Evidence to the North Review. Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 87

According to ACPO, the strongest argument for North's proposal was the public message it sent to drivers because the perception amongst the general public remained that they were unlikely to be stopped and tested.[67]

Conclusions

50. Some of the most striking reductions in drink driving figures in other countries that reduced their limit from 80mg/100ml to 50mg/100ml have occurred when the lower limit was accompanied by effective enforcement measures. **Effective police enforcement is equally as important to deter drink driving as the level of the legal blood alcohol limit. Enforcement of drink drive law in Great Britain must be much more visible, frequent, sustained and well-publicised.**

51. The police already possess powers to stop and breathalyse people in a wide range of defined situations. The North Review recommends that these powers are widened to provide police with a "general and unrestricted power" to require anyone who is driving a motor vehicle to cooperate with a preliminary breath test. This would, in effect, legally allow "random" breath testing, although the North Review expects that such a power would be used in a targeted and intelligence-led way rather than in a purely random manner.

52. We agree with North that there is a good case to widen the police's powers in respect of breath testing. Doing so would be likely to increase the number of breath tests currently carried out by the police. It is a matter of concern that the UK conducts the second lowest number of alcohol breath tests in western Europe, with the vast majority of drivers in our population never likely to be tested, and consequently not expecting ever to be tested. But the main objective of extending the police's powers, in our view, must be to allow the police to conduct intelligence-led or targeted drink drive enforcement operations, following senior sign-off, where vehicles are stopped, randomly or otherwise, in particular locations or at selected venues and drivers are then *required* to be breathalysed. As already discussed, such operations are not currently legal. Although the current legislation enables police to conduct targeted drink drive enforcement operations whereby any vehicle could be stopped, officers can not breathalyse without suspicion or an element of consent.

53. We are concerned that the North Review proposal for a "general and unrestricted power" is too wide and arbitrary for this specific purpose. Although North hopes that the police use of such a power would be targeted and intelligence-led, there is no guarantee it would be so. We have concerns about the public acceptability of such a power. There is a real risk it could invite concern and criticism regarding the proportionality of its use and real, or perceived, issues of abuse or unfairness. We are also not convinced that the introduction of this power is necessary to send a strong message to the public. In our view, a more specific power that enabled the police to carry out designated drink drive enforcement operations, as part of which any driver was required to provide a breath test, would also have a significant public impact, if properly publicised, and serve as an effective deterrent.

67 Ev 54; Q 88

54. For these reasons, we believe the North Review recommendation to provide the police with a general and unrestricted power to require anyone driving a vehicle to cooperate with a preliminary breath test is excessive. In our view, any change in the legislation must clearly reflect the intended outcome. **The Government should amend the Road Traffic Act 1988 to give police an additional power to enable preliminary breath tests to be required and administered in the course of a designated drink drive enforcement operation.**

3 Drug driving law

55. The current statutory provisions concerning drug driving are contained in sections 4 to 11 of the Road Traffic Act 1988. The principal offence relevant to drug driving mirrors that for drink driving, and can be summarised as driving a vehicle "whilst unfit to drive through drugs". This offence can relate to impairment due to both legal and illegal drugs.

56. Although the drug driving offence is similar to that for alcohol, the context of each crime is different because of the illegality of possessing and supplying controlled drugs. The drug driving offence in Great Britain is based on proof of impairment but some other countries have a more uncompromising legal regime for drug driving whereby it is an automatic offence for somebody to drive a vehicle with a quantity of a listed illegal drug in their bloodstream, regardless of impairment. We examine this issue in more detail later in this chapter (paragraphs 86–99).

57. Drug driving is also a much more complex issue than drink driving, partly because there are numerous substances that have the potential to impair driving abilities, and the number of impairing drugs is ever increasing. Detecting and measuring these substances cannot be done using breath samples but require more intrusive methods to gather samples of bodily fluids such as blood, urine or saliva. In addition, whereas alcohol use is common among most segments of the driving age population, different types of drugs tend to be used by sub-groups within the population.

58. Any centrally-acting drug has the potential negatively to affect driving skill or interfere with the ability to operate a vehicle safely. Depressant drugs, including medicines such as benzodiazepines, can cause slowed response time, slower neural processing, slower recall, greater error rates in complex tasks, balance and orientation changes, lowered alertness and sedation, and can be related to impairment. Hallucinogens, and drugs with sedation as their main effect or side effect, have an obvious adverse effect on overall driving performance. Stimulants, such as amphetamines, methamphetamine and cocaine, can affect critical judgement, increase impulsiveness and error rate, and interrupt normal sleep patterns.[68]

68 Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, pp 139–140

The scale of the problem

Evidence and opinions

59. Driver impairment due to drugs (both illicit and medicinal) was listed as a contributory factor in 56 fatal road accidents in Great Britain in 2008 (3% of all fatal road accidents that year), 280 serious injuries and 745 slight injuries. It was cited as a contributory factor by police in 0.5% of all reported road accidents that year (compared to 6% for alcohol).[69] In 2008 there were 253 drugs driving proceedings in the courts in England and Wales and 168 findings of guilt.[70] This compares with over 73,000 drink-drive proceedings, and almost 70,000 guilty verdicts that year.[71]

60. The North Review found that it was difficult to determine definitively the scale of drug driving in Great Britain although the official figures were most likely to be under-estimates of the true scale of the problem. The evidence in relation to drug driving was "poor", partly because of the illegality of the possession and supply of controlled drugs in society and the ethical problems associated with obtaining samples. Inadequate recognition of drug driving as a problem, minimal screening of fatalities for drugs by coroners, and the dominant role that alcohol plays in assessment of vehicle accidents also contributed to a lack of recent data from Great Britain on the impact of drug driving on casualty rates.[72]

61. The North Review argued, however, that it was "reasonable to assume" that there was a "significant" drug driving problem in Great Britain, which was likely to be much more widespread than suggested by the 168 drug driving convictions in England and Wales in 2008.[73] North based this assumption on three types of available evidence. First, the prevalence of illicit drug use amongst the general population is high. The most recent British Crime Survey found that one in ten 16 to 59 year olds used illicit drugs: cannabis was the most common substance, although the use of Class A drugs and tranquilisers was found to have increased considerably over the past 15 years.[74]

62. Second, the small number of studies on drug driving in Great Britain suggest it is a fairly common activity. Tunbridge *et al* conducted the most recent study of drug use among road accident fatalities in 2001,[75] following up on a similar study in 1989.[76] This found that illicit drugs were present in 18% of road accident victims (both driver and non-driver) in 2000, a six-fold increase from 1989. Cannabis was by far the most prevalent drug detected in fatalities.[77] A 2006 survey of drivers in Scotland aged between 17 and 39 found

69 Department for Transport, *Reported Road Casualties Great Britain 2008*, 2009

70 There were 2,599 "drink or drugs" driving proceedings and 1,426 guilty verdicts.

71 Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 151. Source collated from Ministry of Justice, 2008.

72 Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 167

73 Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 168

74 Home Office, *British Crime Survey, 2008–2009*, 2010

75 Based on blood and urine samples taken from 1,184 road accident fatalities (both driver and non-driver) between 1996 and 2000.

76 JT Everest, RJ Tunbridge and B Widdop, *The incidence of drugs in road accident fatalities*, TRL Report, 1989

77 RJ Tunbridge, M Keigan and F James, *The incidence of drugs and alcohol in road accident fatalities*, TRL Report, 2001

that 6% had claimed to have driven under the influence of illicit drugs and 3.5% in the last year. Researchers suspected that there was likely to be under-reporting of this finding, which raised estimates to 11% and 6% respectively.[78] A 2005 study in Glasgow that involved random roadside drug testing of over 1,300 drivers not involved in accidents found that almost 11% of drivers were drug users, with the most common drugs detected being ecstasy (5% of cases) and cannabis (3%).[79]

63. Third, international research indicates that drug driving is common in several other countries. North considered this to be informative, given the similarity in the prevalence of drug use amongst the general population in Great Britain and several other developed countries, particularly in Europe, and in the absence of up to date British research.[80] A recent review of international evidence concluded that drugs other than alcohol were "not uncommon" among drivers involved in serious road crashes, with most studies reporting the incidence of drugs amongst drivers injured or killed in motor vehicle crashes to be in the range of 14% to 17%, with cannabis the most commonly found substance followed by benzodiazepines. Roadside surveys of night-time drivers in North America determined that psychoactive drugs were found in 10% to 16% of drivers, in excess of the proportion of drivers who had been drinking.[81]

64. North argued that greater efforts were required to improve the evidence base about drug driving. He noted that the UK had not participated actively in recent international research programmes on drug driving. The DRUID study (Driving under the Influence of Drugs, Alcohol and Medicines), due to report in 2012, is an extensive EU project aimed to gain new insights into the degree of impairment caused by psychoactive drugs and their actual impact on road safety. It involves the participation of 19 European countries, including most of those in western Europe. The Organisation for Economic Co-operation and Development (OECD) conducted a recent review of the role and impact of drugs in accident risk. This involved 12 countries, including the United States, France, Germany and Australia. The UK participated actively in neither study.

65. Witnesses criticised the UK's lack of involvement with international research programmes, such as DRIUD and the OECD review.[82] Giving evidence, Sir Peter North expressed disappointment that international programmes had "not been given priority" by successive governments: he believed the UK should take part in DRUID because the project was "getting input of the experience of a whole range of European states and the UK is outside it". North believed, based on anecdotal evidence, that the UK's hesitancy was partly driven by human rights concerns because the evidence-gathering included random stopping of vehicles and asking people voluntarily to take drugs tests (but not penalising them if found positive). He was not convinced by this argument:

78 Scottish Executive Social Research, *Illicit drugs and driving*, 2006

79 IMMORTAL EU Research Project, *The prevalence of drug driving and relative risk estimations: a study conducted in the Netherlands, Norway and United Kingdom*, 2005

80 Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 168

81 OECD/Transport Research Centre, *Drugs and Driving: Detection and Deterrence*, October 2010

82 For example, PACTS [Ev 62], Dtec International Ltd [Ev 84], Dr Rob Tunbridge [Ev 88].

> "[...] that is a problem that does not seem to have affected other states which are parties to the European Convention on Human Rights. It does not seem to have taken account of the fact we are trying to stop being killed on the roads, and that is a pretty powerful human right".[83]

66. The Department for Transport gave two main reasons to explain the previous Administration's decisions not to participate fully in the DRUID and the OECD projects. First, limited research resources (funding and staff) had restricted the Department's contribution to both projects, although the Department had responded "fully" to requests about available UK data. The second problem, in relation to DRUID, was the "likely implications of any UK sample due to difficulties we would face in replicating methodologies used by other member countries". Previous experience had shown that it was "not possible to get ethical approval to collect unbiased samples for non-fatally injured drivers in the UK".[84]

Conclusions

67. The state of knowledge about drug driving in Great Britain is far behind drink driving. There is much anecdotal evidence but very little hard evidence, which makes it impossible to determine the exact scale of drug driving in Great Britain. The most recent study of incidence of drugs in road accident victims—albeit conducted almost a decade ago—showed the presence of illegal drugs in almost one in five road fatalities. Drug driving is prevalent in several other developed countries that have similar high levels of illicit drug use in the general population as Great Britain. We believe there is good reason to assume that people impaired by drugs drive regularly on our roads.

68. But police enforcement and public awareness of drug driving still pales in comparison to the situation with drink driving (we discuss enforcement in more detail in paragraphs 72 to 85). Cultural norms about the two are also different and the perception remains that drug driving is not as dangerous as drink driving. Given the potential impairing effects of illicit drugs and the fact that somebody in charge of a motor vehicle whilst impaired on drugs poses a significant risk to others, it is unacceptable that our progress in dealing with drug driving, and our attitudes towards the problem, have changed so little in the past few decades.

69. **Drug driving is as important an issue as drink driving, given the risks involved to other road users, the relative lack of public awareness and the current lack of adequate police enforcement. The Government should aim to improve the detection of drug driving so that it is as important a road safety priority as combating drink driving. We recommend that the Government develop a five-year strategy for tackling drug driving.**

70. **Improving public awareness about the likelihood of being caught by the police is essential in order to deter people from driving under the influence of drugs. A high-profile drug driving advertising and information campaign should be central to a five-year strategy. This should highlight the consequences of being caught and convicted for**

83 Q 51

84 Ev 102

this crime. The campaign should also inform the public about the significant safety risks that a driver impaired on drugs poses to themself and others.

71. Given our limited evidence base, the results of international drug driving programmes, such as DRUID and the OECD review, provide valuable information to assist countries develop public policy and enforcement and prevention programmes. The UK's minimal involvement in these programmes may only add to the impression that drug driving is not a road safety priority, especially when compared to other countries. This is unfortunate considering the potential benefits that can be gained from pooling resources and expertise amongst countries with similar high levels of illicit drug use amongst the general population.

Drug-testing devices

72. Police officers currently lack the ability to test suspected drug drivers for drugs, either at the roadside or the police station. The Railways and Transport Safety Act 2003 permitted police officers to use a "type-approved" device to conduct a preliminary drug test to indicate whether a person has a drug in their body, but no device has yet been type-approved by the Secretary of State.

73. The current process for detecting and deterring drug driving is thus as follows:

- A police officer suspects that the person may be under the influence of a drug, has committed a traffic offence or has been involved in an accident. He or she may administer a breathalyser test to test for alcohol and, whether or not that is positive, a FIT test (physical balance exercises and a pupillary examination).

- Observations and inferences made from the person's performance of the FIT test or, where the FIT test was not or could not be administered, from the suspect's general demeanour, driving or other relevant factors may lead the officer to conclude that the impairment offence has been committed.

- As a result, the person is arrested and taken to a police station. A forensic physician is called out and asked to examine the suspect to make a judgement about whether the person has 'a condition which might be due to a drug'.[85]

- If the answer is affirmative, the police officer will require the person to provide a specimen of blood or urine to be tested for drugs. This is sent to a laboratory for analysis.

- Where the analysis shows that a drug was present, the person may be charged with driving whilst unfit due to a drug, provided there is sufficient evidence of impairment at the time of driving.

74. The Government has made efforts in recent years to develop portable preliminary drug screening equipment which can be used by police officers at the roadside.[86] Roadside

85 The legislation does not require the forensic physician to form a view as to whether the person is impaired or to say categorically that the condition is due to a drug.

86 Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 155

devices are required to cope with a wide range of storage and user temperatures, must be rugged and robust, small and portable, weather resistant and easy to operate. Despite these efforts, a roadside device has not been type-approved by the Home Office. The North Review recommended that the Government focus its efforts in the short term on type approval of more robust and reliable devices for preliminary drug screening in the more controlled environment of a police station. The Government has since announced a commitment to have screening devices for a range of substances installed in every police station by 2012.

Evidence and opinions

75. Witnesses said that the fact the police could not screen a suspected drug driver for drugs—either at the roadside or the police station—contributed to the low level of drug driving proceedings and successful prosecutions in this country.[87] Commercially available roadside saliva screening devices are used widely for enforcement in other countries, including Germany, Italy, Australia, Switzerland, Finland, Poland, Iceland, Czech Republic and Luxembourg. Dtec International, a drug testing product company, said that Germany, a country with a very similar population to the UK where the police used drug screening devices, successfully prosecuted 34,500 drug drivers in 2009.[88] Great Britain's 168 drug driving guilty verdicts in 2008 compares very baldly.

76. The North Review found that the current process for detecting and deterring drug driving (described in paragraph 73) contributed to the low level of successful prosecutions and proceedings. In particular, the requirement for all suspected drivers to be assessed by a forensic physician delayed the process in two respects—the delay in getting the doctor to the station and the time spent carrying out the examination—and thus increased the chance that rapidly metabolised illicit drugs might disappear from the detainee's body. Police representatives argued that these factors were a barrier to the prosecution of those drug driving suspects who reached the station but also acted as a disincentive to take suspects back to the station in the first place.[89] Drug screening devices, North argued, would remove the requirement for all suspected drug drivers to be assessed by a forensic physician.[90]

77. Some witnesses argued for a drug screening device to be type-approved as soon as possible. Some criticised the lack of progress made in approving a device since the legislation that provided for it came into force as far back as 2003. The Home Office's conditions for type-approval in Great Britain were said to be too stringent.[91] We were told that commercially available saliva screening devices used in other countries were of

87 For example, Dr Rob Tunbridge [Ev 88].

88 Ev 84

89 Evidence given to the North Review. Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 165.

90 Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 153

91 The Home Office, we were told, was requiring screening devices to be of the same order and scientific quality as an evidential blood sample. Dtec International Ltd argued that the specification for type-approval in Great Britain was "far too restrictive to accept any current device, or device likely for the next few years". [Ev 84] Concanteno Ltd, another drug testing company, said the Home Office was looking for a "golden bullet" that did not currently exist whereas technology was available—and in use in other countries—that would "significantly reduce the incidences of driving under the influence of drugs" [Q 216].

sufficient scientific validity to be accepted for use in Great Britain.[92] Recent evaluations of drug screening devices have highlighted continued improvements in sensitivity and in general performance. Some devices available on the market demonstrate excellent sensitivity for amphetamine/MDMA (between 92% and 100%) and moderate sensitivity for cocaine (67 to 75%).[93]

78. Giving evidence, Sir Peter North said that he approved of the stringent conditions for type-approval because it gave "good protection for the citizen". He also argued that the conditions for type-approval for devices in some other countries, such as Australia, were less stringent than in Great Britain but their penalties for drug driving were much more lenient.[94]

79. The Home Office defended its "rigorous" process for type-approval of police equipment. This had been developed to "overcome the scope our Courts allow offenders to challenge process":

> "Road traffic law against drink driving, speeding, and some other offences, has been beset by successful challenges on the basis that something was wrong—or unproven—about the equipment the police used to detect the offence. These challenges are not confined to equipment used for evidential purposes: questions about screening equipment have also derailed cases. [...]
>
> "The answer—first adopted for breath testing equipment—is to provide in law that, if a device the police has used is of a type that has been approved, and has been used properly, its use and results cannot be challenged. [...] The Courts can have confidence in the results the devices produce and in actions based on those results, because the devices have proved to be reliable, consistent, accurate and precise. Without type approval, it is likely that scientific evidence on the device's performance would have to be given separately in every case, with consequent heavy demands on the police, police suppliers and the criminal justice system."

80. Specifications for a preliminary device had to be "stringent" because:

> "[...] a device which produces a high rate of false negatives [...] has the virtue that it catches some offenders; but they can be expected to win challenges in our Courts on the grounds that other, equally impaired, drivers are getting off because the testing device is not consistent or reliable. Besides, if a large number of drug users are known to be avoiding getting caught then an approach could lose credibility. Conversely a high number of false positives [...] could lead to legal challenges over false arrests. If a high standard is not set, the type-approval itself could also be subject to judicial review."

International comparisons may not be helpful, the Home Office said, because other countries had different judicial systems to Great Britain, did not offer the same

92 Dr Rob Tunbridge [Ev 88]

93 PG Jackson and CJ Hilditch, *A review of evidence related to drug driving in the UK*, 2010

94 Q 43

opportunities for judicial review or for challenges to prosecution and did not have a type-approval system like ours.[95]

Conclusions

81. The police currently lack the ability properly to enforce drug driving legislation. This, we believe, largely explains the low number of successful drug driving prosecutions in this country. More effective police enforcement would not only increase drug driving convictions but also deter people from committing this crime. At the moment, people assume—quite correctly—that they can take drugs and drive a vehicle with little chance of being caught and convicted. Publicity campaigns can only achieve so much if people do not expect to be punished.

82. The best way to improve enforcement is to ensure police officers have the use of devices to screen suspected impaired drivers for drugs. Ideally, police would conduct these tests at the roadside, in a similar way to drink driving tests. We accept, however, that development of suitable portable drug screening technology is confounded by difficulties relating to accuracy and interference from substances in the outdoor environment. Given that the penalties for drug driving in this country are comparatively strong—in our view, rightly so—combined with the potential for legal challenges in the courts, it is important that any drug screening device is robust and reliable.

83. There is a clear desire on the part of the Government and the police to introduce preliminary drug screening devices for use in the police station. We agree that the use of such devices in the station would eliminate the difficulties and disadvantages of environmental interference that the use of screening devices at the roadside present.

84. **It is unfortunate that a drug screening device has not been type-approved seven years after police were granted the legal power to use them. However, we welcome the Government's commitment to install drug screening devices in every police station by 2012. We will monitor progress to ensure the Government meets its target so that no further time is lost.**

85. **Drug screening devices for use at the police station should only be an interim measure. The Government's aim for the medium-term should be to develop and type-approve a drug screening device for use at the roadside, drawing on experience in other parts of the world in developing such devices.**

Zero-tolerance or impairment levels?

86. Section 4(1) of the Road Traffic Act 1988 states that it is illegal to drive "while unfit through drink or drugs", also known as the 'impairment offence'. Unlike with drink driving, there is no objective test for impairment, no legal definition of impairment in the Road Traffic Act, and no offence of driving in breach of a prescribed limit.

87. The North Review considered whether a new drug driving offence was necessary. Two main options for an offence were considered. The first was to move to a drink driving style

95 Ev 102

offence where the driver, once tested, has to be shown to have had a level of drugs in their system above a medically agreed limit that would suggest they were unfit to drive. The second option was to adopt a 'zero-tolerance' approach, whereby anyone driving with a quantity of a specific listed drug in their system would be committing an offence.

88. North's preference is to base the future drug driving offence on prescribed impairment levels of categories of certain controlled drugs. He recommends that the Government conduct research to determine the levels of the active and impairing metabolites of eight categories of controlled drugs, including cannabis, amphetamines, opiates and cocaine.[96] Once this research established the impairing levels of these drugs, North recommended that prescribed levels should be set in legislation and a new offence introduced which made it unlawful to drive with any of the listed drugs in the body in excess of the prescribed level.

89. North acknowledges the scientific and medical difficulties of reaching a consensus about the impairment levels for particular drugs. If it proves impossible to reach a consensus on specific levels of deemed impairment, he recommends that the Government consider a 'zero tolerance' offence for the same eight categories of controlled drugs.

Evidence and opinions

90. Witnesses had mixed views about the most appropriate drug driving offence. Some organisations, such as PACTS and the AA, agreed with North that proving impairment should ideally remain central to the offence.[97] A zero-tolerance approach was criticised because it had the potential to penalise drivers who were not impaired and posed no risk to safety. We were told that it could result in people who had smoked cannabis three weeks earlier being arrested because traces of the drug were still in their system, even though the impairment effects had long worn off.[98] A zero tolerance offence was also said to confuse road safety policy—traditionally based on driver impairment—with wider social (drugs) policy.[99]

91. Others, such as the Royal Society for the Prevention of Accidents and the Association of Chief Police Officers, preferred a zero-tolerance offence whereby driving with a listed controlled drug in the body was an automatic offence.[100] Several other countries enforce zero-tolerance offences for certain illegal drugs, such as France, Sweden and Australia, although some of these also retain a separate impairment offence to include people impaired by other drugs (for example, medicines and 'legal highs'). Some witnesses were sceptical whether it was possible to establish a scientific and medical consensus on impairment levels for certain drugs, as proposed by North. The British Medical Association said it would be difficult to establish such a consensus.[101] Dr Tunbridge believed it was "an impossibility" because the range of tolerance levels in the population

96 Opiates; amphetamines; methamphetamine; cocaine; benzodiazepines; cannabinoids; methadone; ecstasy.

97 Ev 62; Ev 77

98 Sir Peter North [Q 45]

99 Evidence given to the North Review. Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 161

100 Ev W4; Ev 54

101 Q 157

was far too great.[102] Zero tolerance, on the other hand, was said to overcome the difficulties associated with proving impairment and deciding on scientifically valid impairment limits from conflicting sources of data.

92. Giving evidence, Sir Peter North accepted this was a difficult issue but reiterated his belief that drug driving should remain a road safety issue with impairment central to the offence. Zero tolerance offences were problematic, he said, because it was not illegal to take drugs (only to possess or supply them) and some drugs, such as cannabis, stayed in the system for weeks even though the impairment effect had worn off. He said:

> "[....] you have got to think very hard about whether [a zero tolerance regime] is compatible with road safety provisions which are aimed at impairment. It seems to be sliding into a drug control regime. It might be right to do that, but it is very hard to justify that as protecting the public from impaired drivers".[103]

Sir Peter accepted that it was a challenge to establish a medical consensus on impairment levels for the main categories of controlled drugs. However, he argued that there had initially been "quite tricky science" in establishing impairment levels for alcohol, yet that had been achieved. The EU DRUID research was examining impairment effects of drugs and he was hopeful the results of this research might "shorten timescales significantly".[104]

93. Some witnesses rebutted the criticism made by Sir Peter North and others that a zero-tolerance offence could implicate drivers that had taken drugs days, or weeks, earlier. Dtec International, a drug testing company, said that commercially available drug screening devices could detect the compound in cannabis that caused impairment (known as THC) which was present in the body for only a short time: the devices therefore only detected those likely to still be impaired.[105] Concanteno Ltd, another drug testing company, explained that, in other countries with a zero-tolerance offence, the drug screening devices were set to a "cut-off level" that gave a positive result once a certain quantity of drugs was detected in the system—as opposed to the mere presence of drugs. Although this level could not prove that one was impaired, it could, for instance in the case of somebody testing positive for a particular opiate compound, distinguish between a heroin user and somebody taking codeine for medicinal purposes.[106]

94. Similarly, giving evidence to the North Review, the Forensic Science Service felt that "threshold values" for drugs should be established which precluded false positives, but which provided certainty as to the presence of a drug, which could not be present, for example, through passive inhalation. However, these threshold levels "would not in any way equate to the effects that a drug could produce on a person".[107]

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102 Evidence given to the North Review. See also Q 229.

103 Q 45

104 Q 46; Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 176

105 Ev 84

106 Q 228

107 Sir Peter North CBE QC, *Report of the Review of Drink and Drug Driving Law*, June 2010, p 163

Conclusions

95. The North Review recommends that the Government actively pursue research to determine levels of active and impairing metabolites of eight categories of controlled drugs, in order to create a new drug drive offence to make it illegal to drive with any of the listed drugs in excess of a prescribed level. This approach would mirror that for drink driving. Based on the available medical evidence, and given that the effects of drugs vary so considerably, we doubt whether it will be possible to establish a medical consensus on impairment levels in the short to medium term, if ever. Given this country's relatively poor record on prosecuting drug drivers, we are concerned that this proposal would further delay effective action to detect and tackle drug driving. We are also extremely uncomfortable with the notion that there could be a "legal" amount of illegal drugs that it would be possible to consume and drive a motor vehicle. This, to us, seems politically unrealistic.

96. Many other countries operate a 'zero-tolerance' offence. We heard concerns that a zero-tolerance approach could implicate people who had consumed drugs days, or even weeks, earlier and were not under the influence of those drugs whilst driving. We accept that it would not be fair to arrest a person driving a vehicle who simply had presence of drugs in their bloodstream from weeks earlier or through passive inhalation. Given the severity of our drug driving penalties, this would not be practical or proportionate legislation. It is clear, however, that some of these fears are misinformed. As with the widely-agreed definition of 'zero-tolerance' for alcohol—20mg of alcohol per 100ml of blood—the term should also not be taken literally in the case of drugs. A zero tolerance drug driving offence would still require a baseline "cut-off" level to minimise the possibility that a positive test is not a false positive. Drug screening devices used by police in other countries indicate the presence of a certain quantity of drugs in the system—which can be used to make a judgement about whether the drug had been taken recently and for what purpose.

97. There is an important distinction to be made between proving a driver (i) has taken a certain quantity of illegal drugs relatively recently at the time of driving or (ii) is impaired by drugs at the time of driving. As we have seen, the latter is fraught with difficulties. Proving impairment due to drugs requires either a scientific consensus on impairment levels—which, as we have said, is a long term ambition at best—or through current methods such as a FIT test. Neither is particularly satisfactory to deter and detect drug drivers. In our view, proof that a driver has a certain quantity of a specified illegal drug (that is known to affect driving abilities) in their body at the time of driving is sufficient to bring somebody through the criminal system on a charge of drug driving—regardless of impairment.

98. **On balance we favour the adoption of a "zero-tolerance" offence for illegal drugs which are known to impair driving, which are widely misused, including among drivers, and which represent a substantial part of the drug driving problem. As with alcohol, "zero-tolerance" would not necessarily mean the detection of drugs in the bloodstream. An appropriate quantity would need to be detected in order to rule out, for example, passive inhalation.**

99. **If a new offence is created, the Government should retain the current impairment offence to cover other drugs that impair driving ability, such as medicines and 'legal highs'.**

Conclusions and recommendations

1. We recommend that individual police forces should be consulted to assess the respective cost-benefit implications of more effectively enforcing the current drink drive limit against any proposed reduction. (Paragraph 36)

2. In the long term, the Government should aim for an "effectively zero" limit of 20mg/100ml but we acknowledge that this is too great a step at this stage. (Paragraph 38)

3. We believe that any reduction in the legal drink drive limit should only occur after an extensive Government education campaign, run in conjunction with the pub, restaurant and hospitality industries, about drink strengths and their effect on the body. In doing so, the Government should look to learn from experiences in other countries which have successfully implemented a reduction in the drink drive limit to either 50mg/100ml or 20mg/100ml. (Paragraph 39)

4. The success of Great Britain's drink driving policy has been largely attributable to the deterrent effect of the current 12-month mandatory disqualification penalty and we believe that it should remain even after a reduction in the legal BAC limit. (Paragraph 41)

5. Effective police enforcement is equally as important to deter drink driving as the level of the legal blood alcohol limit. Enforcement of drink drive law in Great Britain must be much more visible, frequent, sustained and well-publicised. (Paragraph 50)

6. The Government should amend the Road Traffic Act 1988 to give police an additional power to enable preliminary breath tests to be required and administered in the course of a designated drink drive enforcement operation. (Paragraph 54)

7. Drug driving is as important an issue as drink driving, given the risks involved to other road users, the relative lack of public awareness and the current lack of adequate police enforcement. The Government should aim to improve the detection of drug driving so that it is as important a road safety priority as combating drink driving. We recommend that the Government develop a five-year strategy for tackling drug driving. (Paragraph 69)

8. Improving public awareness about the likelihood of being caught by the police is essential in order to deter people from driving under the influence of drugs. A high-profile drug driving advertising and information campaign should be central to a five-year strategy. This should highlight the consequences of being caught and convicted for this crime. The campaign should also inform the public about the significant safety risks that a driver impaired on drugs poses to themself and others. (Paragraph 70)

9. It is unfortunate that a drug screening device has not been type-approved seven years after police were granted the legal power to use them. However, we welcome the Government's commitment to install drug screening devices in every police station

by 2012. We will monitor progress to ensure the Government meets its target so that no further time is lost. (Paragraph 84)

10. Drug screening devices for use at the police station should only be an interim measure. The Government's aim for the medium-term should be to develop and type-approve a drug screening device for use at the roadside, drawing on experience in other parts of the world in developing such devices. (Paragraph 85)

11. On balance we favour the adoption of a "zero-tolerance" offence for illegal drugs which are known to impair driving, which are widely misused, including among drivers, and which represent a substantial part of the drug driving problem. As with alcohol, "zero-tolerance" would not necessarily mean the detection of drugs in the bloodstream. An appropriate quantity would need to be detected in order to rule out, for example, passive inhalation. (Paragraph 98)

12. If a new offence is created, the Government should retain the current impairment offence to cover other drugs that impair driving ability, such as medicines and 'legal highs'. (Paragraph 99)

Formal Minutes

Wednesday 24 November 2010

Members present:

Mrs Louise Ellman, in the Chair

Steve Baker	Mr John Leech
Mr Tom Harris	Paul Maynard
Julie Hilling	Gavin Shuker
Kelvin Hopkins	Iain Stewart
Kwasi Kwarteng	Julian Sturdy

The following declaration of interest relating to the inquiry was made:

14 September 2010

The Chair declared a non-pecuniary interest in that her son owns a retail business which sells drug testing equipment, amongst other things; and declared that she intended to take no part in those parts of the inquiry relating to drug driving.

Draft Report (*Drink driving law),* proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 2 read and agreed to.

Paragraphs—(*Mr Tom Harris*)—brought up, read the first and second time, and inserted (now paragraphs 3 and 4).

Paragraphs 3 to 6 (now paragraphs 5 to 7) read and agreed to.

Paragraph 7 read, as follows:

Amendment proposed, at the end, to add "Nevertheless, we note that other witnesses alluded to the greater likely uncertainty in the public's mind about what could constitute a 'legal drink' within a 50mg/100ml limit."—(*Iain Stewart.*)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 7	Noes, 3
Steve Baker	Kelvin Hopkins
Mr Tom Harris	Mr John Leech
Julie Hilling	Gavin Shuker
Kwasi Kwarteng	
Paul Maynard	
Iain Stewart	
Julian Sturdy	

Paragraph, as amended, agreed to (now paragraph 9).

Paragraphs 8 to 32 (now paragraphs 10 to 34) read and agreed to.

Paragraphs 33 to 41 read, as follows:

"We have considered the evidence for and against a reduction in the drink-drive limit from 80mg per 100ml of blood to 50mg per 100ml of blood, as recommended by the North Review. The medical and statistical evidence to support a lower limit is strong. The risk of an accident, or death, increases substantially when one is driving with a blood alcohol content level between 50mg/100ml and 80mg/100ml compared to a driver who has not consumed alcohol. Reducing the drink-drive limit to 50mg/100ml would save potentially tens of deaths and hundreds of serious injuries per year. More broadly, a 50mg/100ml limit would help to create a "social norm" and culture against drink driving. It is likely that many more people would no longer risk drinking alcohol at all if driving. A 50mg/100ml limit is also consistent with the approach adopted by a large majority of countries in the EU and the general trend worldwide to reduce the legal blood alcohol limit.

We are not convinced by the evidence against a reduction in the blood alcohol limit, although two criticisms in particular require examination. The first relates to the potential resource implications for the police. In the current economic climate police forces are under increased pressure to use their limited resources in the most effective and appropriate way possible, and it is reasonable to explore whether such a legal change might place unmanageable pressures on their resources. But we found the evidence given by police representatives persuasive. Operationally, a 50mg/100ml BAC limit in itself would not change the procedures used by police officers to enforce drink driving law. And, whilst the number of arrests may increase, fewer drink drive accidents on our roads would ease the burden on police resources considerably. We discuss police enforcement later in this chapter (paragraphs 44–54).

The second criticism comes from pub, restaurant and hospitality representatives, who argued that the effects of a 50mg/100ml BAC limit would put hundreds of outlets out of business. Whilst we accept that some individual businesses might be affected, we are not convinced that there would be widespread closures of the kind feared by the pub and hospitality sector. Drink drive legislation had its most significant impact on the industry with the introduction of the legal blood alcohol limit in 1967 and the industry has diversified since then. A reduction to 50mg/100ml BAC would not, in our view, have a significant economic effect on the sector. As such, we are doubtful whether the economic impacts outweigh the importance of significantly reducing the number of fatalities and serious injuries on our roads.

In view of the evidence received, we believe that the North Review is correct to recommend a reduction in the drink drive limit to 50mg of blood per 100ml of alcohol. The arguments to do so are compelling. **We recommend that the Government reduce the drink driving limit from 80mg per 100ml of blood to 50mg per 100ml of blood.**

We accept that a 50mg/100ml limit would not solve the problem of mixed messages communicated to the public, given that the official Government advice is not to drink and drive at all. This is the argument made by supporters of a 20mg/100ml limit, effectively "zero tolerance". However, **we share the concerns of many of our witnesses that a 20mg/100ml limit would be a step too far at this time. There is little evidence to suggest the public would support such a drastic change in the law and we doubt whether it is proportionate.**

The weight of the evidence supports retaining the current minimum penalty of 12-month mandatory disqualification for somebody driving with a BAC level in excess of 50mg/100ml. The success of Great Britain's drink driving policy has been largely attributable to the deterrent effect of this penalty. Given that there is considerable public support for strong action on drink driving and in view of the evidence about the level of impairment at 50mg/100ml, we do not consider that a 12-month ban for somebody driving with a BAC between 50mg/100ml and 80mg/100ml is excessive, nor would it be considered so by the public. A 12-month disqualification at this level would be considered a strong penalty compared to other countries but it would also be more simple and consistent with our existing system of penalties.

The Government should retain the current minimum penalty of 12-month mandatory disqualification for a lower legal blood alcohol limit of 50mg of alcohol per 100ml of blood."

Motion made, to leave out paragraphs 33 to 41 and insert the following new paragraphs:

"We have considered the evidence for and against a reduction in the drink-drive limit from the current 80mg per 100ml of blood. We note the medical and statistical evidence that the risk of accident, or death, increases substantially when blood alcohol levels exceed 20mg/100ml of blood. Such evidence makes a strong case for reducing the legal blood alcohol limit.

However, we also accept that there are valid criticisms against such an immediate and unilateral reduction, which warrant further examination. The first relates to the potential resource implications for the police. In the current economic climate police forces are under increased pressure to use their limited resources in the most effective and appropriate way possible, and it is reasonable to explore whether such a legal change might place unmanageable pressures on their resources. **We recommend that individual police forces should be consulted to assess the respective cost-benefit implications of more effectively enforcing the current drink drive limit against any proposed reduction.** We further note that this is an area of policy which may fall within the remit of the Government's proposed directly-elected Police Commissioners.

The second concern relates to public awareness and acceptance of the legal alcohol limit. We note the evidence that suggests a lack of public understanding about the current BAC limit and what it means in terms of drinks that may be "legally" consumed before driving. The introduction of a 50mg/100ml limit is likely to increase such public confusion, given that the amounts and measurements in which drinks are served and consumed are not easily converted by the average drinker into units of alcohol, let alone into microgrammes of alcohol in blood. It is also complicated by the fact that a person's ability to absorb alcohol into the bloodstream can be affected by many different variables such as the physical build of the drinker, the strength of the drink and when it is consumed. We agree with the Government's official advice that a driver should not drink at all and are concerned that a reduction to 50mg/100ml risks sending out a mixed message.

In the long term, the Government should aim for an "effectively zero" limit of 20mg/100ml but we acknowledge that this is too great a step at this stage. There is little evidence to suggest the public would support such a drastic, immediate, change in the law.

We believe that any reduction in the legal drink-drive limit should only occur after an extensive Government education campaign, run in conjunction with the pub, restaurant and hospitality industries, about drink strengths and their effect on the body. In doing so, the Government should look to learn from experiences in other countries which have successfully implemented a reduction in the drink drive limit to either 50mg/100ml or 20mg/100ml.

We also considered concerns expressed by pub, restaurant and hospitality representatives, who argued that the effects of a 50mg/100ml BAC limit would put hundreds of outlets out of business. Whilst we accept that some individual businesses might be affected, we are not convinced that there would be widespread closures of the kind feared by the pub and hospitality sector. Drink-drive legislation had its most significant impact on the industry with the introduction of the legal blood alcohol limit in 1967 and the industry has diversified since then. A reduction to 50mg/100ml BAC would not, in our view, have a significant economic effect on the sector.

The weight of the evidence supports retaining the current minimum penalty of 12-month mandatory disqualification for somebody driving with a BAC level in excess of 80mg/100ml. **The success of Great Britain's drink driving policy has been largely attributable to the deterrent effect of the current 12-month mandatory disqualification penalty and we believe that it should remain even after a reduction in the legal BAC limit.**"—(*Iain Stewart.*)

Question put, That the Motion be made.

The Committee divided.

Ayes, 7	Noes, 3
Steve Baker	Kelvin Hopkins
Mr Tom Harris	Mr John Leech
Julie Hilling	Gavin Shuker
Kwasi Kwarteng	
Paul Maynard	
Iain Stewart	
Julian Sturdy	

Paragraphs 33 to 41 disagreed to and new paragraphs inserted (now paragraphs 35 to 41).

Paragraphs 42 to 54 read and agreed to.

Paragraphs—(*Mr Tom Harris*)—brought up, read the first and second time, and added (now paragraphs 55 to 99).

Summary, line 6 to end, read as follows:

"We agree with North that the drink drive limit should be reduced from 80mg alcohol per 100ml of blood to 50mg per 100ml. The medical and statistical evidence to support a lower limit is strong. It is estimated that reducing the drink drive limit to 50mg/100ml will save tens of lives and prevent hundreds of serious injuries from occurring each year. There is considerable public support for a lower limit. Furthermore, it would help to create a "social norm" and culture against drink driving and be consistent with the approach adopted by a large majority of countries in the EU and the general trend worldwide to reduce the legal blood alcohol limit.

We were not persuaded by the arguments in favour of retaining the current 80mg/100ml limit. We doubt whether the economic impact on the licensed trade would outweigh the importance of significantly reducing the number of fatalities and serious injuries on our roads and we were persuaded by evidence from police representatives that a lower limit could be effectively enforced within existing resources, despite forthcoming budget cuts. We recommend that the police should have an additional power to enable preliminary breath tests to be required and administered in the course of a designated drink drive enforcement operation. Enforcement of drink driving legislation must be more visible, frequent, sustained and well-publicised.

We noted arguments to reduce the drink drive limit to 20mg/100ml—effectively zero tolerance—but consider this to be a step too far at this time.

We support the retention of the current minimum penalty of 12-month mandatory disqualification for a lower legal blood alcohol limit."

Amendment proposed, to leave out line 6 to end of the Summary and insert the following:

"While we agree that medical and statistical evidence supports a reduction in the current drink drive limit of 80mg alcohol per 100ml blood, we note that currently 2% of drivers killed in road accidents have a blood alcohol concentration (BAC) between 50mg/100ml and 80mg/100ml, while 18% have a BAC greater than 80mg. We recommend that the police should have an additional power to enable preliminary breath tests to be required and administered in the course of a designated drink drive enforcement operation.

We are concerned that a reduction in the limit to 50mg/100ml would send out a mixed message with the Government's official advice to not drink and drive at all, particularly in light of the strong evidence of public uncertainty about what constitutes a "legal drink". In the long term, we believe that the Government should aim for an "effectively zero" limit of 20mg/100ml but we acknowledge that is too great a step at this stage. Instead of an "interim" reduction to 50mg/100ml, the Government should concentrate on working with individual police forces to achieve a stricter enforcement of the current limit and beginning a public education campaign to help achieve public acceptance of a 20mg/100ml limit.

We support the retention of the current minimum penalty of 12-month mandatory disqualification."—(*Iain Stewart.*)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 6	Noes, 3
Steve Baker	Kelvin Hopkins
Mr Tom Harris	Mr John Leech
Kwasi Kwarteng	Gavin Shuker
Paul Maynard	
Iain Stewart	
Julian Sturdy	

Another amendment made.

Summary, as amended, agreed to.

Resolved, That the title of the Report be changed to the following: *Drink and drug driving law.*—(*Mr Tom Harris.*)

Motion made, and Question put, That the Report, as amended, be the First Report of the Committee to the House.

The Committee divided.

Ayes, 6	Noes, 3
Steve Baker	Kelvin Hopkins
Mr Tom Harris	Mr John Leech
Kwasi Kwarteng	Gavin Shuker
Paul Maynard	
Iain Stewart	
Julian Sturdy	

Ordered, That the Chair make the Report to the House.

Written evidence was ordered to be reported to the House for printing with the Report, together with written evidence reported and ordered to be published on 12 October.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 30 November at 10.00 a.m.

Witnesses

List of printed written evidence

List of additional written evidence

(published in Volume II on the Committee's website www.parliament.uk/transcom)

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2010–11

First Special Report	The major road network: Government response to the Committee's Eighth Report of Session 2009–10	HC 421
Second Special Report	Update on the London Underground and the public-private (PPP) partnership agreements: Government response to the Committee's Seventh Report of Session 2009–10	HC 467
Third Special Report	The performance of the Department for Transport: Government response to the Committee's Fourth Report of Session 2009–10	HC 549
First Report	Drink and drug driving law	HC 460

Oral evidence

Taken before the Transport Committee

on Tuesday 14 September 2010

Members present:

Mrs Louise Ellman (Chair)

Lilian Greenwood	Paul Maynard
Kelvin Hopkins	Angela Smith
Kwasi Kwarteng	Iain Stewart
Mr John Leech	Julian Sturdy

Examination of Witnesses

Witnesses: **Sir Peter North CBE QC**, Independent Reviewer of Drink and Drug Driving Law, and **Dr Liz Brutus**, Medical Adviser to the Review, gave evidence.

Q1 Chair: Good morning and welcome to our Inquiry. I wish to declare a non-pecuniary interest in relation to this Inquiry in that my son owns a retail business which sells drug testing equipment and other things. I do not benefit from my son's business in any way and I will not ask questions relating to drug-driving. Could I ask our witnesses, please, to identify themselves for our records?
Sir Peter North: Yes. I am Peter North and the Report of my Inquiry is what you want to discuss today.
Chair: Thank you.
Dr Brutus: I am Liz Brutus and I was Medical Adviser to the North Review.

Q2 Chair: Thank you very much.
Sir Peter, your Report has a fairly controversial recommendation about reducing the drink-drive limit to 50 mg. Is there any really firm evidence that that will save lives?
Sir Peter North: The evidence is of a variety of kinds, I think. There is the judgment evidence which the Report received, of which the weight of the evidence was in favour of a reduction. Some of the evidence was in favour of a reduction to what is, realistically, zero, which is 20, but the bulk of the evidence supported a reduction to 50 and, what I might call the polling evidence—the evidence that was put to us of surveys that had been done—supported that. So that's, if you like, the opinion evidence.
Perhaps more significantly, you might say, would be the crucial evidence of what impact that would have on road safety in terms of the avoidance of deaths and injuries on the road. Some people said to us, "Well, we would certainly support a reduction to 50 if there was evidence that this would have an impact on road safety and the avoidance of accidents."
So there were really two chunks of evidence to us on that issue: one was evidence from Professor Richard Allsop which indicated—I'm sorry, I perhaps need to digress a minute. The figures in the Report of the numbers of deaths and injuries were the figures available at the time of the production of the Report. As happens each year, those figures are revised by the Department for Transport—the statistics are revised. So, if I can just use the figures that appeared in the Report, all the numbers will have come down a bit because the numbers of deaths in the revised figures—deaths and injuries—have come down a bit, which is good.
Richard Allsop estimated that bringing the limit down would save of the order of 43 lives a year and avoid a substantial number of serious injuries. So that's roughly a life a week.
The other evidence we had was that, coincidentally with the Review, the Department for Transport commissioned the National Institute for Health and Clinical Excellence, NICE, to do a review of this issue, and, so, published at the same time as my Report, was the NICE Report, along with the evidence also of the research work that was done on their behalf. What NICE did was they looked at the impact of the reduction of limits in Australia and in Europe. They then projected the impact in those two different parts of the world on to the GB position—actually on to the England and Wales position. That is another complexity of this, I'm afraid. Their estimate was, if you took the Australian experience, that there would be a saving of 160 or thereabout lives rising, over a period of six years, to over 300 lives. If you took the European experience, the figures were somewhat lower but, at the higher end, they would still be of the order of three lives a week.
The figures in our Report are actually grossed-up figures because—I'm sorry about this—the NICE work was done on England and Wales. At the moment the legal regime is Great Britain; so we grossed those up for the 7% of accidents which occur in Scotland.

Q3 Chair: That sounds very complicated—
Sir Peter North: I'm sorry about that.
Chair:—and there has been criticism that the NICE Report that you used quite heavily did relate to another country, Australia, and didn't refer to here. What do you say to those people who would put it to you that the real problem about dangerous driving under the influence of alcohol is with those who drive with a great deal of excessive alcohol in their blood, over 100 mg, and that that's where the very large number of accidents take place, and the focus would be much better there rather than at the lower end?
Sir Peter North: I would say to them that they are right that it is a real problem, but it is not the only

real problem. Again, I'm sorry about this statistical issue. We know what the numbers of deaths are which are caused by people who are over the current legal limit. That is where the 430 in our Report—now about 400 in reality—comes from.

We also have to address the number of deaths caused by people who are under the current legal limit but which might be saved by bringing the limit down, and my estimation of that is it is about 270 deaths. So we've got two issues.

Q4 Chair: Can I just stop you? Is that your estimate or is there any solid evidence that, at that level, people are dying and being injured on the roads? Is there actual evidence on that?

Sir Peter North: The evidence, and I'm afraid I have to stick with the complexity, is that 35% of all drivers—drivers—killed have alcohol in their blood. 18% of those are over the current legal limit. So 17% are below the current legal limit. If you extrapolate that to the number of deaths, you come up with an answer of about 270. But it's founded on the statistical evidence of how many drivers who are killed have alcohol in their blood.

Now, coming back to your fundamental question, which is, "Isn't there a real problem with those over 80?", the answer is, "Yes", and the Report attempts to address that in a variety of ways. The evidence is that bringing the limit down from 80 to 50 will also avoid some deaths caused by drivers who are over 80. But we've also suggested, in the Report, that the High Risk Offenders Scheme should apply at the new proposed lower level so that it would bring more people into that net. There are proposals in the Report in relation to the confiscation of vehicles. There are proposals in the Report in relation to disqualification. So it's not a problem that's ignored, and bringing the limit down will, to a degree, address that problem, but it will also address the problem, which in a sense you can't see, which is the problem of all those who drive between 50 and 80 at the moment where injury or death is caused. The risk of causing death when driving between 50 and 80 is six times the risk of causing death when driving with no alcohol.

Q5 Chair: Where do you get that figure from?

Sir Peter North: Those are the figures which come from the NICE Report. It's that—

Chair: About Australia, not about the UK.

Sir Peter North: No. Well, yes. It's the NICE estimation of what the risk levels are[1] and, going back to your question, the risk gets even worse when you consider drivers who are above 80; driving at 80 plus creates 11 times the risk. So I'm not ignoring the significance above 80 but what I would do is stress the significance of between 50 and 80.

Q6 Mr Leech: Can I just ask why you look at the 50 mg as opposed to 40 or 60? Is it mainly because other countries have gone for a reduced limit to 50?

Sir Peter North: We looked, realistically, at three numbers—0, 20 and 50 as well as 80. I think 0 is impracticable. It is the law in some jurisdictions but we can generate a small amount of alcohol naturally, as well as through taking mouth washes, cough medicine and the like. So the realistic zero, in my judgment, was 20. So we looked at that as a possibility. 50 rather than 60 or 40? I think the honest answer to that is that 50 is the generally accepted lower level below 80. Most jurisdictions which are below 80 are either 50 or 20.

Q7 Mr Leech: Is there any particular reason why other countries went for 50, then, when they chose to lower their limits?

Sir Peter North: My understanding is that they took the view that, if you like, balancing all the public interest in this, you are balancing that with the number of lives you will save by bringing it down to 50. You are not, at that point, completely preventing people socially from going out and having a drink, and that is where the balance was drawn. I don't think it is a magic number but it seems to be the generally acceptable number below 80.

Q8 Mr Leech: My impression, just from anecdotal evidence, is that most people don't actually know what they can drink safely to be below the 80 mg limit, and one of the reasons why I support a reduction in the limit is that I think if it goes down to 50 a lot of people who think that they can go out and have one drink will just think that they can't drink at all and choose not to drink at all. Is some of the reason why you would like to see a reduction in the limit to 50—

Sir Peter North: I'm sorry, I didn't quite hear that.

Mr Leech: Is some of the reason why you would like to see a reduction in the limit to 50 be that it would have the effect of making a large number of current drivers never have a drink when they are driving?

Sir Peter North: I think it will have that effect on some. I think, to be honest, the 80 limit has a desirable effect on some. There are others who take the view, "Well, I'll obey the law"—this is your point about people not actually knowing—"and I think I'm okay if I do this". Bringing it down to 50 will certainly have the effect, "Well, I think I'm okay if I drink less", but it will confirm the views of those who want to avoid the problem. It will bring down the amount of drinking done by those who think they know—and I think you're right, mistakenly know—what a realistic limit is.

Q9 Julian Sturdy: Are there any records kept by the police when breathalysing drivers of the numbers that fall between the 50 and the 80 bracket and those that are involved in accidents?

Sir Peter North: I think when you take evidence from ACPO you need to ask them, if I may say so, that question. My understanding in relation to the technology—but they will correct this if I'm wrong—is that it is only when we reached the point of having digital read-out breathalysers rather than traffic light ones that it was possible to determine what the actual level is. That is very recent and I'm not absolutely sure that every police force now has those breathalysers, but, again, ACPO will be able to tell you that.

[1] See supplementary written evidence from Sir Peter North CBE QC Ev 104.

I don't know the extent to which records are now kept of the 80 to 50 numbers. They certainly weren't available to me.

Q10 Julian Sturdy: Do you think that this is something that should be progressed; that we should look at getting more evidence now the technology has moved so that we can get that evidence, as you say, with the new breathalysers—that you could start recording people who have been in accidents who are in between those sorts of brackets?
Sir Peter North: I think the more evidence you have of who is doing what in terms of what is dangerous activity, subject to cost, is a reasonable thing to do. My own judgment, and it was clear from the Report, is that you don't need that evidence in order to take a decision to bring the limit down.
Julian Sturdy: Thank you.

Q11 Iain Stewart: I have a couple of questions, if I may, on the international comparisons that your Report covers. First, in terms of looking at the impact of a lower limit, did your study look at any examples of countries which moved from a higher limit to a lower one and what the consequences of that were, or were you just looking at the static position of the lower limit as it is now?
Sir Peter North: No, no. The evidence from the NICE Report is the evidence of the impact in terms of the avoidance of deaths and serious injuries of coming down from 80 to 50. So it is not just: Do other countries do better at a 50 level or do they do better at an 80 level? In terms of enforcement, they do a lot better at both levels than we do. But the important evidence for us was what was the impact of bringing the numbers down, and that was the work that was done looking at what happened in Australia and in Western Europe.

Q12 Iain Stewart: Most other countries had a limit of 80 or thereabouts and have moved, in the last few years, to a lower limit.
Sir Peter North: Yes. The progression has been down. The current position in Europe, for example, is that Ireland is coming down. In Northern Ireland, where this is a devolved matter, all the evidence put to us was that they are coming down. Scotland has asked for this to be a devolved matter. The previous administration and the current administration have both agreed that when the Calman Report is implemented it will become a matter for Scotland to determine the level in Scotland, and all the evidence to us was that they wanted to bring it down. If that happens, England and Wales and Malta will be the only European jurisdictions at as high as 80.

Q13 Iain Stewart: I have a second question, if I may, on the international comparisons. I was looking at Table L in your Report—
Sir Peter North: Page 269?

Q14 Iain Stewart: 269, indeed. Looking at other factors—and one I am particularly looking at is the regularity of random tests that are made by police—it is looking at the behavioural patterns. If people expect that there is a reasonable chance they will be stopped and breathalysed, to what extent does that have an impact on alcohol consumption and driving?
Sir Peter North: In my view, a very large one. This table you have referred to is very striking. The UK, per driver, does the smallest number of breath tests in Western Europe, apart from Italy, and the European average is five times what we do.
You used the word "random" and I think it's a slightly difficult word to use. It tends to be the fashionable word—to talk about "random" breath testing. The police, I am sure, when they give evidence to you, will indicate, as they indicated to me, that they have substantial powers to breath-test people if they suspect they've been drinking, if they've committed a motoring offence and so on. They do not have the power, without any particular cause, to stop and breath-test somebody. So you cannot convey the message that if you drive you could, at any time, be stopped by a police officer and be breath-tested. That is what happens in many other jurisdictions and that means that you know you are at risk. I think the problem with the word "random" is that it's kind of unfair to the police. It suggests that somebody, on some days, says, "Oh, I'll stop this person or that person".
My judgment is that the proper use of resources would be that if the police had this widened power they would use it strategically; they would use it in an intelligence-led way. But the message to the public would be, "Don't drink and drive, and at any time you can be tested". I think that's a powerful message.

Q15 Iain Stewart: Just one final question, if I may. How would you answer those who say that, actually, a far more effective way of combating drink-driving would be to have more regular testing than lowering the limit?
Sir Peter North: I don't think it is an either/or. I think they're both important.

Q16 Kelvin Hopkins: I will put my cards on the table. I start from a position of strongly supporting you and, indeed, I supported an amendment in the previous Parliament, which was defeated, to bring the limit down. So you have convinced me already, but this convinces me that we were right. Very simply, setting other arguments aside—the enforcement and all that—there is a simple curve, like in a demand curve, that if you reduce the level of permitted alcohol in the bloodstream, deaths go down, and those deaths go down by the kind of numbers you've mentioned. Even without changing enforcement you get an improvement. So that's the conclusive argument for me.
There's a secondary argument, and I hope you will agree, which should not confuse that conclusion about enforcement—the fact that five times more breath tests are given on the Continent of Europe, on average, than in Britain. That would make another significant difference. But that's additional to a separate argument from reducing the levels, and they shouldn't be confused—those two arguments.
Sir Peter North: I agree with that entirely. They are both steps that will have an impact and the more steps

you take the greater the impact there will be. I think there is an underlying issue here which you have to bear in mind. Our road safety record is not bad—but don't tell that to grieving parents/families—and it has been steadily brought down by actions taken by different administrations in all sorts of ways. But it's a point, which I stress in here, that you can't get the step gain more than once. You can get the step down by seatbelts or motor cycle helmets, and that will bring deaths down to a lower level and if you enforce that you keep the deaths at that lower level. But it won't do anything to bring the number of deaths down another level and if we are to get the figures down and down we have to have step changes. They may be road design, they may be car design, they may be all sorts of things, but drink-driving is an avoidable problem and I think what this proposal would do is provide another step change down.

Q17 Kelvin Hopkins: Yes. I must say, I'm old enough—probably the only one here—to remember the breathalyser being introduced and the great hostility to it.
Sir Peter North: You're not the only one.

Q18 Kelvin Hopkins: But it was such an obvious, sensible thing to do. But following John Leech's question, and just to reinforce that point, reducing it to 50, the level is sufficiently low to deter people from drinking at all. Perhaps it changes a culture so that people, by and large, don't have a couple of drinks and hope it's okay. They don't drink at all because they fear they might be over the limit.
Is there any evidence that cultural change like that takes place—from abroad, for example? I suspect it would do in Britain.

Q19 Chair: Sir Peter, in your Report you do talk a lot about public attitudes towards your recommendations—
Sir Peter North: Yes.
Chair:—and that does seem to influence what you say. Can you comment on that in relation to Mr Hopkins, first, on that?
Sir Peter North: The public attitudes are really what I would call the "soft evidence", the opinion evidence to us, and surveys conducted by the AA and by others firmly support bringing the limit down. So that's the public attitude.
I think, on public behaviour—in a way, Mr Hopkins' point was, "How will it change public behaviour?"—there will be some people, in my view, who will take the view, "Right, well, I'm not going to have anything to drink at all." It is a phenomenon that some of the young are actually very good at that—not all of them but some of them are.
I think, with others, they will take the view, "Well, I would like to go out for a meal. I need to be a good deal more careful, so I will have one glass of wine and drive home." If they did do that they would be, in my judgment, manifestly within the new lower limit. But there it will pull down the consumption rather than avoid the consumption. But different people will behave in different ways.

Q20 Kelvin Hopkins: One final question. It is just that the emphasis is always about the driver and what might happen to the driver.
Sir Peter North: Yes.
Kelvin Hopkins: The fact is that people drinking and driving kill and maim other people, pedestrians and other drivers. Should we not perhaps emphasise that more in all the reports?
Sir Peter North: Yes. The statistical deaths are the deaths as a result of an accident involving a drink-driver and not just drink-driver deaths.

Q21 Angela Smith: Sir Peter, you have mentioned or rather, if you like, explained the pragmatic basis for your approach, which I appreciate entirely. In a sense, if you have a 50 mg limit rather than a 0 or 20 mg limit, you do accept that people will want to do as you say—go out and have one glass of wine with a meal. Do you not accept, though, that there is, in a sense, nowadays a great deal of confusion over what a glass of wine actually is—whether it is 175 ml or 125. 250, for many people, is a glass of wine. Alsace Gewurztraminer is 13.5%. A lot of wine is 12. The basis for the measurement, I believe, is 9. Becks is 5%. John Smith's is 3. Gordon's gin is 40% and Bombay Sapphire is 47.
Chair: You seem very well informed, Ms Smith.
Angela Smith: My drinking habits are on the record. Nevertheless, the point stands that there is a great deal of confusion over what a measure of alcohol actually is and it is incumbent on us, I believe, if we bring the limit down, to educate people more thoroughly about what a measure of alcohol is and, if necessary, to enforce measures, if you like, within the licensed trade.
Sir Peter North: You are absolutely right that it is not clear. A pint is a pint but the strength of the pint may vary. So the problem is just the same in relation to the size of the glass of wine and the alcohol content of the wine. The problem is worse because the capacity of somebody to deal with alcohol depends on gender, age, build, practical experience, if I can put it like that. In a way, the more you drink, quite often the more you can cope with. It is real, anecdotal evidence, but we heard from police officers how they have tried to test, on themselves—I don't mean going out on the roads—impairment. There was a television programme which the Review Team and I watched which indicated how much people had drunk and who then were put on a driving simulator. It was extraordinarily variable.
I think the difficulty is in giving people firm, practical advice. It is going to be so different from one person to another, and there is a kind of public "Let's not do that" attitude; "Let's leave the uncertainty there". I am not saying this is desirable but I think there is, around, a view that it is kind of safer to say to people, "Oh, I shouldn't have anything to drink", or, "You had better only have one glass", without firm evidence as to whether, in relation to that person, it's impairing or not.
Chair: Dr Kwarteng, did you want to ask a question on that specific point?

Q22 Kwasi Kwarteng: Yes. It seems to me that you could say, as one of my colleagues has said, that the less the amount of alcohol in the bloodstream the fewer deaths will occur. That seems a logical thing. Also, given the fact that there is massive uncertainty out there in the public in terms of, as one of our other colleagues said, what a measure of alcohol is, I was just wondering, with these two facts, do you envisage a time when it will be criminalised completely? I mean, I can see a situation where you are lowering the limit, no one really knows what that limit means, in terms of going out, and you might as well just say, "If you're going to drive, just don't drink".
Sir Peter North: That is a view that was put to us. Going back to what I said earlier, I would actually put that practically at 20 rather than zero. There is a problem which you may want to come on to, but, if I can pick it up now, you can't look at the level in complete isolation from the penalties. You have to fit the two together.
If you look at those jurisdictions in the rest of Europe which have a 20 limit, the legal regime for dealing with those who break that limit is far, far less severe than here. In Sweden, for example, where the limit is 20, it is dealt with administratively rather than through the formal court system, through a process, essentially, of penalty points. You don't get into the court system until your breathalyser level is 100. It is a social balance, this, I think, and a public acceptability balance, which raises the issue, if you bring it right down of whether you can stick with the mandatory disqualification provisions that we have got now? I suspect that would not be acceptable at the moment.
Chair: Ms Smith. I will come back to you, Dr Kwarteng, in a minute.

Q23 Angela Smith: Thank you. I want to go back to the original question. I accept entirely that it is very difficult to judge what an individual measure of alcohol may do to different individuals. Nevertheless, it is true that the concept of the standard measure has become almost degraded beyond recognition, and would it not be the ideal opportunity if we were to bring the limit down, to also say to the licensed trade that a glass of wine has to be standardised across the country, either 125 or 175 ml, because we have to have a standard somewhere? If we are going to make it possible for people to make reasonable judgments, we do have to have a standard. And is it not time to look again at the average alcohol content of a bottle of wine, given that it has gone up from the 9% that it was in the 1970s to 12?
Sir Peter North: Well, it has gone up to 15.
Angela Smith: In some cases it is.
Sir Peter North: My experience is even worse than yours, if I can put it like that. With respect, I think it is a thing that lawyers say, but theoretically that has merit. The problem is, of course, that the wine trade—if we just stick with wine—is international. If you go into a supermarket there is wine from every continent that you can buy and I think there will be very real difficulty in imposing controls on the alcohol level of wine imported from all over the world—and almost all our wine is imported. It is a practical issue.

Q24 Angela Smith: But that's not my question. My question is this. For instance, the average advice always given is that you can have two glasses of wine, but that is based on 1970s measurements. I go back to that.
Sir Peter North: Yes.

Q25 Angela Smith: My other question is, within the licensed trade, it perhaps would be helpful, at least, if we could encourage people to understand that two glasses of wine is 250 ml, not 375.
Sir Peter North: I agree.

Q26 Angela Smith: Can I just ask another question as well? It is about the morning after.
Sir Peter North: Yes.
Angela Smith: Many people will, perhaps, just go over the limit, or, perhaps, be twice over the limit, get up the next morning, then drive to work thinking they're absolutely fine. If we reduce the limit, is it not also incumbent on us to educate people more thoroughly about how long it takes alcohol to leave the system?
Sir Peter North: Yes. One of the arguments put to me was, "I'm unhappy about bringing the limit down to 50 because of the morning after effect". Now, I am utterly unsympathetic to that view because, if you go on a blinder one night and you are driving the next day and your driving is impaired because of what you did the night before, you're as much a danger to the public as somebody who is over the limit but has drunk rather less that morning. So I do not think that the morning after effect is any ground for not addressing the issue. But making sure that people realise that alcohol takes a while to get eradicated or diminished in the bloodstream is important.

Q27 Chair: Dr Brutus, could I ask you on that? Is there any actual medical evidence that people's driving is less impaired when their blood level of alcohol is coming down rather than when it is going up?
Dr Brutus: There is some research that has looked at the impairing effects in terms of rising alcohol and then contrasting that with falling alcohol. I think, as Sir Peter has said already, that with every individual there is so much variation that the actual conclusions on that are, effectively, inconclusive, but there has been some research on rising versus falling levels.

Q28 Paul Maynard: What, in your view, is the purpose of drink and drug-driving legislation?
Sir Peter North: Road safety.

Q29 Paul Maynard: What do you mean by "road safety"?
Sir Peter North: Avoiding deaths and injuries of all kinds on the road.

Q30 Paul Maynard: In your view, is the selection of a numerical limit a guide to enforcement or is it a means of promoting wider social change? What is the purpose of the numerical limit?
Sir Peter North: If you are dealing with alcohol, the numerical limit is there to try to ensure that as few

people as possible are driving over the limit and, therefore, that as few people as possible are driving in an impaired state which puts the lives of other members of the public at risk.

Q31 Paul Maynard: So if we were to follow your recommendations and lower the limit from 80 to 50, are you saying that that should then be enforced rigorously and comprehensively? Or should we, rather, focus more specifically on those who are still significantly over the limit, but expect or hope somehow that, merely by selecting the number 50, we are sending a wider signal? Is this about health education or is what you are proposing here an attempt to get the police to apply the law much more rigorously?

Sir Peter North: It is not health education directly at all. It is a signal, if you like, to people that, "You are really dangerous to everybody else at 80. You are considerably less dangerous to everybody else at 50." That has to be badged alongside the continuous "Don't drink and drive" message because you are also dangerous at 50.

It comes back to the argument, "Why don't you bring it down to 20?" That is part of politics being the art of the possible. It is a step which I do not think would be broadly accepted by the community at large, and this sort of legal regime does need broad community support. It doesn't in any way suggest that the current problem—and, as the Chair was saying it's a real problem with those over 80—is somehow, magically, going to go away. But I don't think you should separate enforcement and the legal regime and say, "Well, you can do this or you can do that". Ideally, you would do both.

Q32 Paul Maynard: But do you concede there is a potential danger that, in reducing the level to 50 and redirecting enforcement activity on adhering to that 50, you then have less resources available to target those who are significantly over the limit at over 100, 110, 120?

Sir Peter North: I don't think, in practice, that is true, but, again, the police, when they give evidence to you, will have a view on it, because, if you are taking more steps to enforce the law by checking drivers, you don't know what their level is when you stop them and check them. You may have caught in your net a 120 person or you may have caught in your net somebody below the 50 limit.

Part of the enforcement problem, actually, in relation to the very bad drink drivers is dealing with the enforcement of the penalty regime after it has been imposed, which is driving whilst disqualified. That is a separate issue. But that is not catching them. That is about energetically deterring them from doing it again. That is why, in the Report, there are a number of recommendations which are addressed to the regime of the High Risk Offenders. Again, I don't see the argument that "You can do this or you can do that". Actually doing testing on the roads encompasses all the groups.

Q33 Lilian Greenwood: There are two quite separate issues I wanted to ask you about. The first is just coming back to this issue about 20 or 50.

Sir Peter North: Yes.

Lilian Greenwood: Given that the message is "Don't drink and drive", do you think it is something of a mixed message if you say, "Don't drink and drive but, on the other hand, there's a little bit of leeway because you can have a drink", and, whether it is 80 or 50, people have an idea that they can have one drink, albeit all the difficulties associated with what a drink is and how many units of alcohol and how quickly your body processes it? I want to understand very clearly the evidence or the reasons why you went for 50 rather than 20.

Sir Peter North: Your point is absolutely good about the mixed message. We have a mixed message at the moment, and I don't think coming down to 50 will eradicate the mixed message issue. I will be absolutely straight about that.

However, one of the very important parts of the current regime is that you know if you drink over the limit and you are caught, you will lose your licence, and you will lose your licence for a year. That is inconvenient and there are all sorts of other costs that flow from that—work related costs, insurance costs. It's a heavy penalty.

I had to take a view as to whether that penalty should remain at 50, and there were varying views put to us. But, at the end of the day, I thought, clearly, mandatory disqualification should stay—it has been a very important road safety tool—and, on balance, I thought it should stay at 12 months.

If you bring the limit down to 20—I go back, if you like, to the popular perception acceptance—I think it would be very hard to get general acceptance, whether political or public, if I can put it like that, for a similar tough penalty regime at that much lower level. I think it would be very difficult today. Maybe in 10 or 20 years' time the public will accept that. If you look across to other countries—if you look across the Channel or elsewhere—those countries which have a low limit do not have a penalty regime anything like as tough as ours.

So, yes, you're right. It is a mixed message. I can't remember which of you said it is pragmatic, and I have to say it is entirely pragmatic. It is: What balance can you deliver now to get road deaths down and keep the public broadly accepting that that should be done?

Lilian Greenwood: Was the view that you took that you will retain public acceptance for a ban for 12 months at 50 but not at 20, a judgment, or was that based on some of the evidence in terms of opinion polling?

Sir Peter North: Some of the evidence to us was strongly in favour of retaining mandatory disqualification; not absolutely in favour. I know that one or two people—organisations—that submitted evidence which rather doubted whether that was right have since taken a view that that is right. What I might call the public opinion polling, basically, was rather more severe: "You should have disqualification for longer periods of time" and the like.

You might say that is a bit knee-jerky. But the weight of opinion evidence—and there is no scientific

evidence that I can produce on this—was in favour of keeping a mandatory limit and generally in favour of keeping the 12-month limit. That is evident, as I say, from the British Social Attitude Survey, which was a very large annual survey. The AA, who I think are talking to you later today, conducted a survey, as did Brake, one of the charities involved in road safety, and I am sure you can ask them about this survey. But it all pointed in that range.

Q34 Lilian Greenwood: In fact might there be some public support for bringing the limit down to 20 and, therefore, 50 is more of a middle ground?
Sir Peter North: In the evidence that I got there was some support, but not much, for coming down to 20. There was a lot of support for keeping the mandatory disqualification. As you say, it is a judgment. The judgment was that what I had recommended provided the right balance.

Q35 Lilian Greenwood: The second part I wanted to ask you about is—
Chair: Ms Greenwood, I have just got two people who want to put a very quick question on that topic and I'll come back to you for your further question.

Q36 Kwasi Kwarteng: Can I understand your personal opinion? You have suggested that there were political objections to lowering it to 20 in terms of the art of the possible and the context that we're in at the moment.
Sir Peter North: Political with a small "p".
Kwasi Kwarteng: Yes, that's what I meant.
Sir Peter North: Not party political.
Kwasi Kwarteng: No, no, no.
Sir Peter North: There may be party political objections—
Kwasi Kwarteng: I agree—
Sir Peter North:—but that's nothing to do with me.
Kwasi Kwarteng: But there was an issue about public opinion in terms of bringing it back to 20.
Sir Peter North: Yes.
Kwasi Kwarteng: What is your personal view? In an ideal world, would you rather have a 20 limit or a 50?
Sir Peter North: I think in a wholly hypothetical ideal world I would rather have 20. I have no confidence that that is deliverable in the real world for a decade or more.
Chair: Mr Leech, just on that point.

Q37 Mr Leech: Yes. If a 12-month ban is still the right minimum ban at 50, is there a case for arguing that, when someone is then still above the 80 limit, the minimum ban should be longer?
Sir Peter North: Yes. Without going into the technical details of the sentencing recommendations in here, a consequence of 50 being the starting point is that the sentencing guidelines which are produced for the Bench should accommodate a rising of the period of disqualification from that point, as they do, at the moment, accommodate a rising from the 80 point. So, if you like, it should all be scaled up from 50.
But that is a matter, constitutionally, for judicial determination and would go to the Sentencing Council for their recommendations as to what judges and lay magistrates should do. The Report recommends that the Council should look at that.
Chair: Ms Greenwood.

Q38 Lilian Greenwood: Yes. The second part I wanted to come back to was about the number of lives that would potentially be saved as a result of reducing the limit from 80 mg to 50. You said earlier that 35% of those involved in accidents who were killed have alcohol in their blood but only 18% are above the legal limit. Is that what you said?
Sir Peter North: Yes.

Q39 Lilian Greenwood: So that's how you have reached the figure that would be the remainder—those 17%?
Sir Peter North: Yes. The problem that we've got is that we know a lot about the people who break the present law. It comes back to the point about the breathalyser evidence. We don't know, other than by projection, as much about the people who would be breaking the law if the limit was brought down from 80 to 50. If you look at the percentages, they would indicate—the Chair said it was getting a bit complicated and I don't want to make it complicated again, but my judgment was that that number of people who are potentially saveable just within the 50 to 80 limit is about 270.
Dr Brutus: I wonder if I could just add, for Ms Greenwood, to your reply. One of the calculations, Professor Allsop's, was based on the categorisation of the different people, whether they were borderline or whether they were under 50 or if it was between 80 and 100. But, actually, NICE's calculation was looking at all road deaths and all road injuries and seeing whether, if you reduce the alcohol limit, as was done in Australia and in Europe, you shift the whole of drinking and driving down. So that's where you get your numbers from and that's why you have a wider estimate.
Lilian Greenwood: Thank you.

Q40 Mr Leech: Why, exactly, do you think the UK is so far behind with drug-driving test kit approval?
Sir Peter North: The UK is behind, I think, in two things. It has not participated energetically in international work, whether in the OECD or in Europe, in investigating drug-driving. So that is why, in our Report, we had to do two things: we commissioned work of our own on drug-driving in the UK and we had the benefit of access to a draft OECD report on the international experience. It has just not been given the priority by governments—I don't think it is a party political issue—in engaging in how to discover exactly what happens and on how to address the issue.
In terms of drug testing equipment, I don't think this story is a particularly good one, though I can understand why. The energies, for quite a long time, were directed at trying to produce for drugs something like the equivalent of the breathalyser at the roadside. There are very serious difficulties with that from the technical point of view. The science of testing for a range of drugs is much more difficult than the science of testing alcohol in the breath. Only much more

recently have energies been switched to trying to produce drug testing kits which would not be so sensitive to environmental concerns because they would be used in the police station. That is one of the recommendations in my Report.

In other jurisdictions, particularly Australia, they have been using both, what I would call, "screening" drug testing, which is a swab which will reveal whether or not there is evidence of one of a small number of drugs. If that is positive, you then have another regime. So it's a bit like the breathalyser: breathalyser on the roadside, evidential testing in the police station; and the Australians have used evidential swab-testing kits. This is very new and is still at something of an exploratory stage. They have overcome the environmental issues by having what they call, I think, "drug buses". So they will have the police officers out on the roadside screening drivers, basically, I think, for cannabis and one other drug, and then, if that test is positive, they are taken round the corner to the drug bus, which is air-conditioned, all the pieces of kit are kept in the fridge and the evidential testing is done there.

The difficulty with that is that the drug testing science is not nearly as strong, evidentially, as the breath testing science. That is overcome, in a way, in Australia by taking a rather robust view which is, "Well, we don't care too much that the science isn't as strong because the penalties will be very low". So you get some penalty points in the Australian experience.

Perhaps I might also add that we have been using drug kits in police stations. There were nearly a quarter of a million tests done last year using drug swab kits for a different legal purpose. It was to determine whether people charged with acquisitive crime were on drugs, and that information does not go to their guilt or innocence at all but if they are found guilty it goes to the disposal that the court wishes to use in dealing with them. My view was that we have got a lot of experience of testing kits being used for that. What we ought to do—and the present administration has indicated that it is going to do it—is to put the energies of the scientific researchers to produce type approval for drug testing kits which are screening kits which can be used in the police station, which would have the advantage of eradicating the need, in every case, to have a doctor or a nurse there to take a judgment as to whether the person might or might not have a condition which may be due to a drug. It won't get rid of the need for a police officer, in the first place, to take a view as to whether the person is impaired.

Q41 Mr Leech: Do you not accept, though, that it doesn't solve the problem about the length of time of getting someone from the roadside to the police station and going through that process as well?

Sir Peter North: I don't accept that it doesn't solve a lot of the time problems. The process is: the police officer stops somebody; believes they are impaired; breathalyses them. They pass the breathalyser test. The officer still thinks they are impaired. He then forms a judgment, using, quite often, what is called a field impairment test of behavioural judgment to see whether they are impaired. If he thinks they are, he takes them to the police station. If it was drink, he has got to take them to the police station because they have got to have the breathalyser in the police station. So that's exactly the same as alcohol.

At the moment, the law requires a doctor to determine whether the condition of the person taken to the police station might be due to a condition caused by a drug. There are real time issues getting the doctor there. If you have got the kit in the police station, you don't need more than a police officer to take the swab test. That is then tested and if that is positive that will justify somebody taking blood. That does not have to be a doctor. It can be the custody nurse. So that is a real time saving.

Q42 Mr Leech: Am I right in thinking that the BMA have raised some concerns about doctors not being involved in the process, though?

Sir Peter North: No. There are two issues. If it is taking blood, blood can be taken by a nurse and the law allows that. So that is not an issue. The issue was: Do you need a doctor to determine whether the person has got a condition which may be due to a drug? If you have a swab testing kit you don't need to go through that process at all. If you haven't got that swab testing kit you do need to go through that process, but the judgment that I reached was you do not need a doctor to do it. You can have a doctor to do it who is well trained to do it. You can have a nurse to do it who is well trained to do it. Nurses in custody suites have to take major medical decisions about the condition of people in custody. Essentially, the evidence to us was that a nurse is perfectly capable of forming this judgment. But if you have got kits in the police station you won't need to do it at all.

Q43 Mr Leech: I have one last question. Just going back to the point you made about Australia and them not being too concerned about the kits being 100% foolproof, are you suggesting that because we would have bigger penalties in this country the kits at the roadside would have to be foolproof?

Sir Peter North: Yes. I don't want to convey the impression that the Australians are cavalier about this, but where the penalty regime is relatively low it becomes generally acceptable that the process is more automatic, so like penalty points and the like. This work is still at an inconclusive stage in Australia. They have been experimenting with this. We ought, actually, to be proud that the scientific requirements in this country of type approval are tough. That is a good protection for the citizen and I don't think we ought to diminish that. But, if you like, the robustness of the kit varies as between whether it is being used for screening or evidential purposes. If it is screening, it is just the same as the doctor forming a view that there might be a condition due to a drug. All you are doing if you have got it wrong—when I say "all you are doing", it is not insignificant—is you are putting the person at risk of having a blood test. You are not putting them at risk of any more than that.

Q44 Julian Sturdy: My original questions were on detection but I think we've covered those very well.

Sir Peter North: Yes.

Q45 Julian Sturdy: Could you just move on to the consequences, basically now? In your Report you talk about the offence of drug-driving being a bit like the drink-driving, so there would be a limit in there. Do you not believe that on this sort of thing we should be looking towards a zero tolerance?

Sir Peter North: I was waiting for someone to ask that. It's a difficult issue. You have to separate—or I think you have to separate—the purpose of the rules. It goes back to Mr Maynard's point in fact. What we're looking at here, in the legal regime, is road safety and trying to keep off the roads people who are impaired by things they have taken—drink or drugs. So anxiety about the impairment of their driving has been central to this. We have a quite good mechanical process, through breathalysers, where we can identify alcohol impairing levels. Now, if you say, after more work, "Well, we can't produce impairing levels for major drugs", you then have—I'm sorry, I ought to correct myself. I think we ought to continue to investigate, scientifically, whether you can. I think that is an open issue and the best answer would be to have the drug equivalent of the breathalyser with levels.

When you come to zero tolerance, what you are saying is, "I stop you. You are shown to be driving and you are shown to be driving having evidence of a drug of one of a number of kinds in your system. You have broken the law". The problem with that is that it is not illegal to take drugs. It is illegal to possess and distribute controlled drugs, but it is not illegal to take them and it is certainly not illegal to take prescribed medicines. So you have got a problem with people committing a criminal offence because they have got drugs in their system without it being unlawful in itself to have drugs in your system and without any evidence, at all, that their driving is impaired by it. Dr Brutus will be better at describing some of this, but some drugs have the effect of making you more impaired and some less impaired. Some of them have a process of starting off impaired and going on in the system for a very long time—weeks, in the case of cannabis?

Dr Brutus: Yes.

Sir Peter North: But the impairing point is long gone. But in week three, the presence of the drug will still appear on the kit. If one is thinking hard about going to a zero tolerance regime you have got to think very hard about whether this is compatible with road safety provisions which are aimed at impairment. It seems to be sliding into a drug control regime. Now, it might be right to do that, but it is very hard, in my view, to justify that as protecting the public from impaired drivers.

Q46 Julian Sturdy: Have you not just made a very good example of the problems, though, of putting limits on because of the different drugs. Whereas with alcohol it is quite straightforward—and maybe Dr Brutus could answer this—with the difference in the kind of drugs, there are different controls you would have to have for each different one, basically.

Sir Peter North: I agree that it is a problem. It is a problem which is being investigated at the moment. It is being investigated across Europe by an investigation called DRUID and this is a long-term European research programme into this issue.

I am not putting up my hands now and saying, "The scientists will never be able to solve this". The scientists have solved the drink one. We just take the drink regime for granted now but there was quite tricky science in getting to that point.

I think we are not at the point of being able to say, "This is an unachievable Holy Grail". I think we are at the point of saying we need swab testing kit for screening purposes fast, and it looks as though that is the direction in which we are moving, we need smartening up of the procedures in a variety of ways, and what we want the scientists to do when, they clear the type approval and the like for the swab testing kit is, and I hope internationally co-operating, to address this: How can you get—can you get?—drug testing kit for the major drugs at a level which will give you the same confidence as the breathalyser? I would not throw up my hands now and say, "You can't do it".

Q47 Iain Stewart: I would like to focus on the issue of awareness of the drug-driving law as it currently stands. To what extent do you think there is an ignorance that it is against the law as it is now and, also, an ignorance in the sense of, "What drugs could I take?" and what the effect would be, in the same way as we are talking about the different impact of sizes of measures/strength of alcoholic drink? Whereas I think most people have a reasonable idea of what would make them drunk, with drugs is there a perception that, "Actually, I'll be fine to drive"? Is there more of an issue of education to be done as well as changing the law?

Sir Peter North: Yes. I think the simple answer is: Absolutely, yes. The knowledge that we have institutionally about drug-driving, the amount of it and the impact, is poor. The amount of education of the public at large about the risks of drug-driving is poor. I think, as a country, we have slid back in comparison with other well developed nations in addressing this. One of the hopes that I have is that this Report will actually produce a bit of a spur for us saying, "This is a problem as serious as drink is", because if you are impaired by drugs you are as much a danger to everybody else as if you are over the alcohol limit.

Q48 Iain Stewart: In your opinion, are we looking at two entirely different parts of the population? Are those who have a preponderance to drug-drive different from those who drink-drive, or is there an overlap, so we are actually going after the same people who are just going to flagrantly disregard driving while they are impaired?

Sir Peter North: The honest answer is "Probably the latter", but I can only say that because the statistical evidence of drug-driving is so poor. One of the reasons, which is an understandable reason but I think we need to address it, is that if you are a police officer and you stop somebody who appears to be driving in a dodgy way, your first instinct is to breathalyse them, and if they are over the limit with the breathalyser, you pursue that as an issue. The penalty for being impaired by drugs is the same as the penalty for being

impaired by drink—the basic penalty—and the police officer, for quite understandable reasons, will take the drink case ahead and we will not know whether there were drugs as well.

One of the problems that I tried to address, which you kind of touched on, is not the overlap: it is the combination. There is certainly evidence from the Report that we have referred to that a relatively small amount of drink and a relatively small amount of drugs in combination is more than double the problem, if I can describe it as that. What we have recommended is that, when there is evidence of both drink and drugs, the sentencing body—the judge or magistrates—should, under the sentencing guidelines, regard this as an aggravating factor justifying a higher penalty.

Q49 Iain Stewart: Actually, just on that point, is there a potential for someone who has a very little drink in them, below the limit, and a little amount of drugs in their system, so, independently, they are legal but, combined, they would not be?

Sir Peter North: Probably.

Iain Stewart: Is that an area you have looked at?

Sir Peter North: Yes, that is theoretically possible, absolutely.

Iain Stewart: I am trying to think of a type of person who would do that but—

Sir Peter North: No. There's an easy example. You have gone out and you have had a pint of beer. You suffer from hay fever and you have taken two antihistamines. That may put you in that position, and you are not allowed to drive impaired by drugs. It does not matter what sort of drugs.

Iain Stewart: Yes. That can mean both legal and illegal.

Sir Peter North: Yes.

Q50 Angela Smith: You mentioned that some of the recommendations that may arise from this Committee could relate to better education around drugs and alcohol. Equally, we may want to look at the input of the UK into the research that you referred to in relation to developing devices and mechanisms for measuring drug impacts on drivers and so on. Would you be sympathetic to any recommendations that referred to the importance of scientific research on the impact of drugs on the body and on driving ability?

Sir Peter North: Yes.

Q51 Angela Smith: Is the UK part of the European project that you referred to?

Sir Peter North: No.

Angela Smith: It is not part of that project?

Sir Peter North: No.

Angela Smith: Do you think we should be?

Sir Peter North: Yes, because it is getting input from a whole range of European states. It is getting input of the experience of those states and the UK is outside it. One of the problems that I was told was that some of the evidence gathering has been random stopping of vehicles and asking people to take tests. This is nothing to do with penalising them. It is discovering whether they are driving under the influence of drugs. It is said, and this is anecdotal to me, that the human rights implications of doing that are such that the UK felt uncomfortable in participating. That is a problem that does not seem to have affected other states which are parties to the European Convention on Human Rights. It does not seem to have taken account of the fact we are trying to stop people being killed on the roads, and that is a pretty powerful human right.

Angela Smith: Absolutely; thank you.

Chair: Mr Maynard, you want to put a quick question.

Q52 Paul Maynard: What evidence is there regarding the balance in drug-driving convictions between those who are taking legal prescription medicines and those who are taking illegal non-prescription medicines? Do you concede there is a danger that this debate acquires a moral overtone that says, "Drug-driving is bad because taking drugs is bad", when, actually, many of those drugs may be being taken for perfectly reasonable legal reasons? The problem is with the pharmaceutical industry failing to have some sort of traffic light system, for example, that allows the driver to assess whether it is safe to drive or not.

Sir Peter North: The statistics are very small, very poor, and they don't answer your question. The issue of whether it is a good drug or a bad drug doesn't go to the danger to the public from you being impaired by either of them. So I am not sympathetic to excluding prescription drugs from the current regime and the current law catches them.

I agree entirely with what you say and there is a chunk of the Report which addresses the obligations on the pharmaceutical industry and, indeed, on the medical profession, to ensure that people are made much more and much better aware of the driving implications of both drugs and medical treatment. There are recommendations in here which address that.

Chair: Thank you very much. Thank you, Sir Peter, for coming and answering so many questions in such detail. Thank you very much.

Sir Peter North: Thank you.

Examination of Witnesses

Witnesses: **Edmund King**, President, Automobile Association (AA), **Philip Gomm**, Head of External Communication, RAC Foundation, and **Malcolm Heymer**, Traffic Management Adviser, Association of British Drivers (ABD), gave evidence.

Q53 Chair: Good morning, gentlemen. Would you like to identify yourselves for our records, please?
Edmund King: Yes. Good morning. I am Edmund King. I am President of the Automobile Association.
Malcolm Heymer: I am Malcolm Heymer. I am Traffic Management Adviser to the Association of British Drivers.
Philip Gomm: I am Philip Gomm, Head of External Communications for the RAC Foundation.

Q54 Chair: Thank you. Perhaps I could start with you, Mr King. Could you tell us why the AA supports the North Report recommendations in relation to drinking and driving?
Edmund King: Yes. At the AA, we carried out a number of surveys using our AA/Populus Panel. That is a Panel of 150,000 members that we survey on a monthly basis. We did some specific questions for the North Report as a request from Sir Peter. The sample size for those questions was approximately 20,000 drivers from across the United Kingdom and all demographics. What we actually found, on a number of the issues on the drink-drive limits, is that 66% were in favour of a lower limit than the current limit. It varied, the number who said 50, 20, but, overall, putting it together, that was the support.
There was also a majority in support of a 12-month ban if you did reduce the limit to 50. That was 64% would support a 12-month ban, or indeed more than a 12-month ban if there was a 50 limit.
I think other issues that came out quite strongly in the research, in terms of the police having powers, whether it is changed or not, to stop motorists and target them with a breathalyser—79% were in support of that.
So I think, generally, our research shows that there is an appetite amongst the motoring public for changes because of the road safety implications. Likewise, on drug- driving, we actually found that 50% of AA members thought that drug-driving might be as big a problem as drink-driving and, again, as Sir Peter has pointed out, the statistics for drug- driving are so sparse. The fact that the Coroner doesn't automatically test for drugs in the system after a fatality means that we haven't got the real evidence.
The other issue that perhaps wasn't addressed in the previous session was this real problem of the mixture of drink and drugs. We certainly know evidence about some people, and I think it was a question here. There was a survey done a few years ago of clubgoers in Strathclyde by the police up there and there was some evidence that people taking drugs—younger people going to a club—would also have half a pint of lager so that if they were stopped by the police the police would smell the alcohol, they would be breathalysed, they would pass the breathalyser and they would be on their way. It is only relatively recently that more police resources have been put into the field impairment test which the police have to carry out at the roadside. It is a cumbersome process and in the forces around the country it varies how many officers they have trained in field impairment tests. If they haven't got many trained and if they don't know the telltale signs of the drug-driver dilated pupils, etc, then we're not picking the people up.
So, again, our evidence from our members certainly indicated that more action was needed on drug-drivers as well as the drink-drive issue, although I would stress, and I know it was raised before, we would still accept that the biggest problem when it comes to drink- driving, without a doubt, is those people who are way over the limit and they are represented more in the fatalities. In the first instance, we would rather see better targeting of the hardcore drink-drivers, the repeat offenders and issues like more drink-drive rehabilitation, confiscation of cars, etc. In terms of road safety, actually getting those people off the road should be the first priority and then we would see the limit as a second priority.

Q55 Chair: Mr Gomm, the RAC Foundation doesn't accept that the 50 mg limit would save lives but you still support it. Is that right?
Philip Gomm: I think we accept it would save lives. I think there is a dispute in the evidence about how many lives it would save and whether the investment in reducing the limit and trying to enforce it would be the best way forward. I think Sir Peter recognised, and it is recognised, that it is the hardened drinkers above the 80 threshold who pose the biggest problem. As I understand it, the effect of drink-driving increases exponentially and it is that hardened group who have the most crashes and suffer the most fatalities when you are looking at the drink-driving population. It is that 1% of drivers that you need to perhaps concentrate on. There is 2% or so of the driving population who fall between the 80 and the 50 and the rest below the 50, who are not particularly a problem at all and wouldn't be encapsulated in any change in the legislation. So we recognise that lives would be saved. Whether that is a meaningful amount and whether that is the best way forward we are not completely sure. We do think it would underline the social norm about drinking. That has been very successful and I think that would underline the stance that the Government and society takes on drink-driving.

Q56 Chair: Is that the main reason that you support the lowering of the level to 50 mg?
Philip Gomm: It is, yes.
Chair: To change perceptions and social norms in relation to—
Philip Gomm: Yes, and to continue the good work that we have already done. But, just in terms of saving lives, there have been various figures mentioned. I think 43 was one and 60 or so was another. There might be better ways of spending money or using

police enforcement time to make greater contributions to the road safety figures.

Q57 Chair: Mr Heymer, the Association of British Drivers is opposed to reducing the drink-driving limits.
Malcolm Heymer: That is correct.
Chair: Can you tell us why you hold that view?
Malcolm Heymer: We actually believe that road safety law should be based, as far as possible, on sound science and we believe that the current limit, which has been in force, now, for some 43 years, is based on sound science. It was based on a very large-scale study carried out in the United States in 1964 which found that the risk of having an accident stayed more or less constant from zero up to just below what is now the current limit and then starts to rise quite sharply. As a consequence, we believe that the limit is still correct.
Responsible drivers do not attempt to drive up to the limit. Nobody seeks to drive at, say, 75 mg, and people who are breathalysed and are found to have levels of blood alcohol at that sort of level have probably not been trying particularly hard to stay within the limit. They have just been lucky. The majority of drivers will probably not go much above 50 mg anyway because nobody can be certain what their blood alcohol level is. It is impossible to tell.
One of the main reasons we think we shouldn't be lowering the limit is because of the morning after effect. People who may do everything right the night before—they will get a taxi or get someone to drive them—if they have had a few pints or the equivalent may still be slightly over the limit the following morning. That can still apply with the current limit but it is likely to be much more of an issue with a reduced limit, and if people are being penalised for being over a reduced limit the following morning, that could reduce respect for the law which has grown steadily over the last 43 years. There is medical evidence that, for a given blood alcohol concentration, the level of impairment is less when the alcohol level is falling than when it is rising.

Q58 Chair: Could you tell us where that evidence is?
Malcolm Heymer: Yes. There is a publication called "Loosening The Grip: A Handbook of Alcohol Information", by Kinney and Leaton. In the ABD's written evidence I have reproduced a paragraph from that publication. If you wish, I can read it out to you now but it is up to you.
Chair: No, we just need to know the basis of it. That appears to be disputed by other sources but we just want to be clear where your information is from.
Malcolm Heymer: Yes, that is where it is from.
Chair: Thank you. Mr Leech.

Q59 Mr Leech: I just wanted to go back to a point made by Mr King in relation to his survey. Did you find that there was a big discrepancy between people's views in cities and towns to people's views in rural and semi-rural areas, because, often, one of the arguments being made by people is the impact that a reduction in the limit would have on rural communities? Did your members have differing views depending on where they lived?
Edmund King: Yes. The geographic breakdown that we get from Populus is by TV region. So you can have Anglia as East Anglia. It gives the region view, but I couldn't really tell you what the difference was in Norwich compared with a village outside Norwich. But I am happy to give the Committee the full breakdown from that but I don't think I could categorically say that support in cities was higher than in rural areas. I could say broadly, in geographic terms, what the differences are.

Q60 Mr Leech: Have the RAC Foundation and the Association of British Drivers done similar surveys of their members?
Philip Gomm: Our colleagues at RAC Motoring Services do an annual report on motoring and I believe that, last year, they found that there was over 50% support for reducing the limit, not quite as extensive as Edmund's members or the Populus poll, but I think there is widespread public concern about it.
Mr Leech: How many people did that cover?
Philip Gomm: That was, I think, a thousand. I would need to check the numbers.
Mr Leech: Yours sounded like 150,000.
Edmund King: No. We have 150,000 on our Panel, but the response rates to these questions varied between 17,000 and 21,000 because we asked at different times. Ours is the biggest motoring poll in Europe in terms of the numbers. So I think ours is pretty comprehensive.

Philip Gomm: I am sorry. Edmund's is a survey of drivers. I think this was a public survey so it was not necessarily motorists.
Mr Leech: Mr Heymer?
Malcolm Heymer: We have not actually polled our members directly, but it has been ABD policy to oppose a reduction in the drink-drive limit since 1998, I think it was, when the previous consultation took place. That policy is on our website and members are aware of it, and they haven't complained to us that they think it is wrong. So we assume that the majority of our members support that view.

Q61 Iain Stewart: Partly on this issue of surveys, to what extent is there evidence that this is an age-related issue? My perception is, and it may be inaccurate, that the younger generation regard drink-driving as a no-no. With my peers, we just don't do it. If we're out for an evening we don't drink if we are driving. But my parents' generation think it is perfectly acceptable to have a couple of pints or a couple of glasses of wine and then drive. Is that borne out by your survey evidence? The related question is: If it is an age-related attitude is it the older generation that are the excessive drinkers? Is there evidence to support that?
Edmund King: If I may take that, I think, 10 years ago, I would agree with that assumption, in that the drink-drive campaigns over the years were quite effective and there was a generation of younger drivers who did not drink and drive 10 years ago. Unfortunately, the figures, in terms of the casualties over the last decade, for younger drivers have crept

up. In fact, the 20 to 24 age group, in terms of fatalities, are one of the biggest groups.

I actually think it has slipped and that there are two targets. One is younger drivers and one is some of the older drivers who, perhaps, always said that one for the road at the golf club won't do them any harm. But from our surveys, in terms of changes that were required, we actually found it was across the board. The only difference is that female drivers tended to be slightly more in favour of the reductions than male drivers. That showed slightly more than the age demographics.

But I think it shows with drink-driving, like any other things, the importance of targeted and persistent campaigns to get the message across. I think someone asked a question before about drugs and driving. One of the problems there is that we haven't had the same kind of campaigns, and the social acceptability of drugs and driving amongst the younger age group is much higher.

There is a very good report about ecstasy use in Northern Ireland and it quotes a 19-year old girl who said something like, "My father used to go to the Working Men's Club and have a couple of pints and I would always have a go at him for drinking and driving. I now go to a club, have an ecstasy tab and think nothing of the consequences". It kind of shows that amongst some people it has not got that stigma of drugs and driving as the drink-driving has done. Therefore, I think that is why drug-driving needs more targeting by the police, by campaigns, to get the message across that it is as dangerous as drink-driving.

Philip Gomm: Can I just pick up on that? There is a real issue on the mix of education and enforcement, and the RAC Foundation has just published a report looking at the effects of public information campaigns. The report, which was not done by our staff but by Professor Frank McKenna of the University of Reading, suggests that, across public health, there is a lot of doubt now as to the effectiveness of education alone. If it is not accompanied by enforcement—the big stick—then telling somebody that they shouldn't do something, especially when it is linked to medical conditions like addiction with drink and drugs, is not necessarily very effective. I think that would be one of our concerns about any change in the law, whether it was drink or drug related—that you need the enforcement alongside it. There are real concerns how that will happen. As we perceive with speed cameras, for instance, if the money is not there locally to support the enforcement of speed cameras, whatever your view on speed cameras, what is the point of changing a law and making it harder? I think that is an important point to bear in mind as these changes may or may not go through.

Q62 Kelvin Hopkins: If I can go back to Mr King's first remarks, and I think we dealt with this in the first session about an either/or—either better enforcement of the present law or reducing the limit—is it not the case that both are important? If you reduce the limit, you make a step change. If you have enforcement, you make another step change. But without changing enforcement you would still actually reduce the number of people dying on the roads by reducing the limit?

Edmund King: I absolutely accept that. I think my point was: If the objective is purely a statistical one of reducing the casualties, if you could target that hard core who are way over the limit, they are the ones who crash more and kill more people. That is what I was saying. That's not to say that there aren't those between 50 and 80 who also cause crashes.

Q63 Kelvin Hopkins: I would follow up Mr Stewart's point about age- related drinking as well. When they introduced random breath tests in Australia, they found that they were catching vast numbers of middle-aged drinkers who were very clever at driving when they were fairly well oiled. That's what happened. Because they were experienced drivers they could get away with it more than the young people could.

Mr Heymer, again a point made earlier on about drinking at night and then not being fit to drive in the morning. Surely, if we become more conscious of the fact that we might not be able to drive to work in the morning if we drink too much at night, is that not a good thing? We would be more careful about drinking too much the night before.

Malcolm Heymer: Possibly, but, of course, people may not be aware of the problem because, as I have already said, the medical evidence suggests that when the alcohol level is falling people are less impaired. So they may wake up the next morning, feel perfectly fine and, possibly, be quite safe to drive but they might still be over the limit, especially if the limit were lowered.

Q64 Kelvin Hopkins: Is it not the case that many people—experienced drinkers and drivers—feel perfectly fit to drive and it is only this annoying law that stops them doing it?

Malcolm Heymer: I think most responsible drivers realise that you can only have so much before you become seriously impaired and a risk. As Mr King was saying, it really is the hardened drinkers, the ones who go way over the current limit, who are the main problem and should be the target of enforcement because, without enforcement, it is pointless reducing the limit anyway. You have got to have enforcement to catch the people who are really causing the problem.

Q65 Kelvin Hopkins: Would it not be the hardened drinkers that drink a lot the night before and think they are all right in the morning, though, and that the only thing that is going to stop them is enforcement and being breathalysed?

To come to Mr Gomm's point about enforcement, in the past we had a voluntary use of seatbelts. It just didn't work. People didn't put seatbelts on. I knew many drivers, and particularly males, who would think it was a bit feeble to put your seatbelt on, a bit soft. It was only when they became compulsory that we all put our seatbelts on and completely accepted it. Sometimes is it not the case that the law has to lead, rather than follow, public opinion when safety matters are concerned?

Philip Gomm: I think what education does do is pave the way. So if you implement a law, if you have told people why that law is coming in and if you have armed them with the facts, then they might be more accepting. I think things like the smoking ban, going back to this research we have recently done, was an example of that. People might know something is bad for them because you tell them a thousand times, but they don't change their own behaviour for a variety of reasons—they enjoy the risk, they don't think it will happen to them, etc. But when they realise the risk and it is combined with proper enforcement and legislation, then you can move forward, but one or the other.

Q66 Chair: Mr Gomm, is this why the RAC Foundation is supporting this—the proposed reduced limit—even though you are not convinced it will save as many lives?

Philip Gomm: I think we say that we can see a case for reducing the limit. I don't think we said 100% because there are so many factors, but, yes, that would be one of the reasons. If you create a social norm, you tell people that it is not acceptable to drink and drive; these are the reasons why; this is going to be the legal limit and these will be the sanctions if you fail to obey that. You need the whole package and one without the other is meaningless.

I think—sorry, just to continue that—you notice with mobile phone use at the wheel the level for drivers observed using their mobile phone at the wheel is now back to the level it was in December 2003 when that legislation came in. I would suggest that part of that is down to enforcement—the police just haven't got the resources and time to—

Chair: Enforcement is a key part of this. Mr Hopkins, are there any further questions?

Kelvin Hopkins: I think we've made the point. That's fine.

Chair: Okay. Thank you. Mr Maynard.

Q67 Paul Maynard: Mr King, you mentioned the increased incidence of drink-driving amongst those under 24 and how that is changing over time. Do you have any views as to the legislation that they have in Europe—that they have lower drink-drive limits for drivers who are under 25? Do you think that that is a solution to this problem or does it not work?

Edmund King: I think one of the reasons—not to make an excuse for it—for the increase in drink-driving amongst that age group is total confusion that was touched on before about drinks—things like the introduction of alcopops that don't necessarily taste alcoholic but are alcoholic, the different glass sizes, happy hours, three drinks for the price of two. I think a combination of those things has probably had more of an effect.

What has happened in other countries, in France, for example, with the lower limit, the 50, in France a couple of years ago Chirac decided it was totally unacceptable that 6,000 people a year, or whatever it was, were dying on the roads and there was an absolute concerted effort in terms of enforcement, random breath tests, stopping people. In France, it was quite dramatic how the fatalities came down almost overnight, including younger drivers, because people going out thought that there was a likelihood that they would get caught coming back from the café.

So I think our view is that to have a separate limit for younger drivers—some people have talked about having a 20 limit for younger drivers, then a 50 limit—would slightly confuse the issue. We would rather have concerted enforcement across the board initially at a 50 limit rather than confusing the issue. One of the other things is that, if you are a younger driver, does that mean that, when you are 24, you can drink a bit more? It is this question of mixed messages going out. We would rather have a firm limit that the police acted on and enforced.

Q68 Paul Maynard: I am getting a very strong sense from all of you that enforcement is as important as what the actual limit is. How would changing the limit change the nature of enforcement in itself?

Edmund King: I actually don't think it particularly works because a breathalyser is a breathalyser is a breathalyser and you set it different. So changing the limit itself doesn't necessarily change enforcement. Yes, if you breathalyse the same amount as you do today there would be a small proportion today that would be over the new limit.

I think our concern is more generally in roads policing with comprehensive spending reviews and cuts all round that, if police resources—and numbers of traffic police have reduced over the last 15 years anyway—particularly traffic police and those enforcing drink and drug-driving are reduced, then the wrong message goes out.

It was interesting looking at Australia and Holland. Both those countries, when they lowered the limit from 80 to 50, had concerted enforcement campaigns, and indeed education campaigns. The evidence suggests that you need the two to go hand in hand for it to have some effect. So I think enforcement is crucial.

Q69 Angela Smith: It appears to me that the law itself and enforcement and education are the three parts of a necessary package for dealing with issues around drink, drugs and driving, and that they are all equally important.

Just to focus on education, once again, as I did with the previous witnesses, I just wonder whether or not it is sensible for us, as a country, to focus as hard as we do on the education messages around the Christmas period and to basically ignore it for the rest of the year. Does that not, in itself, send out mixed messages? And if we reduce the limit is it not even more important that we focus on the importance of not drinking or driving or taking drugs and driving throughout the year?

Edmund King: I would agree with that. Actually, looking at the figures, it is not every December that is the worst time. I think the last time I looked at it, it was actually summer time—

Angela Smith: Barbecues.

Edmund King: Yes, barbecues and things like the World Cup or sporting events, because with the activities at Christmas people normally plan for them. They know when the office party is. They know when

the family party is. So it is actually easier to plan for a taxi or designated driver.

In our experience, it is the more ad hoc events that people haven't planned for—people going for a drink after work or barbecue, etc. So I think the message does have to be reinforced across the year. Also, we have to change the way the message goes out. A TV campaign at 8 o'clock with Cliff Richard singing about mistletoe and wine will not be seen by the 20 to 24 year old group who are the main culprits. We have got to have more viral campaigns online and more creative campaigns that don't necessarily cost a lot of money but get through to the target audiences. You need to get peer pressure, particularly for young drivers, not to get into a car with a driver who is going to drink at all. It is a combination of things but I totally agree it shouldn't just be Christmas.

Q70 Angela Smith: Do you think enough resource is dedicated at the moment to education around this issue? I know you said we can do it more effectively and more cheaply. Nevertheless, is there enough resource?

Edmund King: I think my fear is that in the current economic climate of the Department for Transport where most of the resource comes forward through the Think campaign there is basically a moratorium on spending. Our fear is that there will be less rather than more and, I think as I said before, the social acceptability over time and attitudes over time do change. The initial campaigns "Don't drink and drive", like the initial seatbelt campaigns "Clunk Click", had an immense effect, but they are wearing off; so we do have to find new ways.

Q71 Kwasi Kwarteng: I will just ask a question that I asked the earlier witness. Do you see a time where there will be, essentially, a ban on drink-driving with a 20 limit, which is, essentially, what that is?

Edmund King: My view is that, if you look across Europe, in Southern Ireland they are going to lower the limit next year and, with the exception of Malta, every other country has a 50 or lower limit. So I think, just in terms of UK citizens, even driving to France, etc, they need to understand the limits—that in other countries you can't get away with 80 as you can in the UK. I think 50 is the right approach. I think it is more acceptable. I think it will be some time before you go to a 20 limit. The reason I say that is that at 50 I do believe you can still have a deterrent of a 12-month ban and I think that is an incredibly strong deterrent, and certainly AA members support that—a 12-month ban at 50.

I think, as Sir Peter North indicated, if you went to 20 you probably couldn't justify a 12-month ban and, therefore, it wouldn't be so effective. One of the reasons that even though we have got a higher limit our drink-driving has been more effective in the past than some other countries is because the penalties are harsher, and that is part of the equation. I think we could do more, though, to indicate to people, "It's not just the 12-month ban. You might lose your job. Your insurance costs will more than double." So there are a lot of other effects on the individual rather than just the ban. I think, sometimes, that some of those implications, as well as the safety implications and the human suffering from death and injury caused by them—there are severe financial implications for individuals—we should stress more.

Philip Gomm: I can't see that going down to 20 would happen any time soon and there doesn't seem to be a reason for it. If you are concentrating so much on an area where, I think I am right in saying, in 2008 impairment by alcohol was a factor in 11% of fatal accidents, you can focus on that and focus on that but, then, there is 89% of fatalities on roads that you are missing. If you are boring in on that single issue and enforcing that all the way down to, basically, zero tolerance, then what about all the other areas of road safety that might have better cost-benefit return? I think that that is the case with enforcement judgments across the board. Where are you going to make the biggest impact?

Malcolm Heymer: You also have to bear in mind that any lowering of the limit does have negative consequences, for example, in the economy of rural areas where pubs may close, and not just the economy but the social life in those areas. There isn't a no-cost option to reduce the limit. You have to look at the consequences.

Edmund King: I think I disagree with my colleagues on this. We are talking about 430 deaths on the roads from drink-driving. It is a serious element out of the 2,222 deaths. It is an incredibly crucial issue in terms of road safety.

Malcolm Heymer: Yes, but most of those are above the current limit.

Q72 Mr Leech: In your opinions what main changes need to be made to improve the drug-driving law?

Edmund King: In terms of drug-driving, I do think the first thing we ought to do is help ourselves to evaluate the extent of the problem, because a lot of the evidence—and, I accept, our own evidence—on drug driving is anecdotal, from surveys, what people think, because we haven't got the hard statistical evidence. So, first and foremost, we should build up a truer picture of what's going on. I think coroners looking at it would help. I also think it would be helpful to have more pilots of stopping motorists on the road, whether it is done on a voluntary basis or not, and actually testing for drugs. I think more police training—and I know it has improved in the last 12 months, and that is only because I have been talking to police forces—is essential to look for the telltale signs of drugs and driving, and being able to carry out field impairment tests, and I think, ultimately, a roadside "drugaliser", would be the main deterrent.

The problem at the moment is that many people who take drugs and drive think, probably quite rightly, they will get away with it. They do get away with it, basically. Even if they are stopped, many of them get away with it. If they think that and drugs become part of their lifestyle, they'll continue doing it.

Q73 Mr Leech: You mentioned, at the beginning of what you said, that some drug users will drink half a pint of lager so that they've got an alcohol smell on their breath to avoid the prospects of being checked for drug use.

Edmund King: Yes.

Mr Leech: Do you think it would be useful for everyone who is breathalysed to also be drug tested as well?

Edmund King: No. I think there are ways of looking for telltale signs if the police officers are actually trained—dilation of pupils, speech. There are signs, depending on the drug. Different drugs give off different effects but I think with better training of the police, in terms of targeting the individuals, and better awareness, they will do it.

I think part of the problem is that at the moment to carry out a field impairment test by the side of the road takes at least 15/20 minutes. If it is pouring down with rain it, actually, is quite complicated—getting someone to stand on one leg and count backwards. It is not easy to do and I think, to some extent, because of the difficulty of that enforcement we haven't picked up as many people as we should.

Ultimately, if we can get a roadside screening device, whether it is a swab test or whatever, that just showed the presence of drugs, I think that would be helpful.

Philip Gomm: I think if you had the capability of doing both tests at the roadside then you would do both because that would help unveil the scale of the problem as well. As Sir Peter indicated, if the first test you do is alcohol and you get a positive on that, you then don't pursue it through to the drugs and the scale of the drug-taking might remain hidden. So I think if the availability of the roadside test was there rather than the field impairment test then, why not, for the sake of another 30 seconds or so?

Q74 Angela Smith: I have a point to take up on the development of a roadside test, because Sir Peter did indicate that there is a European research project which is aiming to develop something along those lines but that the UK isn't part of it, on the grounds that it may infringe human rights of drivers.

I have already developed quite a view on this in the few minutes since Sir Peter told us about that. But I would like to hear the views of the witnesses before us now on that issue of the human rights and the balance of human rights when it relates to drivers perhaps being randomly tested as part of a research project versus the human rights of people generally not to be killed at the hands of a drug-driver.

Philip Gomm: I don't think the surveys say we are against drug impairment testing because they violate our human rights. I think all of the public attitude surveys about drink and drug-driving show that the public is very keen to see both areas tackled hard. I suspect that human rights would be a very minor issue.

Q75 Angela Smith: So you think the Government is, perhaps, being too timid, and I'm talking about—

Philip Gomm: I don't know all of the legalities now, but, yes, I would certainly suggest so.

Angela Smith: Yes, they were too timid.

Edmund King: Yes, I think so. At the AA last year we held a round table on drug-driving. We brought together forensic people, Home Office people, Government transport people and international experts. One of the things that was coming through is that there was more progress in other countries with testing devices being used in Australia, South Africa, etc. So I think we have been a little timid.

We haven't asked our members specifically on drug-driving testing but in terms of drink-driving testing and targeted drink-driving and police stopping at random, our members certainly would support that for the greater good of road safety.

Chair: Thank you. Are there any other questions on this topic?

Q76 Kelvin Hopkins: It is an example where, and it happens so often, I think, now, that Governments—and I say both Governments—are behind public opinion rather than being ahead of it. That is very disappointing.

Edmund King: I think that is the case. I think our surveys do demonstrate that the motoring public in general are ready for change on these issues.

Chair: Mr Heymer, do you want to come back? How many members do you have in your organisation?

Malcolm Heymer: I think it is about 1,300 at the moment. Yes, I was going to say that while we, obviously, support roadside testing where people are suspected of being impaired by drink or drugs, we wouldn't really support random testing because we don't think it is necessary, and the police should be or are able to tell whether somebody is likely to be driving in an impaired condition through whatever substance. They have got the right to stop anyone who they suspect of so doing. So it seems rather pointless to waste resources which, as we already know, are going to be fairly limited in the foreseeable future on random testing rather than on more targeted testing.

Also on the subject of drugs and roadside testing, while we would support that, in a way, you are going to be chasing a moving target because as soon as one illegal substance is banned—becomes illegal—someone, somewhere, produces another designer drug and you are forever trying to keep up with it. I think you are always going to have to have as your basis of dealing with drug-driving measures of impairment rather than simple measures of the levels of substances in a person's body because that would be changing all the time and the drugs would be changing all the time.

Chair: Thank you very much for coming and for answering our questions. Thank you.

Examination of Witnesses

Witnesses: **Robert Gifford**, Executive Director, Parliamentary Advisory Council for Transport Safety (PACTS), **Deputy Chief Constable Adam Briggs**, Association of Chief Police Officers (ACPO), and **Ellen Booth**, Campaigns Officer, Brake, gave evidence.

Q77 Chair: Good afternoon. Could I ask our witnesses to introduce themselves, please, for our records?

Robert Gifford: I am Robert Gifford. I am Executive Director of PACTS, the Parliamentary Advisory Council for Transport Safety.

DCC Briggs: I am Adam Briggs. I am the Deputy Chief Constable of North Yorkshire Police and have national responsibility within the ACPO Roads Policing Business Area.

Ellen Booth: I am Ellen Booth and I am the Campaigns Officer for Brake, the road safety charity.

Chair: Thank you very much. Deputy Chief Constable, one of the constant points that has been made in our evidence session today is the importance of enforcement. At a time of scarce resources, it has been suggested that, perhaps, enforcement at a lower level of alcohol permitted in the blood would not be as effective in saving lives as would more enforcement of people who have much more excessive drinking than the current limit allows. What are your views on that?

DCC Briggs: Okay, I think there are a number of different elements of this. The first thing I would say is that actually dealing with the culture and psychology of the issue and the psychology of the fact that people will get caught for drink-driving is an important message to get across.

We have increased our enforcement activity over the past few years and all our Christmas and summer campaigns have seen big increases in that. So we do support the lowering of the limit to 50. We do say that that will have an effect on saving lives and reducing the toll on our roads, and we do believe that we can get some effective enforcement messages out to actually deal with that.

The other side of the argument, for me, is that, when we look at the resources that are required to actually deal with the collisions that take place and the tragedy that follows from them, then the reduction in those collisions and the fatal and serious consequences is something that will ease our resources rather than put more strain on them.

Q78 Chair: Are you saying, then, that in current circumstances and with the predicted problems on funding for the police you are going to be able to enforce a lower limit and that that would not be at the expense of going after the people who are driving at higher levels of alcohol than are currently allowed and killing more people?

DCC Briggs: We would always advocate a very strong message around drinking and driving. We will target our resources appropriately and so, again, we are in support of the measures around random testing but that random testing will be intelligence-led. So it needs to be at the right place at the right time to be targeted. We will always prioritise our resources around what needs to be done, but we do think the message and the evidence is very clear—that the limit should be reduced to 50 and if it is reduced to 50 our commitment is there to enforce it.

Robert Gifford: Thank you very much, Mrs Ellman. I think what Mr Briggs has said is absolutely right. There is a correlation between breath testing and statistics. I know the Committee has got the Report. I was just going to draw your attention to chart 3.7 in Sir Peter's Report, on page 63, which shows how the number of breath tests has changed over the last decade and how the number of killed and serious injury casualties has changed as well. Put very crudely, the more testing you have, the fewer people will be killed and injured. It is not an absolute year on year correlation. It is what I call a lagging indicator. As the numbers of breath tests go down, the number of casualties goes up the next year, and in reverse. I think that is really important so I don't think we should lose sight of that. There is a lot of police activity going on at the moment with the current limit which will continue with the new limit. It is just that we catch some different and extra people.

Chair: Mr Leech, you wanted to ask a specific question.

Q79 Mr Leech: Yes. First of all, can I declare an interest, that I am a member of PACTS, just in case I am asking questions of Mr Gifford.

Mr Briggs, can you tell me what the difference would be in the stopping and breathalysing regime if the limit was reduced from 80 to 50, because I can't see that there would actually be any difference in the way you would stop people because, surely, you would still be stopping people who looked as though they were being impaired by drink or drugs?

DCC Briggs: The regime would not change. There would still be the same operational ways of dealing with these matters. If we suspected that a driver was impaired or if a collision had taken place, we would breathalyse the drivers concerned in that. So, operationally, that wouldn't change.

Q80 Mr Leech: In terms of the actual potential extra resources that might be necessary for the police, it would only be if the number of people who were over the limit was increased and the amount of activity that would be required in terms of taking people to police stations and going through all those procedures?

DCC Briggs: Again, there is a balance there, to where we see the reduction in casualties and tragedies that are associated with casualties and the real resource that takes to actually deal with that because, obviously, our traffic resources, our officers, are far too often tied up for a long time dealing with these serious incidents.

Q81 Chair: Was your answer to Mr Leech's question, "Yes"? It is important that is on the record—that you said that.

DCC Briggs: Yes.

Q82 Mr Leech: Would you agree with me, then, that the argument that people make about it being more difficult to enforce is a bit bogus?
DCC Briggs: Well, I don't make that argument. I think enforcement would continue as it is now. Yes, there would be more people who are actually caught breaking the law but I, again, commit to enforcing that because I think it is the right thing to do.

Q83 Paul Maynard: Are there changes to the enforcement process that you would have liked to see independent of any changes to the drink-drive limit and would your ability to implement any such changes be affected by a change in that limit?
DCC Briggs: In terms of drink-driving or drink-driving and drugs?
Paul Maynard: Both.
DCC Briggs: I will start with drugs, if I may, because we have a slightly different view to Sir Peter's Report. We feel that the law on drug-driving should be changed. The reason for that is that, currently, the law and procedure around drug-driving is very, very difficult to do operationally. I think you have heard evidence around the field impairment testing—some of the difficulties around that. But, also, the police station procedure is difficult as well with the Medical Examiner and with some of the issues around impairment.
We would like there to be a very clear law that says, "If you take illegal drugs and drive that is an absolute offence". We feel the impairment side of that should be removed. If that was the case, that would make it more effective to use technology to start to deal with examining the presence of drugs within people, either at the roadside or at a police station. But we seek to have impairment removed from the current legislation, which we do not think is fit for purpose. We think there should be significant change around that.

Q84 Paul Maynard: How would that affect those who are taking legal prescription drugs?
DCC Briggs: In the first instance, we would like to see the law focus around the drugs that we think are the biggest problem: for example, skunk cannabis, heroin, amphetamines and cocaine. On a risk basis, those recreational drugs are probably the basket that causes the most problems. Yes, of course, there are peripheral drugs—prescription drugs—and other issues around that. But we think that there should be a change in the law around those drugs which are illegal to possess and illegal to take—it should also be illegal to drive with those in your blood.

Q85 Paul Maynard: Is there an evidence base available that demonstrates that it is illegal drugs which are the problem rather than prescription drugs?
DCC Briggs: Frankly, there is a shortage of data and evidence around this. I think that, for us, our anecdotal view of this particular world is around the drugs culture within this country and within Europe and the consequence of people subsequently driving as well as taking drugs. But I have to be frank: the evidence base is not where we would like it to be, but we do believe that one of the current real problems with challenging this hidden issue of drug-driving is the fact that, procedurally and legally, it is very, very difficult for us to be successful at it.

Q86 Paul Maynard: Would it be accurate, therefore, to say that your views on drug-driving are couched in a wider consideration of drug culture, rather than on a specific road safety measure?
DCC Briggs: What I would say is, in the road safety business, from a police officer's perspective, we are in the business of reducing harm and reducing risk—harm to our communities.
My perspective of drug taking is this, really. If somebody takes drugs in a recreational way then, okay, that is a matter for them. It is illegal, but it is a matter for them. When somebody takes drugs and gets into a motor vehicle, it is a real, serious concern. So I do see a difference. The taking of illegal drugs is against the law, but getting into a motor vehicle is a real aggravating factor, in my view.
Chair: Mr Gifford, you want to come in on this one.
Robert Gifford: I was going to answer, if I might, on the drink part as well because I think, quite rightly, Mr Briggs concentrated on drugs there, and that was the question which the Committee was grappling with earlier about random/targeted/intelligence-led breath-testing.
As I understand it, the current position of the police is they can breathalyse you if you are involved in a crash; they can breathalyse you if you commit a moving traffic offence; they can breathalyse you if they believe you are driving under the influence of alcohol or drugs. Operationally, probably they can catch you anyway. But I think the question is whether the general public believes they can be stopped at any point—or the driving public, rather.
When the Road Safety Bill was going through Parliament, there was an amendment tabled which was based on the Dangerous Knives Act which allows an Inspector to declare an area where anybody can be searched. We felt that that posed a very interesting model for, if you like, a targeted drink intervention. So I think it is not so much, "Would it change what the police do?" Probably not. But, "Would it send a clear message to the driving public that, within that area, over a 24-hour or a week period, they might well be stopped?" That might just culturally change their mindset a little bit. I think that is something that would be worth considering. That Act may not be the right model. I'm not saying it is, but it was there on the Statute Book.

Q87 Iain Stewart: My question actually follows on very neatly from that. I accept the point about changing public perception but, at the moment, to what extent do police target certain areas and times and groups of people not to randomly breathalyse them but to watch for signs that they are driving erratically? Do you target, for example, after big sporting events or city centre night clubs? Is that already part of police operations or is it just that a police officer sees someone driving erratically and will pull them over?

DCC Briggs: We have intelligence-led operations in relation to where we believe there is a specific issue. So that is the first thing. Obviously, officers on patrol will deal with what they deal with, as such, and particularly during campaigns. We actually have roadside campaigns in some forces where we will stop a series of vehicles. We will give a drink-drive message to drivers. If we suspect that alcohol has been taken, we will conduct a breath test. Some forces ask all drivers if they will voluntarily take a breath test, and when we have tried these pilots, if you like, then we have found there is a lot of public support for that kind of police activity.

It sounds controversial but, again, the public feedback that we have had is that the public are glad that we are actually out there doing this and taking the issue seriously.

Q88 Iain Stewart: In effect, we have almost a random breathalysing by the back door?

DCC Briggs: We have the powers to conduct tests in the way that I have described. I think the big thing about the change in the law on breath-testing is the psychology behind it.

Iain Stewart: I completely accept the point about changing it. Yes.

DCC Briggs: My point, moving on from drugs to drink, is that I think the message for somebody who is a hardened drink-driver, the chances of them being caught being increased considerably is perhaps one of the only avenues for us to actually get into a hard core of people who are the highest risk.

Q89 Iain Stewart: If I can follow on from that—you did touch on it in an earlier answer—if the limit was reduced there will be a group of people who might not be driving erratically but still be in that 50 to 80 band. How would you change your attempt to enforce that limit?

DCC Briggs: There are a number of things, really, around that. The first thing I can say around the 50 is that the evidence is there for us around impairment—the fact that people do become impaired at that level of alcohol.

How do we change enforcement? Obviously, if we had the powers to do the random testing then the random testing regime would collect that, as would some of our campaigns as I have described. But, also, the fact is that, with our new breath-testing equipment, we have seen 2% of drivers that have been involved in collisions between 50 and 80. So we have already spotted 2% in that collision area. Obviously, the principal reason for stopping somebody is an observed offence or an observed driving behaviour. So people would be caught and dealt with as a result of those observations.

Iain Stewart: May I be permitted one separate question, and it is quite a specific geographic one? Sir Peter touched on the point that it is proposed that the law in Scotland should be devolved to Holyrood. Do you foresee any difficulties, particularly in enforcement, if, potentially, you had one limit in Scotland and one in England or, apart from, maybe, in Berwick-on-Tweed and Carlisle, will it not be a significant issue?

Chair: Can I ask Mr Briggs about that one?

DCC Briggs: I really do believe in consistency in enforcement. Part of my role within ACPO is for European roads policing and so I work closely with colleagues throughout Europe and I am a member of TISPOL, which is a European network of roads policing officers. As I think you are aware, every country in Europe, except ourselves and Malta, is at 0.5 and I think, from the motorists' perspective, the public's perspective, that consistency is really important. I would be concerned if there was a different limit between England and Scotland.

Robert Gifford: Two points, if may: one in answer to Mr Stewart's question about the cross-border issue. In Europe, at the moment, there is quite a live discussion on a directive on cross-border enforcement which is looking at the wider enforcement of road traffic penalties. That is, I think, a priority for the Belgian Presidency and, no doubt, this House will want to consider it. It doesn't include drink-driving. It is mostly about speeding and seatbelt wearing but I think there is an issue there.

Also, on the impairment point, if I may just to back up what Mr Briggs was saying, I fundamentally disagree with Mr Heymer's interpretation of what he called the Grand Rapids Study and the impairment curve. I would draw your attention, again, within Sir Peter's Report, to paragraph 329 onwards—

Mr Leech: What page?

Robert Gifford: Page 65. That was when he was looking at the international evidence on, and drawing on that NICE Report, the link between alcohol consumption and accident involvement. The Grand Rapids Study, which was undertaken in America in the 1960s, identified that the risk of involvement in a crash doubles between a BAC of 50 and 80. That's not including the number of people who die as a result. That's just a statistical and scientific piece of evidence. I think that is why, historically, we have always supported 50, because the scientific evidence is there that backs that up. It then goes up even steeper once you are over 80 but I think it is worth you looking at those paragraphs in detail. I'm sorry to give you your homework.

Q90 Chair: Thank you. Ms Booth, do you have any views on the cross-border issue? I mean, a different rule in Scotland.

Ellen Booth: Yes. Obviously, from an enforcement point of view having consistency would clearly make sense, and as well from a public perception point of view. If we are talking about setting limits, of course, that does make a difference to what people perceive to be a safe limit as well because, if we set a limit by law, people then say, "Of course, that's a safe limit". So if we have two different limits, in Scotland and England, there will be increasing confusion about what is a safe limit. So I would say it is better to have consistency.

Angela Smith: I have two separate questions. The first one relates to the relationship between alcohol and speed. If we are talking about consistency of message, in a lot of cases alcohol may, of course, help to underpin speed, which may have caused the fatality or the serious accident. Nevertheless, if you leave

alcohol to one side, speeding is still one of the major causes of fatality on the road. Is it not inconsistent, therefore, for legislators or Government to send out a message which says, "Drink driving is dangerous and we are going to clamp down on it, we are going to reduce the limit and enforce it", etc, while, on the other hand, perhaps saying, "We are going to release the pressure in terms of enforcement on speed"? Is it not important to have a consistency of message across the board when it comes to road safety and driving?

DCC Briggs: It is important. For me—and I have studied this across Europe—the three main killers, across Europe, are drink and drug-driving, speed and seatbelts. The consistency of message around enforcement and education is linked to that. But enforcement is a really important aspect of that. The example in France is a 40% reduction as a result of starting to enforce. So there is a good evidence base across the Continent. There has to be a consistency of message around that, and we have seen casualty reduction consistently in this country because of our commitment to enforcement and education that supports that.

Robert Gifford: I think you are absolutely right about consistency of message and what one would hope is that, in the run-up to 2011, we will see a new road safety strategy emerging from the current Government which will pick up what should be the priority areas. The only caveat I would put on your comparison, if you like, between speed and alcohol—and it is not a substantial one—is that, clearly, a driver who has consumed an amount of alcohol which is impairing his ability to do things, who then gets in a car and sits behind the wheel, is making a conscious decision, "I am going to drink and drive knowing that I am impaired". On the other hand, a driver's choice of speed may change across a journey almost moment by moment. It is still impairing because it leaves him—predominantly him—less room for manoeuvre when he or somebody else makes a mistake. But it doesn't quite have the same mental connection in the mind as, "I know I've had something to drink. I may fall over". "I know I'm going to speed. I may crash". They haven't quite made that.

Angela Smith: It is a tricky moral area.

Robert Gifford: I know. I'm just being absolutely honest with you. It is really difficult. That, in a sense, is where, although, historically, successive Ministers have been absolutely right to say, "We want to make speeding as socially unacceptable as drink- driving", it is a much harder task to do.

Q91 Angela Smith: But that's the importance of enforcement, is it not?

Robert Gifford: Absolutely, yes—including cameras.

Lilian Greenwood: I am concerned specifically with enforcement, really, which, I think, probably concerns all three of you, in terms of the evidence that there is of the value in bringing the limit down to 50 rather than 80 because people are impaired between 50 and 80. Mr Briggs, you said that enforcement was very important. In the context of the current fiscal situation and there being a reduction in police funding, which potentially might change the amount of resources available for enforcement, do you think reducing the limit would still have an effect, or might there be unintended consequences in that there would be less time or less resources to concentrate on those people who are most in excess of the limit? For example, if you breathalyse someone and they are at 60, you then have to go back to the police station to deal with all the processing of that and then you are not catching other people. Does that make sense? Can you lower the limit when you may not have the same resources for enforcement, Mr Briggs?

DCC Briggs: I understand the context of the points that you make there and I'm not saying that there aren't going to be real challenges around this in terms of the financial outlook. But the first thing that we should say, from an enforcement point of view, is: where is the law rightly placed? Where should the law be, and what's the evidence around that? Then we should target and prioritise our resources in the best way that we can. So I wouldn't say that there wouldn't be resourcing challenges, but our duty, first of all, is to comment on what we think the legislative framework should be in terms of effectiveness. That is for others to decide, not for us, but we should give a professional view of that, and our professional view is that the limit should be at 50. We will enforce it. There might be some implications around resourcing as a whole within policing, but we will enforce the change in the law if the law changes.

Q92 Angela Smith: My further question relates to an earlier point I made around education. I want to separate education as a really necessary part of drink-driving and drug-driving laws, from the confusion that arises around an understanding of how much people are actually drinking when they are in pubs and restaurants. The Report makes it clear that people's lack of understanding and confusion around what they can safely drink means that, actually, very often they deliberately target at a very low level to make sure they are under the limit. The difficulty, however, is that in many pubs, when you think you might be drinking one unit you are drinking two.

DCC Briggs: Yes.

Q93 Angela Smith: Is it time to force licensed establishments to standardise what they offer in terms of, for instance, a glass of wine—125 ml rather than 175—as being the understood measure? I appreciate that there are different amounts of alcohol in different drinks but is it not time, nevertheless, to say that a glass of wine is 125 ml rather than 175?

Robert Gifford: I think that matter probably goes wider than this Inquiry. I absolutely agree with you. I was present when you put that question to Sir Peter. I have had the experience of going into a pub and, when I asked what size a small glass was, being told, "Well, it's 250", which is not what I call small. Then you are told, "Oh, by the way, if you and your wife have two, you can have the rest of the bottle free"—hang on a minute, this is going way too far. So I think you are absolutely right to raise that question, although it feels like it is slightly outside the terms.

Can I just give another example, which is on a parallel with that? I was on holiday in France this summer and it is the law, certainly in cafés in northern France, that

if you have a happy hour and you are offering cheap alcohol, you have to have the same happy hour for cheap non-alcoholic drinks. That is quite an interesting one.

Q94 Angela Smith: Absolutely. But is it beyond the scope of this Inquiry because, if we lower the limit, it's incumbent on us to make it easier for people to stay within the new law?
Chair: Anything we ask is in the scope of the Inquiry.
Robert Gifford: Okay. I think it raises the question, and actually the Department of the Environment, Transport and the Regions did do that within its combating drink-driving consultation over a decade ago, which said, "If we are going to lower the limit then we will have to educate people about units". That is a real challenge to us in road safety because our historic position is, "Don't do it. Don't drink and drive". But, actually, possibly a more mature approach is to say, "Okay, that is what a unit of alcohol is"—with all the qualifications about it; personal, time of day, what you ate, etc, etc—"and, therefore, you will need to think very carefully about what you're doing". That becomes a more mature relationship between the state and its citizens.
Angela Smith: I agree with that.

Q95 Kwasi Kwarteng: Can I ask a question specifically on this point? It seems to me now that there are an infinite amount of alcoholic drinks you can buy. It was not the same 30 years ago. If you went into a pub 30 years ago there may be two or three things you would buy but, now, there are lots of things. Given the number of drinks and the different strengths and all the rest of it, how realistic do you think education on that front is? How realistic is it to say, "One pint of this lager equals one point of this bitter equals whatever"?
Chair: Mr Gifford, do you want to comment on that?
Kwasi Kwarteng: Honestly.
Robert Gifford: Actually, honestly, I don't know. It is an absolute challenge because you are quite right. What has happened is we are undertaking a debate about drinking and driving within a context of wholesale change of alcohol consumption and provision.
Kwasi Kwarteng: Completely, yes.
Robert Gifford: So the simplist in me says, "Lower the limit. It'll be absolutely fine." The realist in me says, "Hang on a minute. Is that going to tackle the problems in city centres on Saturday and Sunday night? Do those people think about how many they are consuming? Do I sometimes think about it when I have a glass or two of wine at home?" You are absolutely right to raise the question. This Inquiry is also part of a wider debate about alcohol in our society.

Q96 Chair: Ms Booth, do you have a view on this?
Ellen Booth: Yes, Brake does have a view. We think one of the major issues with a drink-drive limit that is over 20 mg is that you are asking people to make a judgment, and they do not have the knowledge with which to make that judgment. So, in effect, you might well be criminalising people by asking them to calculate how units of drinks of varying strengths translate into a certain BAC limit and then to estimate whether they are safe to drive.
Our point of view is that you should lower the limit to 20 mg which, effectively, means no drink-driving and we back that for a number of reasons. We back that because, even at measures above 20, you are still, as a driver, three times more likely to be involved in a fatal crash. That would be just involving yourself, but then you have to consider that there are other road users that you share the road with. So, for a number of reasons, we would say that that is a really favourable idea, again, for this idea of confusion over compliance, and we would say, actually, although this seems to have been passed over, there is a great deal of support for taking a zero tolerance approach to drink-driving.

Q97 Chair: The North Report said there wasn't.
Ellen Booth: Yes. I can cite the Royal College of Nursing's Annual Conference where they voted in favour of a zero tolerance approach; the British Social Attitude Survey 2009, where 83% of respondents said that people shouldn't drink any alcohol before driving—83% agreed and 58% strongly agreed; and Brake's own 2010 survey which surveyed 800 random drivers and found that 55% of drivers felt that a limit of 20 or less would be preferable. There is a good degree of evidence out there that people really do feel strongly about this.

Q98 Chair: You are disputing the findings of the Report which said there was not public support?
Ellen Booth: The British Social Attitude Survey and the Royal College of Nursing were actually within the North Report, which he did cite.
Julian Sturdy: If I can just pick up on two points with Mr Briggs, one of which you have already covered slightly, but I would just like to delve into it a little bit more. You talked about the testing that we have at the moment for drink-driving and the fact there is new equipment now. This is something I asked Sir Peter North. Can you get some statistics on the basis of between 50 and 80? You said it is 2%.
DCC Briggs: 2% involved in collisions, yes.

Q99 Julian Sturdy: 2% involved in collisions that had been tested?
DCC Briggs: Yes.

Q100 Julian Sturdy: And for how long has that information been collected and calibrated? Do you feel that is enough or is it something that should be expanded?
DCC Briggs: I would like to see more research on this. I would like to see us expand the evidence base. This has developed over the last 12 to 18 months as new equipment has been brought in and new equipment is being used by police forces across the country. But we do need to be more robust in collating such data and analysing it in a more informed way.

Q101 Julian Sturdy: As a police force, you would be quite happy to do that or capable of doing that? It is not too onerous to ask you to take that on?

DCC Briggs: We have the data to be able to present around the 2%, and we are tightening up the quality of that data across the country as this equipment settles down and is used more effectively. So as our database grows over time, we will be in a position to be more informed about it.

Q102 Julian Sturdy: Thank you. The second point was on drug- driving. What is your view on zero tolerance—specifically on illegal drugs. Do you think that is enforceable?

DCC Briggs: Yes, I do think it is enforceable, and this is where I would really pitch my argument for significant change in this area, because there isn't the deterrent out there for people who take recreational drugs and drive. We need to have a much stronger legislative framework to work within. That will then lead to us being able to use new technology quicker and more effectively, and if we take the impairment argument out of the way, we will also save a huge amount of time and cost on Medical Examiners, on the cost to the courts and everyone else, because the current procedural framework is just a series of opportunist loopholes on various aspects of the legal process. So I am seeking change on that.

Q103 Kelvin Hopkins: On enforcement, the most striking statistic in all the reports is the fact that on the Continent, on average, countries across the board breath- test five times more drivers than we do, which is quite astonishing. Is that a matter of policy or resource, or is it to do with the fact that, by law, we don't randomly breath test, although you have said that, effectively, you can because you only need the slightest excuse to stop someone? But just raising that figure to the continental average would, surely, transform the situation?

DCC Briggs: I think it would in terms of the prevention aspect of what we are seeking to do. The reason why the figures are so high across the Continent is simply due to the tactics used in random testing. For example, in Holland, at any point of any road, night or day, they will put a random screening operation into place and they will breath-test everybody. So they will breath-test every driver in a long line of traffic around that. That has been the way that they have enforced for years. So, when you look at those screening numbers, they are huge. So there are different approaches across the Continent. If random testing comes within the law here, there will be an increase in activity.

Q104 Kelvin Hopkins: Is it not the case, yet again, of British Governments dragging their feet on these measures? In almost every road safety measure, we have always been behind the curve, in a sense.

DCC Briggs: I think random testing will really improve safety on the roads. That is my professional opinion. I think that that will encourage some of my colleagues in police forces across the country to conduct more of a testing regime around it. I think there is public support for it and, professionally, I just think that that is the right way for us to develop our tactics.

Q105 Kelvin Hopkins: Another aspect of the debate—we were broadening the debate somewhat—involves other factors such as restricting alcohol consumption by raising price and so on. There has been a lot of talk about that. Would that help in deterring young people at least from drug and drink-driving?

DCC Briggs: In another job that I have within the Safer Communities Forum, we are looking at the cross-cutting issues of alcohol. I am trying not to stray too far from the issues that the Committee is addressing. You heard evidence earlier regarding young people, but we all know that, in the recent past, we have had a cultural change to this volume drinking, and that has to have a knock-on to driving. It is inevitable. So I do have a view on pricing structure and availability of cheap alcohol, and the consequences across different areas of social and criminal justice. So I do have a broader view on that particular point.

Chair: Mr Gifford, did you want to comment on that?

Robert Gifford: I just wanted to extend, if I might, the answer on enforcement of a moment ago and refer to another of Sir Peter's recommendations, which is that drink and drug-driving should be included in the list of offences brought to justice. I don't know whether the Home Office still has said list. Certainly under the previous Government there was a list of offences brought to justice which Chief Constables had to report on.

Drink-driving is a fantastic offence for the police because you get a very, very high level of conviction. The evidence is pretty robust: 90% of the people who are charged with it are convicted for it, and, therefore, it is a good success story. So if drink and drug-driving were to be included in whatever is reported to the Home Office, that would also raise their political—with a small "p"—importance in terms of enforcement. I can appreciate, otherwise, that if I was a Chief Constable, I might be thinking, "Where does roads policing fit against drug-driving or anti-terrorism or whatever?" If it is on something that I have to report to the Home Secretary about, it becomes more important. As I say, I don't know where the current thinking is on those kinds of issues, but I think Sir Peter made a very important point with that recommendation.

Q106 Kelvin Hopkins: There was one more question, which goes even broader than that. I have long thought that the driving age is too young in Britain. If it was raised just by another year—

Q107 Angela Smith: To 18.

Q108 Kelvin Hopkins:– to 18, the age of majority, would that not be a sensible move which would help?

Angela Smith: That is an interesting one.

Chair: It really is not within the scope of the Inquiry. No, we will not pursue that one now. Ms Greenwood, did you want to come back on that?

Q109 Lilian Greenwood: Yes, and really to come back to Ms Booth. I have some sympathy with a

reduction to 20 because it takes away the mixed message that, somehow, it is okay to drink a bit and drive, and nobody really understands. It is very clear in Sir Peter's Report; people don't understand how much "a bit" is. But when Sir Peter was giving evidence earlier it became clear to me that the main reason he seemed to reject that was that you would not be able to retain the 12-month ban if you reduced it down to 20 because of public acceptance. I am wondering what your view is and also what the view of the others is.

Ellen Booth: I don't think that necessarily follows. Brake's point of view is that if we are to ban drink-driving altogether, there is no reason why we should say, "Well, if you drink a little bit and drive that is more acceptable than drinking, say, 50 and driving or 80 and driving". If we are going to send out a clear message, then, yes, you would just say, "All drink-driving is illegal".

Q110 Lilian Greenwood: That is Brake's position?

Ellen Booth: That's Brake's position, yes.

Q111 Lilian Greenwood: Do you have any evidence that there would be public support for those who were caught at, say, 25 or 30 to then suffer a 12-month ban?

Ellen Booth: Yes. I guess Brake have chosen that position for clarity because we work with bereaved families who have very, very strong opinions on these things. If your son is killed you don't ask—this is one example that I was given by a police officer—"Was this driver over 80?" You ask, "Was this driver drinking?" So drink-driving—maybe this is something that not everybody has come to terms with—is a very dangerous activity that does cost people's lives, so taking a tough stance is acceptable from our point of view.

DCC Briggs: I do understand that point of view and have some sympathy with it in relation to what an ideal would be. I do take a slightly pragmatic view, though, in relation to this in terms of acceptability of enforcement to the public, and, also, the rationale in terms of the evidence base around it. So I think that it would be more difficult for us to achieve that. I am not saying that there should not be an aspiration in that direction, but the first thing we need to do is to move from 80 to 50, evaluate and see how that progresses. This is a continuous process of trying to develop effective law enforcement policy.

Q112 Kwasi Kwarteng: I came here with a relatively open mind , but I am, as you say, very concerned about what "a bit" is. I am fairly mature. I like alcoholic drinks but I have no idea, given the plethora of drinks, what 50 mg is in terms, so education, in terms of telling people what, exactly, the limit is, is absolutely crucial. I would be quite happy to live with that if we could say, and be clear to everyone, what 50 mg is. But without that you might as well go to 20, frankly, and that is not a conclusion that I necessarily wanted to draw.

Robert Gifford: For the record, our position is support for lowering the limit to 50 because that is based on science and support for keeping the continuing punishment regime because that will send a very clear message to those people who are caught. There might well be a case for a further 20 mg limit for, for example, those drivers who are involved in either carriage of goods or passenger transport—taxi drivers, coach drivers, bus drivers, HGV drivers. That brings them into line with the regime that operates in airlines and on the railways. We shouldn't forget that part of this can be done through employers encouraging a better control of alcohol in the workplace; having a very clear policy for their workforce that you don't drink while at work. I take your point entirely that we must, if you like, in the middle be looking a bit wishy-washy. It is about what is achievable rather than a moral absolute. I think that is part of the difficulty.

Q113 Kwasi Kwarteng: I am thinking about the smoking ban, actually, where the Government took a very firm decision. I was someone who liked to smoke in pubs, like many people in this room. But there was a clarity about that. We said, "This isn't going to happen any more in public places". I was wondering whether you could argue that the same clarity could be applied to our situation here.

Robert Gifford: Let me put it the other way round. If the Committee came out with a recommendation to lower to 20, I wouldn't be saying, "That's a bad decision". I would be saying, "That's a very, very brave decision which we will thoroughly support".

Chair: No, you mustn't lead the Committee.

Kwasi Kwarteng: I just wanted clarity in my own mind about this.

Q114 Iain Stewart: Just to follow on from the uncertainty about what a unit is—I appreciate that this is a scientific question that you may not be able to answer—are there other factors that influence the level of alcohol in the bloodstream for the same quantity of alcohol? I know, just from my own perception, if I have a glass of wine on an empty stomach on a warm summer's day, it has more of an effect on me than that same glass of wine during the course of a meal. Would that change the level of alcohol in my bloodstream or is it there anyway and it is just other factors that influence it?

Chair: Who can answer that one with authority?

Iain Stewart: I apologise for a scientific question.

DCC Briggs: I wouldn't attempt to be a quasi-scientist in giving a scientific answer. I think the starting point is having nothing to drink. That is the best starting point for any discussion around this. What we have encouraged in many of our campaigns is things like the designated driver. I think that is a really sensible idea. If people go out on a regular basis, you take it in turns. So I think we need to encourage people, in a social way, to change the way that they behave, the way that this tends to work. I do think that there are aspects of size, metabolism, food and the other components that go into this. But I wouldn't attempt

to give you the science behind it because that would be wrong.

Chair: At our next question session we will have some medical experts. We will pursue it then. We will not put you on the hot spot.

Are there any other questions from Members? Thank you very much indeed.

Robert Gifford: Thank you.

DCC Briggs: Thank you very much.

Tuesday 12 October 2010

Members present:

Mrs Louise Ellman (Chair)

Lilian Greenwood	Paul Maynard
Mr Tom Harris	Angela Smith
Kelvin Hopkins	Iain Stewart
Kwasi Kwarteng	Julian Sturdy
Mr John Leech	

Examination of Witnesses

Witnesses: **Professor Mike Kelly**, National Institute for Health and Clinical Excellence (NICE), **Professor Alan Brennan**, National Institute for Health and Clinical Excellence (NICE), **Professor Richard Allsop** and **Dr Hamish Meldrum**, British Medical Association, gave evidence.

Q115 Chair: Good morning, gentlemen. Welcome to the Transport Select Committee. Could I ask you to identify yourselves, please, for our records?

Dr Hamish Meldrum: I am Dr Hamish Meldrum. I am Chairman of Council at the British Medical Association.

Professor Richard Allsop: I am Richard Allsop. I am Emeritus Professor of Transport Studies at University College London. I am a director of PACTS and of the European Transport Safety Council.

Professor Alan Brennan: I am Alan Brennan, Professor of Health Economics and Decision Modelling at the University of Sheffield.

Professor Mike Kelly: I am Professor Mike Kelly. I am the Director of the Centre for Public Health Excellence at NICE.

Q116 Chair: Thank you very much. The evidence that we have received from Professor Allsop and from NICE shows very different estimates concerning the number of casualties that would be reduced with a 50mg limit on alcohol. What is the reason for this discrepancy, if it is indeed a discrepancy? Professor Allsop, would you like to give me your views? Why are your figures so different?

Professor Richard Allsop: I think we were doing different things. First of all, my approach was deliberately cautious. My approach was concerned simply with the reduction of the limit without any consideration of effect that associated increased enforcement and associated new public information might have on people who are already way above the existing limit, but I always recognised in what I wrote that there would be additional savings at those higher levels. I was concerned with the changes coming from the reduction itself. I would also say that my approach is to be rather careful about the interpretation of evidence from other countries in relation to our over-80mg people—people breaking the existing limit—because we have been so effective against those offenders now, and we have reduced to about a fifth now of where we started the amount of offending at that level, whereas some of the other countries that were reducing their limits had been less tough on the people above the existing limit.

Q117 Chair: So is the issue then to do with comparable information on what's happening in this country and what's happened elsewhere: what the impact would be?

Professor Richard Allsop: That is a question, I think, for my colleagues.

Professor Alan Brennan: I think Professor Allsop's estimates were essentially making assumptions about what would happen in this country to various different bands of people. You have a set of people who are currently driving just above the current limit, maybe 80mg to 110mg, and just below the current limit, maybe 50mg to 80mg. In Professor Allsop's figures, as I've read them, he made assumptions about the behavioural effect of changing on those bands of people. He didn't make any assumption at all about what would happen to people above 110mg, so those people who were quite far above the limit. He assumed they would be completely unaffected by the change.

What we did in our modelling was use two core pieces of evidence from overseas: a big European study that looked at 15 countries, and another much more detailed Australian study. In both of those sets of evidence there were behavioural effects seen, not just in the people around the limit but higher above the limit, and indeed those below the current limit. The main difference between our two estimates is that we widened, in ours, the number of people who were affected to the ones very high up and the ones low down. The big issue in numbers terms in the difference between the two estimates is the effects that we looked at for those people above 110mg. So we were essentially using evidence from Australia and 15 European countries that had implemented moving from 0.08 to 0.05.

Q118 Chair: Dr Meldrum, do you have any observations on this issue?

Dr Hamish Meldrum: I think we could spend a long time arguing about the exact numbers, and that is always going to be an estimate. I don't think, though, what is in doubt is the effect on performance that various levels of blood alcohol seem to have. There is a significant difference between performance at 80mg and performance at 50mg. Your performance is quite greatly impaired at 80mg compared to 50mg. It is still impaired at 50mg but not nearly so much. On that evidence alone one can assume that you would actually reduce the number of accidents and reduce

the number of fatalities. As the other speakers have said, because we don't know exactly where we are starting from it is difficult to put absolute figures on, but there is no doubt that actually you will reduce the level of accidents if you stop people who have an impaired performance driving.

Q119 Chair: So you are looking at general impairment?
Dr Hamish Meldrum: Yes.

Q120 Iain Stewart: Just to follow up on that point—forgive me if this is a naïve medical question—in my mind the intake of a particular quantity of alcohol affects people in different ways at different times. If I have a glass of wine on an empty stomach, it affects me more than the same quantity of alcohol with an evening meal, for example. Are there other factors that affect the quantity of alcohol in the bloodstream and therefore the level of impairment?
Dr Hamish Meldrum: How you consume alcohol, in what form and whether you are eating with it affects how quickly it gets into your bloodstream and therefore affects the level in your bloodstream. For instance, if you drink sparkling wine on an empty stomach that will raise your blood alcohol levels quite quickly. If you drink something with a meal then it won't; but it is the level of alcohol in your blood that affects your performance. It is not directly how much you've drunk. How much you've drunk is related to that, but, as you say, there are other factors and how quickly you absorb it. What is crucial is the level of alcohol in your blood, and that is what you are measuring when you breathalyse people or take their blood alcohol. It is the level of alcohol in your blood that affects your performance, not necessarily how you have taken in that alcohol and what other factors apply.

Q121 Iain Stewart: I just ask to make sure that we are not failing to consider other tests as well as purely the alcohol level in the bloodstream.
Dr Hamish Meldrum: I think these other things are constant. If you basically said to me, "You can't drive if you've drunk X glasses of wine", although that's helpful for the public to know that, because of the factors you've mentioned what is crucial about impairment is the level of alcohol in your blood.
Iain Stewart: Thank you.

Q122 Kelvin Hopkins: In a previous session, we touched on this, but I'm interested in the impact of lowering the limit on behaviour. At 80mg many people, even oneself, take a chance perhaps. You're not quite sure whether one or two glasses of wine will get you over the limit but you think it's probably okay. At 50mg the limit is so low that, rather than take a chance, you don't drink at all. I wondered if there is any evidence to support that theory.
Professor Mike Kelly: Sorry, which theory?

Q123 Kelvin Hopkins: That if the limit is reduced from 80mg to 50mg people don't take a chance on how much they can drink: they don't drink at all before they drive because they are not sure if even one glass of wine might put them over the limit. Rather than take the chance, instead of having a couple of drinks and thinking it will be okay, you drink nothing.
Professor Mike Kelly: Right.
Chair: So you are talking about below 50mg?

Q124 Kelvin Hopkins: Yes, below 50mg.
Professor Mike Kelly: If you are talking about the psychological dynamics, there are two parts of the process where a substance like alcohol confuses the issue for the person consuming alcohol. Some of our behaviour is automatic: you do it on the basis of not thinking through what you're doing. It is an automatic response to a situation. The other part of our behaviour is dictated by certain rational processes where we make calculations. The difficulty with alcohol is that it interferes with the second, and the former comes to predominate. It is in an exponential relationship with behaviour. As the consumption increases, the rational function in the mind decreases. So there is a complex interaction going on. You will see behaviours being changed as a consequence of consumption, even if it is only marginally. But in terms of performance, as Hamish said, you also see this question of impaired performance that moves up the scale as the consumption of alcohol, or the volume of alcohol in the blood, increases.

Q125 Kelvin Hopkins: I am just thinking if I can rephrase the question. If one is going out to a dinner party and one thinks, "Well, 80mg is enough; I can have a couple of glasses of wine", at 50mg it is a level where you think, "It's not worth having one glass because it might be a problem, so I won't drink at all." I just wondered if there is any evidence from abroad perhaps that people do change their behaviour in that marked way.
Professor Mike Kelly: I don't know what my colleagues would say, but I think in terms of the cultural norms in relation to drinking, the not drinking at all and driving seems to be much more common, particularly among certain younger members of the population, than it used to be. From the time when the breathalyser was introduced in 1967, I think there has been a huge shift in cultural norms in relation to drinking and driving. The kind of calculation you are making, which is that it wouldn't be worth drinking at all, is probably much more likely made now than it would have been in 1967 or 1968.

Q126 Chair: Professor Allsop, I think you wanted to come in?
Professor Richard Allsop: Yes. In this context I think it wouldn't be a new reaction. I think we have benefited a great deal in terms of the effectiveness of the existing limit from the fact that many people greatly overestimate their risk of exceeding it with ordinary social drinking, like a couple of glasses of wine with a meal over the evening. Of course, that effect will be greater if the limit is reduced to 50mg. Cautious people will be a bit more cautious. The fact that there will be people who are being more cautious

than they need be is already a very widespread phenomenon.

Q127 Mr Harris: The information we have is that, in 2008, 430 out of 2,538 road accidents were related to drinking alcohol. That is about 17%. From what Professor Brennan was saying, there is a group of people who drink way above 80mg. Am I right in suggesting that this research shows that those people wouldn't feel affected by a mandatory lowering of the limit? Those are people who are problem drinkers and problem drink drivers. What I am trying to work out is, of those 430 and of that 17% of road accidents caused by alcohol, what percentage of that are caused by people who frankly don't care what the law is in terms of the alcohol limit? Those are the people that a reduction won't affect.

Q128 Chair: Professor Brennan, you look as if you want to answer that one. Can I invite you to?
Professor Alan Brennan: There are three or four things to unpack there in the 430 number. It is a kind of Department for Transport definition which says if the person has died while driving, and their blood alcohol has been measured, they've been over 80mg at that point. That isn't all of the people who die as a result of alcohol. There are a whole gang of other people below the 80mg who are also dying due to alcohol. It is a kind of arbitrary threshold—

Q129 Mr Harris: Sorry to interrupt you, but does that figure also include, for example, pedestrians who were not at all drunk but were hit by drivers who had been drinking? It's not just the driver who dies in the car; it is pedestrians also? I see your colleagues are nodding.
Professor Alan Brennan: I'm not sure. I think so, yes.
Professor Richard Allsop: If I can clarify, it is an estimate from the Coroners and other data of the number of people who died in accidents in which at least one driver had an alcohol level over 80mg; but the people who died may have had no alcohol at all.

Q130 Chair: What would the impact be of a 50mg limit on those drivers who take far higher levels of alcohol than the ones that Mr Harris is talking about? There seems to be an assumption somewhere here that lowering the limit would have an impact on those drivers. Why is that?
Dr Hamish Meldrum: I think it is quite difficult to quantify. There are, in a way, two things that help stop people driving. One is the sense of social responsibility to stop people drink-driving; and the other is the fear of getting caught. Whatever system you have, you have to have reliable and effective enforcement. That applies whether your alcohol level is 80mg, 50gm or whatever, particularly I think if you are going to get that category of people who, in my definition, really don't have the same sense of social responsibility about drink-driving. How much more reducing it is going to help that group I would accept is quite difficult to say. I think for the vast majority who have a sense of social responsibility, to get back to Mr Hopkins' point, it will have an effect because they will be even more cautious than they have been. What we are actually trying to aim at is getting people not to drink at all when they're driving, but you have to have an arbitrary level to allow for some of the practicalities of enforceability. It will make them more likely not to drink at all, and that in itself will reduce the number of accidents.

Q131 Mr Harris: Can I just pursue this, Chair? This 430 figure may be something of a shibboleth—I am not sure—but we are asked to believe that according to the European experience that number of fatalities could be reduced by between 77 and 168, which is a massive percentage of that 430; or 144 based on the Australian experience, which is also a very large proportion of that total of 430. That is between a third and a half of all fatalities. That is a huge reduction. If we are to believe that the main effect is going to be on those law-abiding, conscientious, responsible citizens who already respect the drink-driving limits, and yet they don't seem to be responsible for the vast majority of the deaths that already happen, if a change in the law is only really going to affect the law-abiding—the people who already respect the law—how can we expect to see a reduction of 144 deaths a year when, at the moment, 430 deaths are caused by nutcases who just don't care about the law anyway?
Dr Hamish Meldrum: I didn't say it would only affect them.

Q132 Mr Harris: It would largely affect them.
Dr Hamish Meldrum: That might affect them more. I think it still will, and its enforcement as well will help to reduce that.

Q133 Mr Harris: But are you saying enforcement on its own would work without a reduction in the legal limit?
Dr Hamish Meldrum: Enforcement would help with that hard group. As I say, we don't know exactly what the percentage and the make-up of that is, but what I am also saying is there is absolutely clear evidence that the difference in performance between 80mg and 50mg is significant. Therefore, even outside that hard group, you will make a significant difference. We keep getting back to this business of exact figures, but then it is not an exact science because you are comparing figures from abroad. We are not always starting from the same place; we don't have the same enforcement regimes. We don't even have the same culture. I get back to the point that you will have a significant effect on road accidents and deaths if you reduced from 80mg to 50mg. I think we could spend all morning talking about how that is going to be at 10%, 20% or 30%, but to some extent that is a guesstimate then.

Q134 Chair: Professor Brennan, I think this was from your studies, wasn't it? Can you help us on this?
Professor Alan Brennan: Yes; can I have a go at explaining? The 68 to 144 numbers and the 303 number at six years—all of those are seen in the context of the whole 2,800-odd people who are dying. It is not just the ones over 80mg that we have been

looking at: it is everybody. Not all of the effect is in the 430 people over 80mg. There is a lot of effect in the people under 80mg as well, even though they are at much lower risk. If you are at 80mg you are at 11 times more risk of having a fatality than when you're not drinking. There are a lot of people in those groups, so even though they are at a lot lower risk than someone at 150mg or 200mg, because it is exponential, still affecting them a little bit is having the effect because there are a lot of people in those groups of having a large number of road accidents reduced. You are not really talking about the 144 as a proportion of 430. The 144 is more like a 6% reduction in fatalities in the country rather than 30% or 40% or 50%.

Q135 Lilian Greenwood: I think the point is that 430—correct me if I'm wrong—are the people who had a blood alcohol level of 80mg or greater, and within that 2,538 there are people who would fall in the 50mg to 80mg but we just don't have the number because there is no recording of that. Is that right?
Professor Alan Brennan: That is right. There has not been a roadside survey to get those numbers since the late 90s, so we don't have the accurate numbers about exactly how many people are driving round in England and Wales today with what levels of blood alcohol. For our modelling we have had to estimate those numbers by working back to those numbers from looking at 18,000 fatalities and the blood alcohol content for them, and the mathematics of the risk curve and how many people must have been driving in those bands to get that kind of number.

Q136 Chair: Professor Allsop, do you want to add something?
Professor Richard Allsop: What Professor Brennan has said is quite right. I would like to make it clear that I have no problem at all with the modelling and estimation that Professor Brennan has done. I think it is the fact that we are talking about deaths in accidents in which a driver has particular alcohol levels. We have a good estimate which the Department for Transport relies on from year to year, and most of us broadly believe. We have not only the number in which a driver was over 80mg; we have the distribution of the alcohol levels of the drivers over 80mg. We also have the numbers of which drivers had amounts of alcohol less than 80mg, so we have that full distribution, and both Professor Brennan and I have used that. That is one of the common things about our work.
Coming back to Mr Harris's question, I think, notwithstanding what Professor Brennan has said, a very large amount of the reductions that he estimates come from the accidents currently in which a driver has more than 80mg. I do feel that we should be very cautious about the transfer of experience from South Australia and the European study to our situation. I am sceptical about these large numbers because the starting point in South Australia was one where 2.5% of people over the whole week were driving at over 80mg. That emerges from the monitoring work. We are starting from a situation where, over the whole week, only 0.3% of the driving that is being done is estimated by Professor Brennan, and I agree with the estimate, to be done by people who are over 80mg. That means there was a lot more scope for a reduction at those levels in South Australia than there is here.
I have to say that in my judgment—and it is only a judgment—there has been no study which has looked at a lot of people who are driving around at very high alcohol levels and tried to assess, in relation to those real people, what their response might be to the lowering from 80mg to 50mg. If we had such a study, we would all be better off. Really effective enforcement of the 80mg limit began in the early 1980s. In those two and a half decades, or a bit more, we have reduced from more than 2,000 deaths a year in that category to less than 400. One of the results of that is that we have only 0.3% of our driving being done at that level.
When you have done all that, I am very sceptical that one will get the same proportion of further reduction by lowering the limit as in a situation in South Australia where you were starting with 2.5% of people driving around over 80mg. The European figures are estimates from modelling over experience in a large number of countries. They pin down effects on people of different ages and gender, but they don't get to grips with how much of it is coming from how far up the alcohol scale under the existing limit. I feel your scepticism about the size of these numbers. I'm not saying that there will be none. I deliberately said I am not going to count those, but I said there would be some. I am sceptical that they are as large as our colleagues' estimates make them.[1]
Chair: I think that ultimately we have to make a judgment on what all of this means. What is important for us today is that we do draw out from you the basis of the differences and the implications of information from other countries as well.

Q137 Mr Leech: There is obviously a big discrepancy in the number of proposed saved lives, but is there anyone dissenting from the view that a reduction to 50mg would save at least some lives: one or more?
Professor Mike Kelly: No.
Professor Richard Allsop: No dissent at all.
Dr Hamish Meldrum: No dissent.
Chair: Can you just say that again louder for our records?
Professor Richard Allsop: No dissent at all.
Dr Hamish Meldrum: No dissent whatsoever.

Q138 Mr Leech: Has anyone come up with any study that suggests that no lives would be saved?
***Professor Alan Brennan*:** No
Professor Richard Allsop: No.
Chair: Shaking the head doesn't go down.
Dr Hamish Meldrum: Sorry. I'm not aware of any study that suggests that no lives or serious injuries would be saved.

Q139 Mr Leech: So, in your view, implementation of the North Review would save people's lives?

[1] See supplementary written evidence from NICE (Ev 96).

***Professor Alan Brennan*:** No
Professor Richard Allsop: Yes.
Dr Hamish Meldrum: Yes.

Q140 Mr Leech: Can I ask whether you take the view that a reduction to 20mg would save more lives, or do you feel that it could be the case that the difference between 50mg and 20mg wouldn't necessarily save any more lives?
Chair: Dr Meldrum, do you have a view?
Dr Hamish Meldrum: That is a bit more difficult. You do get the law of diminishing returns the further down you go. Also you get into areas of public acceptability and at 20mg just how genuine the effect is. Therefore, you may get a bit of public resistance. On purely performance levels, yes, people's performance improves between 50mg and 20mg, but not by anything like the same degree as it improves between 80mg and 50mg, so you are into the law of diminishing returns. I think, certainly from the BMA, we would argue that moving down to 50mg will create a substantial improvement: moving down to 20mg brings with it rather practical issues and the amount of improvement would be much less. Therefore, we would advocate at this stage a lowering to 50mg.
Professor Richard Allsop: I share that assessment.

Q141 Mr Leech: Is there any evidence that reducing the limit to 50mg would increase the number of people being caught over the limit: the morning after drinking?
Dr Hamish Meldrum: Common sense says that that is the case. Getting back to Mr Stewart's point, obviously how your blood alcohol changes relies on a whole lot of factors; first of all, what level it was; how quickly people metabolise it and get it out of their system—some people do it more rapidly than others. The point is that your level of impairment relates to the level of alcohol in your blood at that time. If you have had a heavy night drinking and have gone on to the early hours, and then drive the next morning before that level has reduced, your driving ability is impaired. Therefore, you will catch more people, but I would argue that it is quite right that you do catch these people because they are more of a danger.

Q142 Mr Leech: I completely agree with that, but if we are assuming that a reduction in the limit from 80mg to 50mg would change some people's behaviour—notwithstanding the idiots who will always drink and drive over the limit—shouldn't that change in behaviour also have an impact in the behaviour of people drinking to excess the night before and then driving in the morning? Surely, there will be a subsequent change in behaviour there as well.
Dr Hamish Meldrum: Yes, I would certainly hope that it would. Certainly that would be part of the education to even the responsible drinkers who have taken a taxi to their function, saying "If you're going to be driving at 7 o'clock the following morning, not only do you need to watch your intake during the evening but you probably need to stop drinking at a relatively early hour if you're going to drive the following day." If it does that, then it will reduce the accident rate.

Q143 Mr Leech: Just one more question. You said, and I completely agree, that it would hopefully then catch more people the following morning who were over the 50mg limit. We've had some conflicting evidence, if it can be called evidence, that if the alcohol in your bloodstream is decreasing rather than increasing, the impairment that creates may be less if the blood alcohol level is going down. Is there any real medical evidence that that is the case?
Dr Hamish Meldrum: Yes. If you measure your blood alcohol at one particular point in time, if it is a time when it is on an upward course, then obviously your impairment is going to get worse over the next hour or two. If it is on a downward course, it is going to get better over the next hour or two. Over the period of time following that period of measurement, then you will become less risky in the morning if your blood alcohol level is dropping, and you will become more risky in the evening if it is still going up. The degree of impairment at that point in time when you measure the blood alcohol is the same, whether it is going up or coming down.

Q144 Iain Stewart: Following on from these points, I have a concern that there is a considerable degree of ignorance in the public about what they can consume in alcohol within all these limits. My further concern is that if we reduce from 80mg to 50mg you are going to increase that uncertainty. Should the message therefore be that you just don't drink and drive at all and you take it down to effectively zero—to understand the higher level of 20mg. I am coming to the view that you might have to argue for either keeping the limit as it is with much stricter enforcement or saying nothing, rather than have this uncertainty in the middle.
Dr Hamish Meldrum: It is always a balance between what might be nice in an ideal world and what is practically achievable. As I said earlier, I would argue that with some of the problems in bringing it down very low, whereas it may be perfectly reasonable and logical in terms of actually trying to reduce the number of alcohol-related accidents to an absolute minimum, you get into these practical issues and public acceptability issues, which might mean that people are less happy with the type of legislation that is being imposed upon them. You need to have, in a way, public ownership of legislation to help to get the degree of co-operation you want. I would take it contrary to you: I think reducing from 80mg to 50mg would have a significant impact both on the number of accidents and on people's behaviour as well. Yes, the message should still go out "Do not drink and drive" and that is the only way to be absolutely safe in terms of both having accidents and getting caught; but I think in terms of enforcement then you get into other areas of difficulty which might cloud the issue.

Q145 Chair: Professor Kelly, you wanted to make a point?

Professor Mike Kelly: Yes. I simply wanted to say, of course, that you're absolutely right. There is a degree of uncertainty—and it is in the various reports that have come forward from NICE and others—among large sections of the population. If the limit were to be lowered this would be an ideal moment to educate the population again, as happened in 1967. Some of the rules of thumb, although they are not scientifically precise but they are close enough, could be very helpful with an education campaign to go with it. I think it is quite clear too, in the evidence that has come to the Committee from us and from others, that this is not just a legislative matter. It is legislation; it is education; it is enforcement. It is a range of things being done together which will produce the effects that we are looking for rather than one single thing.

Q146 Kwasi Kwarteng: I just wanted to reinforce my colleague's point over there. Clearly, yes, you are right to say that education is very important and you mentioned the fact that in 1967 there was a campaign.
Professor Mike Kelly: There certainly was.

Q147 Kwasi Kwarteng: But in 1967 people's drinking habits were completely different to today. We have a much wider range of alcoholic substances. We have alcopops; we've got a huge range of things that people consume. To educate people on that broad range of things that are out there, in terms of one pint of beer equals whatever it might be, I think is perhaps unrealistic. I mean, I remember those posters from 30 years ago, where you were essentially assuming that people either drank wine or beer, and possibly whisky. It was a much more limited range of alcohol that was on offer, so to expect the public to know—given the wide range of things they can drink—what the limits are I think is unrealistic, even after education.
Professor Mike Kelly: I think we have a problem more broadly and it goes well beyond the question of drinking and driving. The levels of alcohol consumption since 1967 have gone up enormously in this country across all sectors of the population with, as you rightly say, a broader range of products and so on. Indeed, an alcohol strategy would have to embrace dealing with that as well as these other things.

Q148 Mr Harris: I am going to have one more shot at this. Professor Allsop, you mentioned that you have breakdowns of the blood alcohol content figures for a range of people contained within those 430 accidents. I don't know if the Committee already has that information. It would be extremely useful if we could have that because it is a missing piece of the jigsaw. At the moment we have a very blunt instrument. We have the figures for people who were over the legal limit, but that doesn't really tell us very much unless we can get the breakdown of what proportion of those people were over, say, 100mg to 110mg.
Chair: Could you send the Committee that information?
Professor Richard Allsop: Can I refer you to Chart 3.5, not necessarily now but when you have time? Chart 3.5 on page 59 gives a breakdown of all killed drivers over the alcohol intervals. I beg your pardon; that is an age diagram.
Chair: We will find it. We know it is there, so we will find it.
Professor Richard Allsop: Let me take time and then come back to you with the right number.

Q149 Mr Harris: The second point I was going to raise, Chair, is: what do you think—all four of you—about the possible consequences of reducing the minimum? The legal maximum blood alcohol content is one measure of getting these road accidents down. Another way would be better enforcement. My understanding is that the roadside tests have reduced by 25%—800,000 to 600,000—in recent years. Do you think that roadside enforcement could have an equal or even a greater effect than reducing the legal upper limit?
Chair: Who would like to give a view on that? Dr Meldrum.
Dr Hamish Meldrum: I think it is difficult to say, because of all the reasons we have talked about earlier about the figures. In my opinion, it might be that you need to do both. It is not just the level. We know the scientific evidence about the degree of impairment at the various levels, and that is incontrovertible. But also you have to have effective enforcement and I would actively accept that you need to do both. Which would be more effective I don't think I can answer, and I'm not sure there are figures out there that would actually answer that. Both would have an effect, and much more than just either one on its own.
Chair: Ms Greenwood, did you want to say something?
Lilian Greenwood: That was precisely the question I was going to ask.
Professor Richard Allsop: May I answer what I wasn't able to? I will still refer Mr Harris to Chart 3.5 because that has four alcohol categories: No alcohol present; Alcohol present but not over the limit; Over the limit; and Over twice the limit. So there is some breakdown there, but I'm sure that Mr Harris has access—or would have friends who have access—to Professor Brennan's own paper. If he will look at Table 2 in Professor Brennan's paper afterwards then the breakdown is there. It is very detailed indeed, at intervals of 10mg right the way from zero up to greater than 300mg.

Q150 Mr Leech: Professor Meldrum, in your—
Dr Hamish Meldrum: I am afraid I'm only a simple doctor.
Mr Leech: Sorry; Dr Meldrum.
Chair: He has been impressing us a lot today.
Mr Leech: In your professional experience dealing with patients, how big a problem would you say is drug-driving?
Dr Hamish Meldrum: I think it is still significant. I am a GP and I still practise one day a week despite my BMA duties. I think, although, as others have said, we have improved considerably over the last 30 years, there are still a number of people in all walks of life who drink above an advisable level for driving and drive with blood alcohol levels that are too high. I

would say I think there is, in some sections of society, a degree of complacency compared with the initial reaction we got in the late '60s and early '70s, following the first drink-drive legislation. Therefore, I think, leaving aside the scientific evidence, if you did agree to a reduction this would have a new impact on that and with the education we've talked about would help to improve that behaviour.

Q151 Mr Leech: Sorry, I think you misheard me. I was actually referring to drug-driving rather than drink-driving.

Dr Hamish Meldrum: I am terribly sorry. There are two categories. There are obviously the illegal or controlled drugs and even taking them of itself is an offence; added to that, driving would impair that too. Although I don't have so much experience in terms of hard drugs like heroin or cocaine, certainly in terms of cannabis, I am sure there are quite a lot of people who drive while taking that, and that does impair their driving. Once it comes to prescribed drugs, I think we really get into a bit of a minefield. We have talked about some of the individual variations in terms of alcohol. They are probably much greater with prescribed drugs. You have to ask: would you rather have somebody who is severely depressed but untreated driving, or would you rather have somebody being adequately treated even though the drug might cause a minimal impairment of that driving ability? The same might apply to somebody who has a very heavy, streaming cold and is sneezing all the time and takes a cold remedy. You do get into much more difficult areas and there is not an easy test. You can't just say that because somebody has got a level of a certain drug in their blood, even if you could measure it, that will cause X degree of impairment. You are much more then into actual judgments about whether, in that individual, their ability has been impaired either through prescribed drugs, controlled drugs or a mixture of drugs and alcohol.

Q152 Mr Leech: Do you think then it is unrealistic to get a medical consensus on impairment through drugs?

Dr Hamish Meldrum: If you are saying, "If you take drugs X and Y, you mustn't drive, but if you take drugs A and B, you can drive", I don't think you would get a medical consensus on that. With controlled drugs—

Q153 Mr Leech: What, now or ever?

Dr Hamish Meldrum: Certainly not with the knowledge and the testing abilities we have at the moment. I don't think you would get an adequate consensus on that. In terms of controlled drugs, I take the view that you are already committing an offence taking them; you are probably adding to the severity of that offence taking them and also driving.

Q154 Mr Leech: But haven't the BMA taken a zero tolerance attitude in relation to drug-driving?

Dr Hamish Meldrum: If you are talking about controlled drugs, yes.

Mr Leech: Just controlled drugs?

Dr Hamish Meldrum: You can't take zero tolerance in terms of prescribed drugs, because I'm afraid the evidence is not there to allow you to make those sorts of accurate judgments. Yes, we know that there are certain drugs that are more likely to impair your ability, but how much they will impair that ability in any individual and in any given set of circumstances—and of course it depends what combination of drugs they are taking and a whole lot of other factors—I think to get a degree of consensus on that, you are almost back to the warning they put on drugs at the moment: "If your ability is impaired, don't drive". But how you make, and who makes, that judgment is much more difficult.

Q155 Mr Leech: Professor Allsop, you suggested that impairment, not just presence, needs to be established as far as drugs are concerned. Why do you think that is so important?

Professor Richard Allsop: Mainly because, as I understand it—and I am on the fringe of my expertise here—with recreational drugs there are some of those which stay in the body for a long time after they have ceased to impair. Therefore, if it were going to be an offence to have it in the body at all, then people could of course give up their recreational drugs but, having taken them, they would face really quite a long time when they shouldn't drive. It depends on voluntary choice or drug enforcement, but it concerns me that people would be committing an offence in a state in which they are not impaired in their driving and they may not be in a position, unless they are quite well educated, to know that they've still got the stuff in them. That is the big difference between alcohol, which I regard as the simple drug in terms of having a driving law, and quite a few of the recreational drugs. With alcohol, the impairment is very closely in time and level matching the presence in the bloodstream, whereas in the case of the other drugs it is not sufficient just to test for presence. You have to test for presence in a way that is impaired. I believe that this is a scientific challenge, but I am not expert on it.

Q156 Mr Leech: Dr Meldrum, when it comes to tests being carried out in custody the BMA have suggested that nurses don't have the relevant training, experience and expertise to undertake this role. Why do you think that, and is there no way that they could get that relevant experience and training?

Dr Hamish Meldrum: I think the main reason we have that view is because it is an area of judgment. It is quite a skilled area of judgment and an imperfect area of judgment too. In terms of actually taking blood samples and things, that is not a problem; but if you are actually making a judgment about whether somebody is impaired, then I think that is quite a skilled practice, and even I, as a GP, wouldn't feel qualified to do that. Of course you could train a nurse to the level of a forensic physician, but if you'd done that I think I would call her or him a forensic physician rather than a nurse.

Q157 Julian Sturdy: I think Mr Leech has covered a lot of the points, but could I just follow up on some of the points he made earlier on. I very much support what North is saying on drug-driving but there is a fundamental problem here, which has been highlighted I think with what the panel has said. I would be interested in everyone's comments on this. North is recommending that the Government should actively pursue research to determine proscribed levels of controlled drugs, similar to the current drink-drive offence. The problem is when we are talking about drink-driving, we are talking about one drug: when we are talking about drugs, we are talking about a huge spectrum of illegal and permitted. The problem here is going to be the medical consensus in the whole process if we take it forward. How do you think we can come to some sort of consensus across the board? I put that to everyone because this is going to be the big issue for drug-driving.
Dr Hamish Meldrum: I have probably said enough, but the way you get consensus in the medical profession is good evidence, and as you've suggested, there isn't good evidence at the moment. I would agree with Sir Peter North that you need to do more research to try to get better evidence. If you can get better evidence then you're more likely to get consensus.

Q158 Julian Sturdy: Do you think that evidence is going to be easy to get?
Dr Hamish Meldrum: No.
Julian Sturdy: That's the problem, isn't it?
Chair: Does anybody else want to comment on whether there can be a consensus? No; there doesn't seem to be. Anything else, Mr Sturdy?
Julian Sturdy: No.

Q159 Iain Stewart: One area that we touched on in a previous session was what we called the combination of drink and drug-driving. I would be interested in your comments on two very separate scenarios. One is what you might term an innocent one. Someone has a very small quantity of alcohol and takes, for example, a couple of antihistamine tablets. Based on your comments, does that combination put them in an impaired driving situation? At the other end of the scale, one of our previous witnesses mentioned that there is evidence that people who take recreational drugs in a nightclub and then driving home will consume a very small amount of alcohol so that if they're stopped and the police test them for drink, they will be under the limit but actually their impairment is considerable because of the drugs. I would just be interested: should we be looking at that combination effect as well as the separate drink-driving and drug-driving?
Dr Hamish Meldrum: You absolutely should because the combination can make a difference. The problem is that unlike alcohol, which in this sense is a fairly simple thing both to test or to assess the degree of impairment, there is much more individual variation. For instance, in your first scenario of the antihistamines plus a small amount of alcohol, antihistamines on their own cause a very variable reaction in people. Some people react quite badly to them; with some people there is very little impairment at all. If you add into that the combination of alcohol, then that variation is still there.
On your point about illegal drugs, again, getting back to your colleague, there is the problem of lack of research and not knowing exactly what levels and what degree of impairment relates to those levels; and also what the effect is of the combination of alcohol. I take your point that some people may well use alcohol to say, "Well, I'll get tested for that and they will forget to test me for drugs". Although you can try and do a fairly broad screen, it is pretty complex and quite time-consuming. If you want to screen for all sorts of drugs, including prescribed drugs, it is very expensive, it is very involved and it is very time-consuming. As I said earlier, the evidence there for what impact that has had in that individual is pretty scanty.

Q160 Mr Harris: It is quite difficult, isn't it, to get a handle on exactly how big this drug-driving problem is because there is not a consensus on testing, or whether it is prescription or controlled drugs? Do any of you have even anecdotal evidence about the actual percentage or the size or scale of the problem that we can actually use as part of our deliberations? Unless we have a figure on a bit of paper saying that X percentage of accidents is caused by drug taking, and of that X%, Y% is controlled and Z% is prescribed—do we have any evidence or do we have to rely on anecdotal evidence?
Chair: Does anybody want to answer that?
Mr Harris: I think that answers the question, actually.
Dr Hamish Meldrum: I think it is mainly anecdotal. We know that there is an increase in the amount of recreational drug use—that is not in doubt—but how much that feeds through then into those people who drive and also what impact that has on their driving, I think, as I have said earlier, we need much more research and much more evidence. Only when you have done that are you likely to get more of a consensus.

Q161 Mr Harris: So you are not recommending changes in legislation in this respect? Presumably you wouldn't if there is so little evidence?
Dr Hamish Meldrum: I think, in terms of controlled drugs, I take the point that it is already committing a crime to consume them or to use them. I would suggest, though it is not for me, if that is the law that it might be considered that you've added to the severity of that by actually driving as well as having taken a controlled drug. In terms of prescribed drugs, I think we need an awful lot more research, because otherwise I think it would be impossible to create legislation given our present degree of knowledge.

Q162 Kelvin Hopkins: Just before you leave us, I wondered if you could reinforce your message. We have talked about a lot of other factors in deaths from drink-driving and drugs, comparisons within different countries, from different starting points and so on. I am concerned that those who would oppose a

reduction in the limit might take some comfort or clutch at straws. Could you say, keeping all other factors constant so that you just look at alcohol consumption and accidents, that if you reduce the level from 80mg to 50mg many lives will be saved, and it is inevitable as a demand curve in economics that if you either reduce the price more will be sold or if you increase the price less will be sold?

Professor Mike Kelly: Yes, if I may. When NICE sets about doing an investigation of anything, it seeks to appraise the best available evidence that we can find, to assess its quality and then to build our recommendations on that. We are not making recommendations here but we've certainly assessed the evidence. I actually have two things in mind. First of all, in terms of the quality of the studies from both Europe and Australia, they are very good. This is good science. The second question: can you apply that in the British context? Well, you can, but there is some variation in terms of how one might predict what will happen on the basis of the different modelling that we have heard about. There is nothing unusual about that in science. Science is about handling uncertainty, and what you have seen here is quite a classic example of the way that building different assumptions into what you do you will get different results but—and this is very important—the direction of travel of this evidence is one way. It is very clear; and it is that there is a direct relationship between the number of accidents, the number of fatalities and the volume of alcohol consumed. Therefore, other things being equal, if you were to reduce that, the number of accidents and the number of fatalities would decline. In terms of the sorts of evidence that I look at in public health, this is pretty compelling stuff, it has to be said. This is not a chance association; it is an association that we've seen over 40 years of research, pored over by very clever statisticians. It only goes one way. That for me is both a practically plausible as well as a scientifically robust argument.

Dr Hamish Meldrum: Can I just add to that? I think you are quite right to ask that question. As scientists we always try to be on one hand and the other hand, but I am in no doubt—and the BMA is in no doubt—that reducing the level from 80mg to 50mg would save many lives. How many I can't say, but it would save many lives.

Q163 Angela Smith: I just wanted to explore briefly the difficulties that could be faced by drivers who take prescribed drugs, particularly antihistamines, which are probably one of the most commonly prescribed drugs. It seems to me that a great deal is left to the judgment of the individual when it comes to antihistamines. You get warnings, for instance, about potential drowsiness when taking these drugs and you are told not to drive if you feel drowsy. That is a particularly broad piece of advice when it comes to something as critical as getting behind the wheel of a car. In addition to that, the advice given on things like antihistamines is pretty broad when it comes to drinking alcohol in combination with them nowadays. I would just like the comments particularly of the BMA on that issue, because I think a lot is left to the judgment of the individual.

Dr Hamish Meldrum: I am afraid it will always be that. I would imagine more antihistamines are bought over-the-counter than are probably prescribed. They are freely available over-the-counter. Therefore, you are relying on either the chemist or people reading the packet. I would say the same about the judgment that an individual has to exercise when they have had a few late nights and they are driving when tired. Falling asleep at the wheel is dangerous. That requires your judgment as to whether or not you feel that you should stop, take a rest, take a break. I am not in any way going to absolve the individual from making a judgment. I think when it comes to these sort of drugs, because they have such an idiosyncratic effect and it varies so much from person to person, then it is quite right and in fact it's the only thing we can really rely on to say, "If you feel you are affected and you feel your ability is impaired, don't do it, and if you want to be absolutely safe don't take them and drive". I think you have to rely on people's common sense and judgment.

Angela Smith: And it will ever be thus.

Dr Hamish Meldrum: And it will ever be thus. We can't devise a system where you take personal responsibility and personal judgment out of it altogether.

Angela Smith: That is helpful.

Chair: Thank you very much for coming and answering all our questions.

Examination of Witnesses

Witnesses: **Brigid Simmonds**, British Beer and Pub Association, **Stephen Oliver**, British Beer and Pub Association, and **Nick Bish**, Association of Licensed Multiple Retailers (ALMR), gave evidence.

Q164 Chair: Good morning and welcome to the Transport Select Committee. Could I ask you to identify yourselves please for our records, with your name and organisation?

Stephen Oliver: Good morning. I am Stephen Oliver. I am from Marston's Plc.

Brigid Simmonds: I am Brigid Simmonds. I'm the Chief Executive of the British Beer and Pub Association.

Nick Bish: Good morning, Chair. My name is Nick Bish and I am Chief Executive of the Association of Licensed Multiple Retailers, which is the trade body solely dedicated to representing the grass roots of the industry, small pubs and bar companies.

Q165 Chair: Thank you very much. In your written evidence the British Beer and Pub Association concentrate on saying that pubs have become

increasingly family friendly, reducing the concentration on alcoholic drinks and having more non-alcoholic drinks, food and other things. Yet you say that if there was a 50mg limit that would have a drastic effect on business in pubs. How can those two things be the same if you are reducing the dependency of the business on alcohol, yet you are saying that reducing the limit would be very harmful indeed? Are those two things compatible?

Brigid Simmonds: I don't think the two are incompatible. Madam Chairman, I think I would have to say at the beginning that this is a hugely sensitive subject and it is one where we very much appreciate that sensitivity. We are very much in favour, and we made it clear to Sir Peter North that we were in favour, of random breath taking. We see that as a next logical step because I think random breath taking and enforcement is hugely important to this. But we are concerned—and we are still closing 39 pubs a week—about the effect of reducing the blood alcohol limit to 50mg because we are concerned that people simply won't understand, and therefore will stop going out because they don't believe that they can have a drink with a meal which, as you rightly say, is happening in more and more pubs now. The smoking ban having taken its effect, many pubs are serving food to survive. In fact, we now serve more food than the whole of the restaurant sector put together.

Q166 Chair: Can I take you up on that bit? You have said, as you have put in your written evidence, that you are increasingly selling more food. Why would this produce a bigger threat to the pubs? If you are increasingly selling more food and reducing dependency on alcohol, why would there be such a dramatic impact if the alcohol level was reduced?

Brigid Simmonds: Because if you sell food, people want to go out and have a meal in a restaurant, and they want to have a drink with it. Our concern is that the effect of reducing it will mean that people will decide that it is not worth taking that risk and they will stay at home.

Q167 Chair: You say also that 17% of all pub visitors drive or are passengers in the vehicle. How did you get to that figure?

Brigid Simmonds: We have a lot of statistics about many different things, so we have statistics about how many people visit pubs overall. We have 52,000 pubs in this country and we took that as an average, and having talked to our members. Stephen may have a view about how it affects his particular company.

Q168 Chair: Yes. Mr Oliver, can you help us on this one: how you get to that figure?

Stephen Oliver: I can. Just for the record, Marston's owns five breweries and we also operate 2,200 pubs across England and Wales. To try to answer your question, food is a much more important part of what we offer to our consumers than ever before. We are building at the moment, for instance, 20 new pubs a year and nearly half of the sales in those pubs comes from food. I would add to what Brigid has said by saying that there are still many, many pubs however in the UK which do rely on drink for a substantial part of their turnover. That includes many rural pubs as well. In my view, a change downwards in the drink-drive limit would have an impact on those because consumers would think very carefully indeed about going out and having a drink, whether it is with a meal or just having a drink in general.

We have seen over the last few years some very substantial impacts on the British pub industry. At one stage, over 50 pubs a week were closing: it is now down to somewhere in the region of 39 or 40. There are a range of reasons for that, not least of which is the smoking ban. A reduction in the drink-drive limit would undoubtedly add much more pressure to many of those pubs, a lot of which are in rural areas.

Q169 Kelvin Hopkins: I am a great supporter of the pub as an institution, the British way of life, part of our culture and all that. Indeed, 25 years ago I used to be Chair of a social club which sold alcohol—a party political one. That closed because of drink-driving effectively. People just wouldn't come into the town centre from their homes to drink because they had to drive home. Is it not the case that the big effect of the drink-drive laws has already had its impact, and that any marginal change now would not make that much difference compared with what has happened already?

Brigid Simmonds: I think the biggest difficulty is that the system that we have at the moment is one that people understand. They are quite clear in their own view that they shouldn't drink and drive and that they can have a drink when they go out. I think by changing it we may move from "you idiot" to "you're unlucky". There is a clear acceptance that we have some of the safest roads in Europe with the drink-drive limits that we have at the moment. I think there is a real chance that we will undermine the moral understanding that we have about drink-driving at the moment. It is something we hugely support. We support the Department for Transport every year, and have for over 40 years, in drink-drive campaigns.

Chair: Mr Bish, do you want to comment on this?

Nick Bish: No, I am content.

Q170 Kelvin Hopkins: Two more questions. One doesn't know—I don't know anyway—what proportion of those who are convicted of drink-driving or of being involved in accidents are actually driving home from pubs. It may be that the great majority are not driving home from pubs and therefore, as I say, the impact has already been effected on pubs. I support pubs, as I mentioned, and local licensed victuallers tell me that the real problem they have is competition from supermarkets selling vast quantities of drink which is below a price that the pubs could possibly operate at. I have argued this case as well and they seem to accept it: that a unit price for alcohol would actually benefit pubs because it would raise the price of alcohol sales in supermarkets but not affect pubs.

Brigid Simmonds: It is true that 70% of all alcohol now is sold in the off-trade rather than in the on-trade, if I can broadly look at it like that. But it is not true for beer. For beer, we still have 50% of what is sold in the off-trade and 50% of what is sold in pubs. Beer

is actually hugely important to the viability of pubs and one of the reasons why people go and visit great British pubs, whether they be from abroad or from here. What has not happened as part, perhaps, of this report is there has not been an economic study which looks specifically at the effect that changing drink-drive laws would have on the pub. That is where our major concerns lie.

Q171 Kelvin Hopkins: My final question is: do we know how many of those who have consumed alcohol in pubs actually drive away afterwards? A high proportion would walk home, go by public transport or be driven by someone else, a family member, or whatever. It may only be a very small proportion of people now who actually drive away from a pub having consumed alcohol.
Brigid Simmonds: I think that this is very true in town centres. People do come by public transport and we can have a discussion about how difficult it is to get home afterwards. I think that is a separate issue. But really in rural and semi-rural locations people still do drive there. People drive there particularly if it has a very good reputation for food. They drive there to go to a particular pub or restaurant because they want to go to that particular pub or restaurant and that is a good reason for going; and, yes, they do still drive.

Q172 Kelvin Hopkins: Just a final point: my family and I regularly go to pubs. What happens is that one of us doesn't drink and the others do.
Brigid Simmonds: I also think that there are a lot of youngsters who would never consider drinking and driving. That is why I say our laws have been hugely effective. You have to make sure that in changing the law you are going to have a law that people really readily understand and is going to be properly enforced.

Q173 Mr Harris: I think in this debate—and I am sure this is not the first time that this room has heard exactly these arguments that are in front of the Select Committee over the years—isn't there a danger that your sector, your organisation, is sometimes, and I think unfairly, seen as the bad guys because you are thinking of the economics of the argument? Would you not agree that the big issue is how do we reduce the number of people killed on the roads through drink-driving? We have had evidence earlier that about 430 people a year do die in that way. Your main argument seems to be that there should be an economic study to show the economic effects on the pub sector as a result of a reducing of the maximum blood alcohol content limit. It sounds to me as if you're not singing from the same hymn sheet as everyone else in the country, who are actually concerned about people's lives and are not really concerned about the economics.
Brigid Simmonds: We are very concerned about people's lives. I have said from the start that we are very much in favour of random breath testing. I think Sir Peter North was very surprised that we were in favour of random breath testing. We are very much in favour of targeted and vigorous enforcement. I think we need higher visibility, and I think it is taking those as the next steps before you consider whether reducing the blood alcohol limit to 50mg is really the right way to go.

Q174 Mr Harris: We have heard this argument about the smoking ban—and for the record I was opposed to the smoking ban and voted against it—and the impact in terms of the number of closures of pubs. Many continental countries have a lower limit than in Britain. Have they seen an appropriate reduction in the number of rural pubs as a result of their lower limit?
Brigid Simmonds: To be honest, the great British pub is unique in that sense, and the way that they operate on the continent is really very different. I think it would be very difficult to make that comparison.

Q175 Chair: But has there been a reduction in pubs on the continent?
Brigid Simmonds: Well, they don't have pubs on the continent. It is different culturally, and I think that is what our concern is here. We have a very specific British culture and the way it works.

Q176 Kwasi Kwarteng: On this particular point, I wanted to raise something that Kelvin mentioned, but he asked about three supplementary questions so I didn't get a chance to follow up, so if I may, Chair. I think he made a good point about the marginal change. What he was saying was that in 1967 there was a pervasive culture of drink-driving. Over the last 40 years, I wouldn't say it has disappeared, because clearly there are problems, but it has gone down substantially. What he wanted to know I think—and I'm not sure he got an answer—was what you felt the marginal change was between going from 80mg as a limit to 50mg. Are you saying that the decline in your business will be greater than it has been for the last 40 years, or are you saying that it will be the same? I thought that was a very interesting approach that he made, and I wanted to have more clarity on this.
Brigid Simmonds: It is very difficult to be that precise. The pubs are closing for a number of reasons, not least the economy that we are in. What I fear though is how the public would react to this—that the public would react by saying, "If we can't have a drink when we go out, we're just not prepared to go out." Yes, that would have a catastrophic effect on our business.

Q177 Kwasi Kwarteng: Do you think that is going to be initiated by the 80mg to 50mg change?
Brigid Simmonds: I do think it is quite possible that that will be initiated by the 80mg to 50mg. If you see a 15% to 20% decrease in your turnover in a pub you become unviable.
Stephen Oliver: Indeed. Can I also make the point that if that were to be the case, and Brigid has surmised that more and more people actually stay at home to do their drinking and that is a trend indeed that we have seen over the last few years, that is why the off-trade has grown so much and this whole question of the morning after becomes even more important. Then people are increasingly drinking in an entirely unregulated environment where the questions of measures and how much they are actually

physically consuming become much more difficult to understand and control. I think it does raise the spectre that the following day, the whole morning after issue becomes more and more important.

Q178 Chair: Mr Bish, do you have a point?
Nick Bish: I would just like to re-emphasise the point that is being made—that only 30% of drinking now takes place in pubs, bars and restaurants and 70% takes place in the home. There is perhaps a misapprehension that the drinking at home is in a private home amongst the family; but of course, it is actually in the unregulated environment, the unsupervised environment. People are going out to drink, just not to pubs. The Sunday lunch trip—is the informal visit where a glass of wine or a beer or a drink might be taken. It is not a lunch or a party where people might plan their homeward journey, but the occasional visit. I think the industry must get across the point that we are all in this together. If you say only 30% of the drinkers are in pubs, it re-emphasises our ambition for there to be no drinking and driving. We are absolutely at one with Government messages on this, and have a track record of saying so almost consistently throughout the years in all sorts of general initiatives, poster initiatives and indeed local initiatives. Yesterday, I was judging a competition in the Royal Borough of Kensington and Chelsea called "Best Bar None". Five of the pubs out of the eight I was judging were offering an initiative called "ScooterMAN". I am sure the Committee will be familiar with the general principle of where somebody comes and takes you home. That's good stuff; it shows that the industry is engaged and that we do have an ambition; we do understand that one death is too many. We are not a different species, as it were.

Q179 Kwasi Kwarteng: The judgment of the panel in the session before you came said that all the evidence suggested that, if you lower the limit, you lower the number of fatalities. That was incontrovertible.
Nick Bish: I heard that, but it was also in the context of it being a package of measures that included enforcement, penalties and the likely deterrent effect. We are behind that. I think our concern about BAC and the concentration of it in isolation is that it becomes so much regarded as a limit up to which drink can be taken and the calculations of a bit of wine, high strength or low strength beer and so on and so forth. We discussed—in fact, I think you mentioned it yourself, Dr Kwarteng—that the range of alcoholic drinks was so wide now that to do formulas and put lists up all round the pub would be impractical and unhelpful. As we see it, the message has got to be, "Don't drink and drive", and the level at which it is set and which you are considering, and on which the Government has to make a decision, is based on where the law kicks in and where penalties apply. We believe that it is the certainty of detection and the severity of the penalty that is certainly the area to explore first. There are many opportunities to improve on figures that have shown a good trend. It is a public policy success over the years and we should not take that away; we should just acknowledge that there is more to do. We believe that the "more to do" is in the context of deterrence and enforcement.
Brigid Simmonds: I am sure that the colleagues who were here before would also admit that of course it will reduce lives if everybody actually follows that change, and it is considered to be proportionate. Our concern is that people will say, "We just don't care any more. If that is the case and you can't go out and have a drink, we are actually[2] going to go out and we are going to flout it". If I can just give a comparison to another piece of legislation, I don't think that the changes that have been brought in affecting people driving with mobile phones have any effect on people's behaviour. I, and I am sure many people in this room, see people driving and speaking on mobile phones all the time, despite the fact that there have been high-profile deaths caused by people talking on mobile phones and holding them to their ears. We have to make sure that changes in legislation really are going to work.

Q180 Kwasi Kwarteng: I think that is what they were suggesting. I am impartial as to who is right, but they were suggesting that changes in the law in other countries, and they suggested that change in law here, would reduce the number of deaths. The gentleman said he wasn't sure by how much that would happen, Chair, but he was convinced that it would reduce the number of fatalities. I was just wondering what your position was on that particular point. Do you accept that?
Brigid Simmonds: I think—

Q181 Chair: Do you accept that deaths will be reduced under the proposal from the North Report?
Brigid Simmonds: If we look at other European countries, they have lower penalties, lower levels of enforcement and they have higher levels of drink-drive deaths and injuries.

Q182 Chair: But would you accept that there would be a reduction?
Brigid Simmonds: If the public absolutely embraced penalties, if it was properly enforced, of course we would accept that there will be a change and you will have less people killed on the roads, yes.

Q183 Iain Stewart: I have two questions—one very factual. Going back to your 17% of pub visitors driving, that is an average across the whole of the industry. My particular concern is the impact of this change on rural pubs. Do you have any data on what percentage of drivers to pubs in rural villages might be?
Brigid Simmonds: I think inevitably it is obviously steered towards those in rural areas who are much more likely to drive than those people going to town centres, so the statistics would move in that way anyway.

Q184 Iain Stewart: So 17% would be the rural figure?

[2] Note by witness: insert "not"

Brigid Simmonds: It would be as much as the rural figure. It would be higher in a rural context than it would be in town centres.

Q185 Iain Stewart: I am trying to gauge how much higher. Is it 50% of visitors?
Stephen Oliver: I would say that incontrovertibly all rural pubs are dependent on people who drive to their pub for a substantial part of their income, and particularly so of course if they are food orientated as well. There is a phrase in the industry called "destination pubs", where people drive to that particular pub because it has a reputation for good food and drink as well. Unquestionably, there is a much higher percentage of people who drive to rural pubs. The key question then is to what extent would a change in the blood alcohol limit have an impact on that behaviour?

Q186 Iain Stewart: I have another question, thinking about designated driver schemes. Do you think, as an industry, you do enough to promote that? I am sometimes the designated driver and have a pint of orange juice and soda water. I feel a bit fleeced because the cost of it is pretty much the same as having a glass of wine or a pint of beer. As an industry, do you think you do enough to promote the option of a designated driver?
Stephen Oliver: I am sure that we could do more. The designated driver scheme has been around in the industry for many, many years very successfully. It tended initially to be focused on particular times like Christmas, New Year, etc., but now in fact increasingly it is run at key periods through the year. I think it is up to individual companies within the industry to decide how far they are able to take this. My view would be that the industry probably could do more to encourage designated drivers. Indeed, of course, we provide water for instance free of charge to anyone who wishes it, so there are options.
Nick Bish: I would just go back to the point that the designated driver scheme should not be just some sort of pub-type initiative in rural pubs. It is a very sound concept and I think Mr Hopkins himself was saying that he took turns in driving, and you mentioned it yourself. Designated drivers actually happen; you don't have to have a label. It is a question of personal responsibility. It should be a universal thing and our industry introduced the concept of it, or at least the label. We would support any sort of widening of that good practice out to the other 70% who are doing their drinking away from pubs.

Q187 Mr Leech: Mrs Simmonds, you said a couple of times—I don't want to put words in your mouth so correct me if I am wrong—that people understand the system at the moment; they understand how much they can drink and be under the limit. Would you accept that there is certainly some anecdotal evidence, whenever I talk to people about the drink-drive limit, that people generally don't know how much they can drink without being over the limit? Why do you feel that people do understand how much they can drink?
Brigid Simmonds: I think one of the reasons I feel they do understand it is because we have the safest roads in Europe, and therefore there is obviously some understanding of people going out there. I also think people do understand. There has been a lot of publicity around this issue in the last few months, and I think people generally understood that they could go out and have a pint of beer or a glass of wine and be under that 80%. I think it would create huge uncertainty if it is 50% because, as Nick has already said, there is such a range of different alcohols and different strength wines and whatever.

Q188 Mr Leech: Isn't it actually the case, though, that most people think they can go out and have two drinks under the current limit?
Nick Bish: I have to slightly differ here from Mrs Simmonds. I think the message has got to be "Don't drink and drive", and if there is uncertainty then it is around limits: that not only is there a level, but it becomes a limit up to which you can drink, and there is a sort of assumption that you can do this and you can do that, and then we change the limit. The press, I am sure—anyone in this room might find themselves on the sofa being interviewed and the conversation will be about, "Okay, what do you think now you can drink to go up to the new, whatever it is, set limit?" Back we will come to the positivities of drinking as opposed to the negativities. We don't want to go that way. It must be "Don't drink and drive".

Q189 Mr Leech: I was going to come on to that. Mrs Simmonds, you also said that people will think, if the limit is reduced to 50mg, that they can't go out and have a drink at all and be safe to drive. But isn't that exactly what Mr Bish is suggesting that we want to get to, whereby people don't think that they can go out and have a single drink because all the empirical evidence suggests that having anything to drink at all impairs your driving? Therefore, if we get the mindset to people that when you go out and when you're driving you don't drink, full stop, that will actually save lives?
Chair: Right. "Don't drink and drive"—what impact would that have?
Mr Leech: Surely, that is a much more understandable position for people to take.
Stephen Oliver: May I just make the point, to answer that question, that we already have a drink-drive limit? One of the problems here is that it is the serial offenders, the substantial amount over that limit. The key question is whether or not reducing that limit by 30mg is actually going to make a difference to that hard-nosed "I will drink and drive" offender. I think it is very debatable whether it actually would do. What it would risk doing is dragging into its net a whole group of people who have had an approach to alcohol which is actually very sensible and very responsible, who suddenly effectively would become criminalised.

Q190 Mr Leech: I accept reducing the limit to 50mg will have no impact on people who will just go out and drink as much as they want and then drive home. As far as I can tell, this is not aimed at those people who will always flout the law. This is aimed at people who will actually change their behaviour if the limit is

reduced. Is it not the case that, if we change people's behaviour so that they no longer believe that it is sensible to go out and have a single drink, and given that all the evidence suggests that it will reduce the number of fatalities, therefore, if we change people's attitudes to believe that they can't drink, it would be a good thing?
Brigid Simmonds: The difficulty for us in our sector is that that means that people will stay at home and decide not to go out at all. Can I just be absolutely unequivocal? Our key message has always been "Don't drink and drive". I think the issue here is at what level do you want to criminalise people? That is where 80mg has been clearly understood in this context. If you move to 50mg you could have the effect that you are talking about, but there is a real danger, in a pubs context, that people won't go.

Q191 Kwasi Kwarteng: It seems that everyone is agreed that the message should be "Don't drink and drive". Everyone seems to be agreed on that. If that is the case—I am just asking generally—don't you think that message is reinforced with a lower limit than the way it is at the moment?
Chair: Is the message reinforced?
Nick Bish: But even Sir Peter North said—because the extension of that argument is to take it to 20mg—that that was not likely to be effective.

Q192 Chair: No, but at the moment we are asking you about the recommendation in the North Report. Would you accept that if you take the objective "Don't drink and drive", the reduction proposed in the North Report would help?
Nick Bish: No.
Chair: No?
Kwasi Kwarteng: You don't think the message—
Nick Bish: No, I don't think it would, for the reasons I've just said. That will then become another limit on which the debate will be how much drink you can have to be up to the 50mg limit.

Q193 Kwasi Kwarteng: But we have said the message should be "Don't drink and drive".
Nick Bish: Which we are 100% and onside. I think we are looking at a proportionate, a sustainable and an enforceable level which has public credibility and which patently has done the job over the years. There are things to do to improve it, and we submit that that is to do with the deterrent effect of penalties and enforcement at the roadside: random breath testing and perhaps the administrative removal of licence at the time of the failed breath test. There are areas we can go—
Chair: Okay. We have dealt with some of those issues. We just need to get a response.

Q194 Julian Sturdy: Thank you. Just going back to the pub closures, do you have any figures regarding the percentage of pubs that are closing that are urban compared to the rural pubs?
Brigid Simmonds: I don't know that we break it down that way. We can break it down that there are an awful lot of pubs that are closing that are in the full trade, which is inevitable because they don't have the support of companies like Marston's to help them keep open. I don't know if you have any evidence as a company?
Stephen Oliver: I would have to look it up and give you some supplementary information, but it is a broad spread. Urban areas, town centres, as well as rural pubs are all affected. The reality is that with the economics many rural pubs are very finely balanced at the moment. You only actually have to have a relatively small decline in overall turnover to tip that pub into a situation where it is just economically unviable, and that sadly is why you do see quite a number of them with the shutters on the windows. I could give you a separate breakdown.

Q195 Julian Sturdy: But your feeling is that rural pubs are suffering more than urban pubs; you just haven't got the figures. Is that what you are saying?
Stephen Oliver: No, I wouldn't say that. I think it is broadly spread across the whole environment where pubs are found.

Q196 Julian Sturdy: Thank you. Can I just come back on something that Dr Kwarteng was talking about earlier on? We were talking about the evidence in the North Report. I think you are disputing some of the evidence within the North Report. Do you think that we need more evidence between the 50mg to 80mg to actually take anything forward? If that evidence was forthcoming over a period of time— i.e. with the new breath test that you can actually calculate the blood levels in there—would you then support the reducing of the limit?
Brigid Simmonds: As far as we are aware, most of the evidence is that people are way over that 80mg, which is why we have those concerns. We are not disputing what the North Report says at all. What we are talking about here, I think, is whether public opinion and public behaviour would mirror and support a change in that law. We are not in any way disputing what he is actually saying.

Q197 Julian Sturdy: I am not talking about the over 80mg: I am talking about the bracket between 50mg and 80mg. When people are breathalysed and tested, it has not been recorded to a great degree.
Brigid Simmonds: I do think that more evidence would be hugely helpful. I think that is probably a question for your next panel, as indeed is the evidence around drugs. I think there is a concern that a lot of people are tested for drink-driving but it may be other things that put them over the limit, which was a discussion you were having with the previous colleagues here.

Q198 Julian Sturdy: If that evidence was forthcoming, would you be supportive then?
Brigid Simmonds: I think we have to be clear. We are supportive of things which cut deaths by drink-driving. Any member of the public has to be supportive of that situation. What we are concerned about is: will that change create the behaviour that you are talking about?

Q199 Lilian Greenwood: I have three very brief questions. The first is that I am slightly confused about the position of the panel. Mr Bish, I think you were very clear that the message is "Don't drink and drive". I am less clear about your position, Mrs Simmonds and Mr Oliver, because you seem to be saying that people can come to the pub, have a meal and have one drink. That is not "Don't drink and drive". That is, "It's okay to come to the pub and, as part of a meal, have one drink". Can you explain for me?

Brigid Simmonds: Our clear message is "Don't drink and drive". We have backed the Portman Group; we have backed the Department for Transport for 40 years in making those messages clear. There is a difference between what we say, "Don't drink and drive", and how people actually behave. That is the difference.

Q200 Lilian Greenwood: My view would be that people don't know how much they can drink. They don't necessarily even know how many units of alcohol are in comparative drinks. Are you saying that you believe that the public know how many units are in a drink—there is a 250ml glass of wine, which is what you will sometimes get in a pub now, as opposed to 125ml; one is large and one is small, it varies between pubs—that they know how many units and they know how many units you can have and still be under 80mg?

Brigid Simmonds: We are actually working with the Department of Health at the moment to do something which will give more awareness around units. We are looking at a poster campaign. We are part of the new Department of Health's "Responsibility Deal", which is looking at something to give people more information. I do think that people have more of an understanding about units than they used to have. I do think that you need to watch very carefully, as you rightly say, what is the strength of a particular unit and how large the glass is, but I don't think it is beyond people to understand that. I think it is a case of we say very clearly you shouldn't drink and drive, what is people's behaviour in reaction to that, and what would their behaviour be if you made a change.

Q201 Lilian Greenwood: The final question is: you have suggested that changing to a 50mg limit would lose respect for the law. How do you respond to the fact that surveys by the AA and others show widespread support for a lower limit?

Brigid Simmonds: I think the difficulty with the AA is they have been largely asked on what is an abstract, and I don't think that their actual understanding of behavioural change is the same as asking in that overall abstract. I think that response reflects people's moral abhorrence of drink-driving and that is encouraging, but I would want to drill a little deeper to get a real and clear response to those questions. I am not sure, but I think the AA survey was very much a quantitative piece of work perhaps rather than qualitative.

Q202 Paul Maynard: You have mentioned how rural pubs differ from urban pubs. Mr Stewart has mentioned the designated driver scheme. I wonder what other initiatives your industry has been taking to promote responsible drinking in a rural pub.

Brigid Simmonds: We very much support Drinkaware. In fact, the industry puts £5 million a year into Drinkaware, of which sum the British Beer and Pub Association members put in half. We also have the Campaign for Smarter Drinking, which is over £100 million over five years. There has recently been a very big campaign, which started in September, particularly looking at youngsters between 18 and 24 and about changing behaviours. We support Pubwatch. We support the Best Bar None scheme, which Nick was talking about. We work with the Home Office on Crime and Disorder Partnerships, and we have been talking to them recently about doing more. So, yes, social responsibility is hugely important to us as an industry and it is something that we care about very deeply. We will work with a lot of partners. Purple Flag is the new scheme. I actually gave the awards for "Best Bar None" in Bournemouth. Bournemouth is actually, I think, the first town in the UK that has all three flags. It has flags for its water, bathing and also for its night-time economy. We are very supportive of social responsibility initiatives, and as an industry we put a lot of resource into it.

Q203 Paul Maynard: Clearly, as an industry, you are showing an impressive capability to educate your customers to adhere to the 80mg limit. Why would it be beyond your ability to demonstrate a similar capability if we were to lower it to a 50mg limit?

Brigid Simmonds: I think you have to be very careful about the word "education" in going to the pub. People go to the pub for a fun night out. They don't go to be told how to do things. I think we have to be careful in some of the discussion. I am actually a great believer in some of these new ideas about how you change behaviour and how you get people to commit to things which will actually change their behaviour. I think actually telling them what to do is a different issue. We do do an awful lot of education in schools, and our message, as we have clearly said, is "Don't drink and drive". That is something that we are prepared to continue to do.

Stephen Oliver: Can I make a supplementary point? One of the most practical ways in which the industry, in a sense, has responded to this and continues to do so is the fact that pubs are now effectively places where you largely go to eat rather than where you just go to drink. That is a trend that has been in place for a long time and will undoubtedly continue.

Q204 Paul Maynard: I am so glad you said that because you have just pre-empted my final question. You were mentioning earlier the importance of destination pubs and of eating food in the pub. Is it not the case that the business model of a successful pub is less and less dependent upon alcohol sales and more and more dependent upon changing social trends? Where is the evidence that, going forward, this will not continue and that, if you want to run a successful pub and a successful industry, alcohol sales will be the last part of your business model? I understand what you are saying and your concerns

about the lowering of the drink-drive limit and the potential economic impact. While you are requesting an economic study, is it not the case that, going forward, social trends are such that alcohol sales are going to be declining per capita anyway because consumption is declining? Are you actually not putting your finger in the dyke here?

Q205 Chair: We keep coming back to this point. In view of all these changes, why would this proposed reduction from the North Report have such a drastic impact?
Brigid Simmonds: Well, I think we have to be careful—
Chair: Mr Maynard is asking Mr Oliver.
Stephen Oliver: I would put forward a proposition that you are absolutely right. There is an ongoing trend and we will expect to see this continue into the future. I think the concern I would have is that the introduction of the 50mg limit may effectively represent a step change in that proportion of pub sales which remain alcohol. It is that step change at a time of really difficult economic pressure in this industry overall that could tip a very significant number of pubs that wouldn't be able to immediately respond to that decline in demand into a position where they effectively fail. A lot of what we do in the industry has worked really effectively over the last few years. We continue this movement towards food and that will be the case in the future, but a change in the alcohol limit is going to have quite a substantial effect on drinking in those pubs where it is a relatively marginal activity. That is why I think a better understanding of the economic impacts of this idea of dropping from 80mg to 50mg is entirely merited in the context of the modern pub.
Chair: Thank you very much indeed for answering our questions.

Examination of Witnesses

Witnesses: **Ean Lewin**, Dtec International Ltd, **Iain Forcer**, Concateno, and **Dr Rob Tunbridge**, gave evidence.

Q206 Chair: Good morning and welcome to the Transport Committee. Could I ask our witnesses please to identify themselves with name and organisation for our records?
Dr Rob Tunbridge: I am Rob Tunbridge. I am the independent member of the Panel. I have been doing drug-driving and drink-driving research for the last—
Chair: Just your organisation.
Dr Rob Tunbridge: I am an independent consultant.
Chair: Independent Member. It is just for our records. That is okay.
Iain Forcer: Iain Forcer; Concanteno.
Ean Lewin: Ean Lewin from Dtec International Ltd.

Q207 Chair: Thank you. Dr Tunbridge, you have said that you think a change in the drink-drive limit should be a relatively low priority. Why is that?
Dr Rob Tunbridge: I certainly think it is important to reduce the limit, but I don't regard it as the most fundamental problem because of enforcement. If you compare the situation in Great Britain as with other countries, we have an 80mg limit, whereas, to give a good example, if you look at France—like most of the European Union—they have a 50mg limit but they actually have a worse drink-drive record than Britain. It is a bit technical to go into it, but there is a universal standard which you can measure right across the world for the problem with drink-driving, and that is the percentage of drivers who are killed in accidents who are above a certain limit. The more enforcement that you have, the less that shows as a problem; fewer people involved in accidents are killed. That is a universal measure.
If you look at France, they don't actually take your licence away for a year until you are at the 200mg level, but in the UK, if you are two-and-a-half times the limit you lose your licence for three years and you have to have a medical intervention to get your licence back. I am definitely supporting a lowering of the limit, but I think all the evidence suggests that better enforcement—and one way of doing that would be to bring in roadside evidential testing—is a more important priority.

Q208 Chair: But do you support the North proposal on reducing the limit?
Dr Rob Tunbridge: I certainly support the reduction to the 50mg limit. I am just saying that I wouldn't regard it as such an important measure as bringing in evidential testing, which would allow the level of enforcement to go up. That would almost certainly bring down drink-driving.
Chair: I just wanted to clarify the position there.

Q209 Lilian Greenwood: Dr Tunbridge, in your professional opinion how prevalent and serious a problem is drug-driving?
Dr Rob Tunbridge: I was about to introduce that. I have been involved with drug-driving since the mid '80s when I was at the Transport Research Laboratory. I ran the first study of the incidence of drugs in road accident fatalities. The great advantage of doing measures in fatalities is that obviously people can't refuse to give you a sample; so providing you do the science properly it does give you an independent measure of the level of drugs in the road accident population. We looked at medicinal drugs and illicit drugs. In the '90s I moved to the Department for Transport, where I was responsible for research into drink and drug-driving. We carried out another study about 10 years later, again of fatalities. That showed a massive increase in the use of illicit drugs from 3% incidence to 18% incidence.
After that period, the Department then started to support lots of research into drug-driving. For instance, we did an experimental study on the effects of cannabis on driving about 10 years ago. That is the only absolute measure, if you like, of the incidence of

drugs. It does show there has been a big increase between the '80s and the '90s, and has continued. As I think one of your other witnesses said, there is a tremendous amount of evidence that over that period as well, if you look at the British Crime Survey, for instance, which has been going for 25 years and is anonymous so it does give a good picture of drug uses, particularly recreational drug use over the time period, the level of increase of use of cannabis and the incidence of seizures of cannabis for instance have increased along with that.

It is a reasonable assumption to say that as the level of drug use in the community goes up, most people drive, and so, like drinking and driving, when you get a mixture of both you have a problem. The problem with drug-driving is that we don't at the moment have a device that can easily measure whether people have drugs or not, unlike drink-driving. We know a lot of information about the level of drink-driving because the police have roadside breath testers. We don't have that situation with drug-driving. I am sure that is what we will come on to, to be a principal point of the discussion, but at the moment we can't get that evidence because we don't have a simple measure. All the indicators of drug use in the population—surveys of people who are asked whether they take drugs and drive—are that there is a higher incidence they do. There is lots and lots of circumstantial evidence, and some evidence from drugs found in fatalities, but the information is nothing like as solid as it is with drink-driving.

Q210 Lilian Greenwood: We know from the previous evidence that there are about 2,500 driving fatalities a year. In how many of those cases were drugs found? Could you put a number on that?

Dr Rob Tunbridge: I do not know whether you have had the chance to read the detail of it. It is what I call the "tip of the iceberg" problem. Roughly between 600,000 and 800,000 roadside breath tests are done each year, of which about 100,000 are positive for drink-driving. That is consistently about 100,000 drink-drivers a year. The police normally have three reasons for stopping you and giving you a breath test: first, that they suspect that your driving is impaired—the way they see you driving; secondly, that you are involved in an accident and they can test you; or thirdly that you are involved in a moving traffic offence. For instance, you may jump a red light or one of your lights is not working.

The work I did at TRL on police records showed that around about 50% of cases were stopped because the police thought their driving was impaired. If you look at that 50% and take the 100,000 from the 800,000, you've got, say, 400,000 motorists, drivers, stopped when the police assumed that they may have been impaired but, because we don't do routine drug tests as opposed to routine alcohol tests, you have a small fraction of 1% which are coming through. They are almost certainly the ones who are extremely impaired. In fact, the study done by the Forensic Science Service in the '90s showed that, in cases that were admittedly suspect, over 90% were positive for at least one drug. That is suggesting there are a lot, but we can't quantify it at the moment because we don't have a testing device at the roadside. We are missing a substantial number of drug-drivers but we can't actually quantify that number at the moment.

Q211 Lilian Greenwood: Why do you think the UK is so far behind other countries in tackling and prosecuting drug-driving?

Dr Rob Tunbridge: That is a very good question and it is one I have personally been involved with for a long time. I think there is an attitude, particularly in the Home Office, that "We are going to do it our way; we are not going to be told". I am not saying it is necessarily anti-European, but the Home Office, who are responsible for type-approving the devices—they would be devices that could be used for drug testing, as they are for setting standards for roadside drink-driving—are suggesting we should have a screening device which is of the same order and standard of scientific quality as you would get if you took an evidential sample, where somebody has to take blood from you back at the police station. I think the thing to remember is that these are only screening devices. My colleagues can give you chapter and verse on their accuracy, but it is my view that the main problems in terms of impairing drugs are with illicit drugs: cannabis, cocaine, heroin and amphetamines. They make up certainly in excess of 90% of the problem with impairing drugs. With the devices that are available at the moment and that are being used in lots of areas of Europe, and particularly in Australia, which tends to lead the field in taking road safety forward if you like, we know that in at least 90% of cases you will get a reliable test. At the moment, even though there is a small possibility that you will get a false positive result at the roadside, you are not going to prosecute that person. You are always going to have to take an evidential sample of blood. At the moment, we have 100% or very close to 100% false negatives because we are not actually testing people.

Q212 Chair: Would either of our other witnesses like to add their comments?

Dr Rob Tunbridge: Sorry; I don't want to hog the conversation.

Kwasi Kwarteng: Chair, I may have to give my apologies. I have to be somewhere else; I am sorry.

Ean Lewin: Just to try and put some facts and figures on the magnitude of the potential problem, as I say, we both work in Australia and we also then work in different countries where we have won contracts. An interesting one to me is that last year we took away nearly 35,000 licences in Germany. That is a population very similar to our population. We all attended a meeting at the Home Office last week for the introduction of the latest draft of the type approval, and a figure was put there that it could be 50% of the size of the alcohol problem, which puts the figure then at 50,000. What I think Rob was alluding to was, if the police screen 400,000 or 500,000 and only 100,000 are prosecuted, why did the police officers apprehend that driver in the first place for bad driving, and did they progress any further with the assessment for impairment, or did they have the ability to screen for impairment? The feedback we get is that they would very much like the ability to be

able to assess for impairment and to screen for impairment, and then take that person further down for the confirmation test at the laboratory.

Q213 Chair: Mr Forcer, is there anything you wanted to say?

Iain Forcer: I think one of the reasons that we are behind other countries with regards to drug-driving is that the legislation of the countries that we work in—Australia, Italy and other parts of Europe—includes an offence where the offence is driving with a named drug in their system. That is screened at the roadside and then confirmed in the laboratory. Because our legislation focuses on impairment, it requires the field impairment test to progress that driver through the legislative channels. Last Christmas, there were 223,000 breath alcohol tests in the Christmas campaign and 489 FIT tests—field impairment tests. The way the legislation is worded, the enforcement levels aren't adequate to meet that legislation. There needs to be an increase in the field impairment testing, and then, where screening can fit into that legislation, that is how we should progress.

Q214 Paul Maynard: Mr Forcer just gave a very striking comparison of figures on alcohol testing and drug testing. Do you have any figures for Germany or Australia that would illustrate the balance there as well, just for comparison?

Iain Forcer: I know the state of Victoria was the first area of Australia to start roadside drug testing about five years ago. When they began testing, their expected positive rate on a breath alcohol test was around one in 250. Because they had been doing breath alcohol testing for a while there was education awareness similar to here in the UK. When they started doing the roadside drug testing they had a positivity rate of around one in 40 or one in 45, just showing the difference in the driver's perception of essentially whether they could be caught drink-driving compared with drug-driving. Since the testing has continued—and they've done hundreds of thousands of tests—that positivity rate has nearly halved, so it is around one in 70 or something. The combination of enforcement and the education and awareness campaigns that they've run—they do blanket road blocks, so they have these booze buses, drug and alcohol testing buses, and if they are on the side of the road you are going to get stopped and you are going to be tested. Now, the other states of Australia have taken up testing as well. If you are driving in Victoria you know that testing is prevalent and there is a good chance that you will be stopped, whether you are impaired or not. I think that is why their rate of prevalence has declined.

Dr Rob Tunbridge: Could I add another point to that? Those numbers represent what the Australians think are their two most serious problem drugs, which are cannabis and methamphetamine. They only test for those two drugs, so that is not including anybody who might be under the influence of opiates or cocaine. Most of the rest of the countries that have done drug-driving research pick up people taking those illicit drugs as well.

Ean Lewin: Could I add another point to that? Victoria was the first state that went with the testing. Each of the subsequent states that has started is following a virtually identical curve on the initial rates that they see, and the implementation of the awareness and the roadside deterrent is giving them the same sort of response curves in halving their occurrence and the rate of positives. I think there is an awful lot to be seen from their experience.

Q215 Paul Maynard: In terms of the equipment used, we are told in this country that the very tight, stringent rules that apply regarding type approval are a good thing because they protect the individual from potential inaccuracy or miscarriages of justice. Is there any evidence from the other countries that you work in that there are particular problems for the individual driver who finds himself banned unfairly because of an inaccurate test, or because of some failure of the equipment or whatever? Does that argument hold any water in your view?

Iain Forcer: I think, from speaking to officers in Australia, the first test is a screening test and they are not evidential and they are not 100% accurate. The police are trained to understand the limitations, as they are for testing. Anyone who is found positive then has a further sample taken, and it is screened in a laboratory using a confirmatory test. That is the only test which could be used in court. That will tell you both the level of drug and also the exact compound that has been detected.

From the Australians' point of view, if they are screening, and eight or nine people out of 10—their screening test result is matching the confirmation test—then that is eight or nine people out of 10 they have brought through their legal system, increasing the safety on their roads.

Q216 Paul Maynard: Why do you feel that this country is so slow, therefore, in adopting this methodology, this equipment and this practice?

Iain Forcer: I think there is a feeling that maybe, whereas Australians are "glass half full" and eight or nine out of 10 is pretty good, here there is a feeling that one or two people might be inconvenienced. They are looking for maybe a golden bullet that at the moment doesn't exist, where there is a technology available that would significantly reduce the incidences of driving under the influence of drugs.

Q217 Paul Maynard: It is more than an inconvenience though. You would be losing your licence for quite some time.

Chair: Dr Tunbridge, do you agree with them?

Dr Rob Tunbridge: Absolutely. Can I just add another point which doesn't explain the reason for it but it is an observation? The attitude of officials—and I am basically talking about particular civil servants now rather than Ministers, because the civil servants advise the Ministers—seems to be much, much tighter. It may well be down the road of human rights. The Home Office has explained why we weren't involved with the DRUID project which, as you might have heard, has taken in 18 countries and tested 11 different roadside devices. There may be human rights issues

of testing, although back in 1998 we conducted roadside trials with what were then prototype devices—the Cozart device and the DrugWipe. We gave people a questionnaire. We actually got 60% of questionnaires back from the roadside, which is a phenomenally high response, and 95% of those people were in favour of roadside testing. The attitude of the civil servants, particularly in the Home Office, has hardened. Just to use a quick analogy—I don't want to be hogging the conversation—if they had adopted that same attitude back in 1967, although I don't think any of you are old enough to have experienced roadside testing—

Chair: Don't take that for granted.

Dr Rob Tunbridge: You may remember that the first roadside screening devices—and you could still buy these in packets at some garages—had a very simple chemical compound that changed from orange to green when alcohol was indicated. If it went beyond a certain point that gave an indication that that person was over the limit. From 1967 to 1983, there really weren't that many tests because, if somebody blew positive at the roadside, the police then had to get a police surgeon to come in and take a blood sample. That is the sort of situation we are now in, if you like, with drugs. It wasn't until 1983 when we brought in evidential testing with a breath-testing device at the police station that over the course of the next 10 years the number of tests went up by a factor of six.

The point I am making is that that device is actually still type-approved by the Home Office. In the Highlands and Islands, some of the officers still only have these devices. So if they see that somebody has driven off the road or something they can breath test them and they can still use those devices, which have been around since the '60s. The point I am making here is that the accuracy of those devices is worse than what is being offered for drugs at the moment. It seems that the strictures, the standards, which the Home Office is setting are much higher than they would have been then and we would not have had any drink-driving enforcement for another 15 years.

Q218 Iain Stewart: I think my question has already been answered, at least in part, but let me just clarify. With regard to the lessons from the other countries—Australia and continental Europe—and the screening for drugs, is that for specific types of drugs? What I am trying to get at is, is there going to be a device that will test generally for the presence of drugs, be they legal or illegal, in the bloodstream?

Dr Rob Tunbridge: No, because they were—

Q219 Iain Stewart: It actually has to be specifically for—

Chair: Can we have short answers, please?

Dr Rob Tunbridge: Sorry. I will get somebody else to answer that because I feel I am hogging the conversation.

Ean Lewin: Just going back on the levels, we have to be careful that we look at, address and set levels at road safety issues, rather than it being at anti-drug levels. That is why we shouldn't really chase the levels down too low to the levels that have been asked for in the UK, which are lower than any other level in any other country we deal with. That is one of the problems we have. The other issue is that countries look at a list of drugs related to accidents. That is a shortlist. It carries 90% to 95% of the accidents and it can be quite competently managed by several manufacturers in the industry. That list is controlled in a road safety issue: for example, in the Department for Transport as opposed to that list being controlled in a list of illegal drugs. The key thing there is to detect the drugs that cause the accidents. If we can solve 90% to 95% of the problem and the only downside is somebody is detained long enough to give a confirmation sample that proves negative, then I think we are addressing the glass half full —I think it is an awful lot more than half full. It is beyond Pareto—the service that a number of companies could give this country at the moment.

Q220 Iain Stewart: Forgive me, I just need to clarify my mind. If, say, you want to check for cannabis presence in the bloodstream, is it the same test? By doing one test for cannabis could you also detect other drugs; for example, these party drugs that are still legal but clearly have an influence on behaviour? Is it the same physical test and can you actually do a catch-all service?

Ean Lewin: It is specified by country. In our experience, different countries say, "We would like this to be on the list". An interesting one is benzodiazepines, which have been added by a country recently. Nobody actually asks us to look for methadone because experience says that methadone consumption will also be detected by other drugs that have been consumed at the same time, but it is the same device that is used.

Q221 Iain Stewart: But it is the same actual procedure; you still take the same swab or whatever it is in the machine?

Ean Lewin: Yes.

Q222 Iain Stewart: It is not that you have to do this test for one drug and then take another sample for another drug: it can all be done from that one?

Iain Forcer: The only difference would be the more drugs there are on the test, the actual time it takes to carry out the test lengthens slightly. That would be the only difference.

Dr Rob Tunbridge: The other issue is that the chemistry is complicated. For the five drug groups—cocaine, amphetamines, opiates, cannabis and benzodiazepines which are the tranquillisers like Valium or Mogadon—the devices, and I don't want to get into showing you what they look like—

Q223 Chair: Dr Tunbridge, can you be a bit more concise?

Dr Rob Tunbridge: In the device for detecting there has to be a chemical marker on the strip which takes your saliva. A new chemical identifier, if you like, has to be developed for each new different type of chemical structure, so at the moment there isn't an immunoassay to detect mephedrone, which has recently become illegal. There is always going to be a catch-up process, which requires a need to show a

problem for the manufacturers to put the money in to developing a test, but at the moment the devices only test for those five or six groups.

Ean Lewin: I would just like to push that answer to the next level. The key thing is there is a screening test and then there is the confirmation. There is also the zero tolerance. All the countries we work with have a zero tolerance law which has this specified list. The police officer always has the country's impairment law. If he still decides there is impairment there, they can still use the impairment law to go back and have the samples. What the zero tolerance system does is it allows that deterrent to be extremely effective, and that is what reduces the accidents and the person's willingness to take the risk to drive after having taken drugs. It is the combination of the two laws, and the combination of the selective list of, shall we say, going for the Pareto problem—going for the 80% or 90% on that.

Q224 Kelvin Hopkins: Very briefly, Dr Tunbridge has reinforced the prejudice I have had for a long time that British officials, by and large, will always find reasons for not doing something rather than doing something.

Dr Rob Tunbridge: Absolutely, particularly the Home Office.

Q225 Kelvin Hopkins: What you were saying is that it had to be driven by the politicians. We would never have had a health service if it weren't for Nye Bevan and we would never have had the breathalyser if it weren't for Barbara Castle.

Dr Rob Tunbridge: Absolutely.

Q226 Kelvin Hopkins: We have got to drive this.

Dr Rob Tunbridge: That is why—

Chair: Do you have any more questions?

Kelvin Hopkins: No.

Q227 Julian Sturdy: My question has really been partly answered. It was about the zero tolerance level. Australia and the other countries that are already doing this testing are doing it at the zero tolerance level at the moment. Is that what you are saying?

Ean Lewin: All countries have both, but the highest level of prosecutions tends to come from the zero tolerance system. They all have the impairment system, as we have, as a back-up, and it is up to the officer to decide: is this going to be a zero tolerance or is that person so impaired that they put them through the impairment route? The impairment route is also there for your medicines, your illegally used medicines, your other drugs and medicines that may impair you and other drugs that come along. With a zero tolerance and an impairment law, the police officer has 100% ability to catch.

Q228 Lilian Greenwood: I just want to clarify what exactly the test does, and I apologise for my ignorance on this. Does it detect the presence of a drug, or does it detect the level of that drug and therefore you can make an assumption about impairment as well?

Iain Forcer: The screening test result that you, as the user, will see will give you a positive or negative. It will give you an indication that there is a presence. The test itself is calibrated to a cut-off level which is set in the legislation. In the countries where we do roadside testing, if they say that if there is a level of cannabis, for instance, above a particular cut-off that is a positive result. The confirmation test will give you a numerical level at a concentration in nanograms per ml of a particular compound. Some countries include things like opiates, for instance, on their screening test —that could be heroin use but it could be codeine use because someone has a bad back or whatever, which could both give a positive screening result. The confirmation would then give a level of the particular opiate compound, and from that the toxicologist could say, "This is as we would expect for the medication that they say they are taking", or, "This is actually from heroin use". There are markers that they would use to distinguish between the two.

Q229 Lilian Greenwood: Can I ask a follow-up? When Hamish Meldrum from the BMA was in earlier, he seemed to suggest that there wasn't a consensus about what levels of presence of drugs in the body would have an impact on impairment in the same way that there is for alcohol. How is it possible to set your levels if there is no consensus about what level is impairing?

Dr Rob Tunbridge: That is why most countries have gone for zero tolerance, because it is extremely difficult, if not impossible, to relate levels of drugs to impairment levels. I will just give one example that I always use to show this. The tolerance to drugs is orders of magnitude, sometimes thousands of times different from the different levels of tolerance for alcohol. An absolute cracking example is that people in this country are allowed, if you are terminally ill, to drive on administration of medical morphine. If you look at those people and test them in experimental tests that relate to driving impairment, you would hardly see any noticeable effect on their driving. If those levels were in any one of our bodies, we would be dead. It just shows that it is so difficult to come up with reasons for tolerance and how quickly people's tolerance changes as they take drugs to excess.

That is why most of the countries have gone to zero tolerance. You don't worry about whether the person is impaired or not. If the drug—and I emphasise again—is found in blood as a confirmation of a screening test, not the screening test itself, above levels where scientists and toxicologists can say, "We are 95% certain that that drug is present at a particular level", that is a confirmatory test, then you have committed an offence.

Of course, that is a big political issue because at the moment it is only illegal to possess drugs: it is not illegal to take drugs. It is entering a whole new political wave, where you would have a road traffic offence for having the presence of drugs in your body, whereas somebody walking around in the same situation and not involved in a traffic offence would not be in that position. There are political, ethical and human rights issues in going to zero tolerance.

Q230 Mr Harris: That is no different from alcohol. You can go round drunk and that is legal, but you can't drive drunk. What is the difference?
Dr Rob Tunbridge: Sorry?

Q231 Mr Harris: The moral and political problem that you are suggesting is no different from what we already have as regards alcohol. Of course, it is perfectly legal to drink alcohol and to get drunk, and to be in a public place drunk. You can do anything you want drunk, but if you are caught driving while you are drunk then that becomes an offence.
Dr Rob Tunbridge: That is a very good point indeed.
Chair: Are there any further questions?

Q232 Lilian Greenwood: But isn't there a possibility that there are some people who have taken, albeit illegal, drugs like cannabis which are going to be detectable in their bloodstream but wouldn't actually be having any impact on their ability to drive? Could it unfairly penalise people?
Ean Lewin: This is if the level goes too low. At the moment, the control is principally the type-approval from the Home Office. If we go too low, we end up in this situation. There are a lot of countries out there that have been through this situation. They have worked their way through and they have tried to research this. There is a lot of information out there, and nobody is going to levels as low as have been proposed here. This is because they are keeping it as a road safety issue and the people who will definitely be impaired at those levels are the ones who are being processed. As technology improves—we've both probably got several generations we are working on, as have many other companies out there—we will look to be more specific on the type of molecule and be more specific on the type of drug; but also we might be able to be lower on the levels. Again, the lower you go, the more chance you make this an anti-drugs issue as opposed to a road safety issue.
Chair: Are there any further questions from anyone?

Q233 Julian Sturdy: Are any of the countries we have been talking about doing anything on prescribed drugs—testing on impairment of the actual prescribed drugs and enforcing that?
Iain Forcer: There are countries in Europe. Italy, for example, tests for a panel of six different drugs, which includes opiates and benzodiazepines, both of which can be prescribed, and opiates can be bought over the counter. The confirmatory test is the level. With the prescribed issues, we can look at the figures from the British Crime Survey, which as Rob said gives a good indication of recreational drug use in 16 to 59-year-olds, so it relates quite nicely to drivers. If you excluded drugs which had medicinal purposes and just looked at cannabis, cocaine, amphetamines and methamphetamines—so moved the prescribed issue to one side—that still accounts for about 86% of drug use in this country. I think in the same way as the Australian idea, if we hit 86%, that is surely better than zero.
Dr Rob Tunbridge: But medicinal drugs are a particular—

Q234 Chair: Did you want to add an additional point?
Dr Rob Tunbridge: Yes.
Chair: Okay, quickly.
Dr Rob Tunbridge: Sorry, Chair. These sorts of drugs are a particular problem, because most of the evidence that these are impairing, such as antihistamines make you drowsy, are taken from young volunteers using males between the ages of 19 and 25, rather than patient populations. You have to take into account the effect, particularly the road safety issues surrounding somebody who is on medicinal drugs. A patient who is depressed or anxious or if their nose is streaming down with something might, untreated, be more of a road safety danger. The drugs are taken as a sort of counter-effect. That makes decisions on medicinal drugs very difficult.
I know you discussed this with the earlier panel members, but it does make it a particularly difficult area to come up with red, green, orange and say what drugs should be labelled up with this. This is why virtually no countries in the world have actually adopted these systems. There are lots of myths saying, "Such-and-such a country has done this," and in fact they haven't, because of the difficulty in establishing, particularly for patients rather than young volunteers, what effects those drugs will have.
Chair: Thank you very much for coming and answering all of our questions. Thank you.

Written evidence

Written evidence from Professor Richard Allsop (DDD 09)

I am submitting this evidence as an individual expert, not on behalf of UCL.

I provided in evidence to Sir Peter North the more cautious of the two estimates he quotes of numbers of deaths and serious injuries that would be prevented by reducing the permitted blood alcohol concentration (BAC) as he proposes. I have followed developments in drink driving law in Britain since the mid-1960s, when I provided as a Scientific Officer of the then Road Research Laboratory one of the main statistical analyses on which the introduction of the BAC limit in 1967 was based. I am a director of PACTS and of the European Transport Safety Council.

SUMMARY

Except for concluding remarks which relate also to drug driving, my evidence is confined to drink driving law.

1. The permitted limit on blood alcohol concentration (BAC) should definitely be reduced as proposed, primarily because the substantial numbers of deaths and serous injuries that this will prevent would clearly outweigh any foreseeable adverse effects of the change, and it is premature to consider a greater reduction than is proposed. The range of estimates of these numbers mentioned in the Review Report is discussed in some detail in this evidence.

2. The mandatory one year driving ban is appropriate for offenders at the new lower level, but if its severity were the principal obstacle to public and parliamentary acceptance of the reduced limit, a lower penalty based on "two strikes and you're out" would be an acceptable alternative for offences at BACs between 50 and 80mg/100ml only.

3. Reducing the permitted BAC limit would have secondary benefits in terms of consistency with limits in other European countries and with the message "Don't drink and drive", and might make a small contribution to wider efforts to moderate the use of alcohol. It would challenge establishments serving alcoholic drinks and to which customers travel by car to offer attractive alternative drinks to the drivers among their customers.

4. Policy and practice in enforcement of the BAC limit would need to make it clear to drivers that those exceeding the reduced limit were at real risk of detection and conviction and that those with BACs over 80mg/100ml were at least as likely to be detected as before. The police will be greatly helped in this by urgent completion of the already long overdue type approval of evidential roadside breathtesting equipment, removal of the "statutory option", inclusion of drink driving among the "Offences Brought to Justice" on which police forces are required to report, and appropriately widened powers to breathtest drivers.

5. Drink and drug driving law should be focussed on road safety rather than on wider policy on alcohol and other drugs, and should reflect the degree of risk caused by impairment. For drink, the risk is closely related to the level of alcohol in the blood, but this relationship is less clear for other drugs, for which impairment, not just presence, needs to be established.

Should the Permitted Blood Alcohol Limit be reduced as proposed?

1. The limit should definitely be reduced as proposed, primarily because this can be expected to prevent substantial numbers of deaths and serous injuries in road traffic accidents by complementing existing and further efforts to deter driving at very high BACs with a parallel effort to deter driving at lower BACs that are nevertheless associated with substantially increased risk. It is premature to consider a greater reduction in the limit than is proposed.

2. Sir Peter's report summarises in paragraphs 3.40–3.44 a range of estimates of numbers of deaths and serious injuries that could be prevented—estimates made by researchers at the University of Sheffield and in my own written evidence to the Review. These estimates are discussed in paragraphs 4.15–4.18 in the course of the argument leading to Recommendation (3) to reduce the BAC limit from 80 to 50 mg/100ml. Although the estimates differ widely, the Review concludes that they all indicate that substantial numbers of deaths and serious injuries would be prevented each year.

3. The report provides a reference to a report from the Sheffield researchers giving full details of the basis for their estimates, but for my own estimates there is no such reference. In case it helps the Committee, I therefore attach for reference a note prepared in 2008 for the Department for Transport (DfT) giving similar details for my own estimates. In view of the considerable difference between our two sets of estimates, especially in numbers of deaths prevented, I have, since seeing the Sheffield estimates for the first time in Sir Peter's report, investigated just why and how the estimates differ so widely. What the two methods have in common and where they differ are summarised in the Appendix to this evidence, and the differences in method make it perfectly understandable that the resulting estimates themselves differ.

4. Just how they differ can be illustrated by applying both methods to deaths in 2007—the latest year for which all the required data were available when evidence was submitted to the North Review. This leads to the following distributions among the BAC ranges 0–20, 20–50, 50–80, 80–110 and over 110mg/100ml of the deaths that it is estimated would have been prevented in Great Britain in 2007 according to the two methods, and for the Sheffield method according to how long before 2007 the reduced limit had been in force.

BAC of drinking driver (mg/100ml)*	*Deaths prevented in 2007 as estimated by Sheffield approach with limit reduced on*			
	1 January 2007 (A)	*1 July 2005 (B)*	*1 July 2001 (C)*	*Allsop approach. (D)*
110 and over	102	247	350	0
80–110	12	29	41	17
50–80	3	13	29	13
20–50	11	5	40	17
0–20	0	−4	−1	0
All BAC levels	128	290	459	47

* under the existing 80mg/100ml limit

Comparing Columns A, B and D shows that the two approaches are found to lead to not dissimilar estimates of the numbers of deaths prevented in the early years of the reduced limit in accidents involving drivers with BACs below 110mg/100ml. The bulk of the difference in the estimates given in these three columns by the two approaches lies in the estimated prevention of deaths in accidents where a driver has a BAC of over 110mg/100ml.

5. It is clear how this comes about, because my own estimates exclude the possibility of preventing deaths in accidents where a driver has a BAC of over 110mg/100ml by reducing the BAC limit. I did this on the grounds that so much has already been done since 1967 to reduce such deaths in Britain, where only an estimated 0.3% of all driving now takes place at BACs over 80mg/100ml. The Sheffield researchers, on the other hand, base their estimate on the effect of reducing the limit on drivers at these BACs being similar to that achieved in Australia, where 2.5% of driving was previously taking place at BACs over 80mg/100ml.

6. While it is not unreasonable in the light of the Australian and other overseas experience to hope for some prevention of deaths at high BACs as a result of increased public information and enforcement associated with a reduction in the limit, I think we in Britain should be cautious in our expectations in this respect because of what has already been achieved here in respect of deaths at high BACs.

7. The Sheffield researchers estimate further, again on the basis of the Australian experience, that the numbers of deaths prevented would increase in subsequent years, as illustrated in Column C of the above table, which estimates what the effect would have been in 2007 if the limit had been reduced six years previously. My own estimates do not consider this possibility, but Column C would imply that seven out of eight of the deaths in 2007 in accidents involving drivers with BACs greater than 20mg/100ml would have been prevented. This would be wonderful, but seems a good deal too much to expect. Another possibility considered by the Sheffield researchers is, however, that the effect of reducing the limit here might be half what it was in Australia, and it is worth noting that halving the numbers in Column C of the table brings those for BACs below 110mg/100ml roughly into line with those in Column D.

8. Although this discussion is necessarily rather detailed, I hope the Committee may find it useful in helping interpret the range of estimates presented in evidence to the North Review.

Is the mandatory One-year Driving Ban appropriate for less severe offenders under the lower BAC limit of 50mg/100ml?

9. In the argument leading to Recommendation (15) for such a ban, Sir Peter reports receiving very persuasive evidence in favour of this level of penalty, and on that basis I am also convinced that it is appropriate.

10. If, however, as implementation of the Review's recommendations is considered, the severity of this penalty were to become the principal obstacle to public and parliamentary acceptance of the reduced limit, an acceptable alternative could be a basic penalty for driving with a BAC between 50 and 80mg/100ml of six penalty points remaining on the licence for 10 years together with up to three months imprisonment and a fine of up to £2,500. This would mean "two strikes within 10 years and you're out". This would be on the understanding that the penalties for exceeding 80mg/100ml and for failing to provide a specimen should remain as they are now.

What wider costs and benefits are likely to result from changes to drink driving law?

11. As well as preventing deaths and serious injuries, lowering the BAC limit will also bring the advantages of:

— reducing drivers' margin for discretion in relation to the advice not to drink alcohol at all before driving,

— better preparing the millions of British drivers who drive in mainland Europe to comply with the law there,

— removing any temptation to drivers coming to Britain from mainland Europe to drink more before driving while they are here because our limit is known to be so high, and

— removing the demoralising effect on those working at all levels on this and other aspects of road casualty reduction, and the damaging effect on the public perception of Government commitment to casualty reduction, of knowing that an important means of reducing death and injury, widely approved by the public, continues to be neglected by Government.

It may also make a small contribution to wider efforts to moderate the use of alcohol, but this should not be seen as an objective in itself of a change in drink driving law.

12. It is reasonable to recognise that reducing the BAC limit might well lead to some reduction in driving to pubs, clubs and restaurants by patrons who are not prepared to adapt their lifestyles to the extent of one driver per vehicle restraining themselves to the level of consumption of alcohol needed to be below the reduced limit for the return journey. To that extent the relevant trade may well be affected, and the businesses concerned will be challenged by this as they are by other ups and downs of trading conditions. The fact that they have faced this challenge for the sake of reducing the numbers killed or seriously injured on the roads could be kept in mind when other aspects of public policy that may affect them are being considered, such as the scope for helping the village pub to accommodate a community shop and post office.

What would be the Implications of changes in Drink Driving Law for Enforcement?

13. Policy and practice in enforcement of the reduced BAC limit would need to make it clear to drivers that those exceeding the reduced limit were at real risk of detection and conviction and that those with BACs over 80mg/100ml were at least as likely to be detected as before.

14. The police can be greatly helped in this in four main ways:

— by urgent completion of the already long overdue type approval of evidential roadside breathtesting equipment according to Recommendation (27);

— by removing the statutory option for a blood or urine test where a recorded breath alcohol concentration is within a certain margin above the threshold for prosecution, according to Recommendation (11), accompanied by implementing Recommendation (13) and, if the BAC limit is reduced, Recommendations (12) and (14) (Recommendations (12)–(14) together provide an elegant resolution of important issues of detail concerning enforcement thresholds and margins for error in measurement of alcohol concentrations.);

— by inclusion of drink driving involving mandatory disqualification among the "Offences Brought to Justice" on which police forces are required to report (Recommendation (25); and

— by giving them a power to require anyone who is actually driving to cooperate with a preliminary breath test, which would allow the police to carry out intelligence-led targeted enforcement in the course of which any passing driver would be equally likely to be tested.

15. Enhanced enforcement might well lead to a short-term increase in workload for the courts and in disruption of offenders' lives as a result of disqualification, but an emphasis on prevention through deterrence rather than punishment through detection can be hoped to result in such impacts being only short-term.

The Purpose of Drink and Drug Driving Law

16. In order to gain and retain public acceptance of and respect for drink and drug driving law, it is important that such law should be seen and understood to be focussed on road safety, and not be mistaken for an indirect approach to wider policy and objectives, however desirable in themselves, concerning alcohol and other drugs. It is also important that offences and penalties under drink and drug driving law should

reflect the degree of risk caused by impairment. For drink, the risk is closely related to the level of alcohol in the blood at the time, which simplifies the definition, detection of offences, and prosecution of offenders. But this relationship is less clear for other drugs, which necessitates definition and detection of offences being based on evidence of drug-related impairment at the time, and not simply on presence of the drug in the body at the time.

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APPENDIX

COMMON GROUND AND DIFFERENCES BETWEEN THE SHEFFIELD RESEARCHERS' METHOD AND ALLSOP'S METHOD OF ESTIMATING NUMBERS OF DEATHS AND SERIOUS INJURIES PREVENTED

A1. The two sets of estimates have three important starting points in common:

— Both assume that the amounts by which a driver's risk of involvement in a fatal accident or in an injury accident increase as functions of the driver's BAC are as estimated by the two exponential functions fitted to data for Great Britain by Maycock (1997 Appendix A).

— Both assume that the distribution of deaths in road accidents with respect to the BACs of involved drivers is estimated by the distribution with respect to BAC of killed drivers. This in turn is estimated each year for Great Britain by the Department for Transport (DfT) and published in summary form one year in arrears in *Reported Road Casualties Great Britain* (RRCGB) (DfT annually)—previously *Road Casualties Great Britain*—and the Sheffield researchers obtained this distribution in detail for recent years from the DfT. When I made my estimates in August 2008 the distribution seemed to have remained stable for many years, so I used a quite detailed summary of the same distribution for 1990–94 from Maycock's (1997) Table 10.

— Both estimate the likely effect of reducing the BAC limit upon the numbers killed or injured by calculating how these numbers could be expected to change in response to certain changes in the distribution of BACs of drivers.

In the absence of any previous experience of changing the BAC limit in Britain, there is no direct evidence as to how the distribution of BACs of drivers here might change. The two approaches differ mainly in their ways of addressing this lack of direct evidence.

A2. The Sheffield researchers use the Maycock risk function for fatal accidents in conjunction with the distribution of driver deaths with respect to BAC to estimate the distribution of driving with respect to driver BAC. Surveys of this distribution were made in Adelaide, South Australia just before, and then six months, two years and six years after, the BAC limit there was reduced from 80mg/100ml to 50mg/100ml in 1991. The Sheffield researchers use results of these surveys as the basis for assumptions about how the BAC distribution of driving in Britain might respond to the same change in BAC limit here. These assumptions, together with the pre-existing distribution of driving and the risk functions lead directly to estimates of reductions in numbers killed and injured over the first six years after reducing the limit. The process of estimation is refined by using the estimated BAC distributions of driving in each of the years 1998–2007 to estimate how this distribution might itself be evolving over subsequent years in advance of any reduction in the BAC limit.

A3. My own approach is more rudimentary. It makes what are intended to be plausible and conservative assumptions about how those currently driving with BACs in the ranges 20–50, 50–80 and 80–110mg/100ml might respond to the reduction in the BAC limit, and makes the further conservative assumption that those already choosing to drive with BACs of over 110mg/100ml would be unaffected by a change in the limit as such—while recognising that they might be affected by associated public information and increases in enforcement activity. These assumptions, together with the pre-existing BAC distribution of killed drivers and the risk functions, lead directly to estimates of reductions in numbers killed and injured in a year. My approach makes no attempt to allow for evolution of the BAC distribution of driving in advance of any reduction in the limit or to estimate how the reductions in numbers killed or injured might change over the years after reducing the limit.

ATTACHMENT

NOTE PROVIDED TO THE DEPARTMENT FOR TRANSPORT THROUGH TRL LTD BY RICHARD ALLSOP FROM UCL CENTRE FOR TRANSPORT STUDIES IN AUGUST 2008

NOTE: This note is placed in the public domain with the agreement of the Department for Transport. In the last paragraph, provisional estimates from Road Casualties Great Britain 2007 of numbers of drink-drive casualties in 2007 have been replaced by final estimates from Reported Road Casualties Great Britain 2008

ESTIMATED CASUALTY REDUCTION IMPACTS OF REDUCING THE DRINK-DRIVE LIMIT TO BAC 50MG/100ML OR 20MG/100ML

NOTE: All references to alcohol levels in this note are to blood alcohol concentration (BAC) in units of mg/100ml without mention of the units.

Approach to Estimation of Casualty Reductions

The approach adopted here in order to estimate casualty reduction impacts of reducing the drink-drive limit uses information about numbers killed and injured in road traffic accidents, the distribution of BACs of drivers killed in road traffic accidents and of drivers involved in road traffic accidents that result in personal injury, estimated relationships between accident risk and driver's BAC, and assumptions about the effect of changes in the drink-drive limit upon the numbers of accident-involved drivers with various levels of BAC.

Because of the many relevant differences between countries, only information about drivers and accidents in Great Britain and relationships derived from such information are used. The assumptions about possible effects of changes in the legal BAC limit upon numbers of accident-involved drivers are developed by the author from a more limited set of similar assumptions made by him in an earlier study which has been in the public domain since 2005.

Sources of Information

Table 3a on page 29 of *Road Casualties Great Britain 2006* provides estimates of numbers of casualties in recent years in accidents in which at least one driver had a BAC over 80.

Pending widespread use of new technology in screening breath tests and in testing accident-involved drivers, and the possible conduct of a fresh roadside survey of the BACs of drivers in general, information about distributions of BACs of drivers killed and drivers involved in injury accidents and estimated relationships between accident risk and driver's BAC are drawn from Maycock's 1997 review. Confidence in the continued relevance of this information is drawn from the general consistency between the unpublished results of the 1998–99 roadside surveys (Tunbridge *et al* 2003) and those of earlier surveys used by Maycock, and the broad stability over time, and consistency with the data used by Maycock, of the distribution of BACs of killed drivers reported in Table 3h of *Road Casualties Great Britain 2006* and corresponding tables in earlier years. The author's earlier thinking about possible effects of changes in the legal BAC limit upon numbers of accident-involved drivers, which started from the corresponding discussion in the consultation paper *Combating drink driving: next steps,* is recorded elsewhere (Allsop 2005).

The Process of Estimation

Table 3a of *Road Casualties Great Britain 2006* shows accidents in which at least one driver's BAC exceeds 80 accounting, in round figures, for about 550 killed, 2,000 seriously injured and 12,000 slightly injured per year. The annual number killed has been broadly steady for a decade, during which the number seriously injured has fallen by about one-third and the number slightly injured has fluctuated between about 12,000 and 17,000. Estimates of reductions made here will be based on there being 550 killed and 2,000 seriously injured per year in such accidents with the present BAC limit and, as a conservative estimate, six slightly injured for every one seriously injured. The recent downward trend in serious injures in such accidents of about 4% per year should be borne in mind when using the estimates of effect on numbers injured. Estimated reductions corresponding to other current annual numbers killed or injured in accidents in which at least one driver's BAC exceeds 80 can be obtained by prorating the estimates made here.

Assumptions which are described here as conservative are so in the sense that they are likely to err on the side of underestimating the casualty reductions to be expected from reducing the legal limit. Other assumptions are made on the basis of being neutral in this respect.

It is assumed that behaviour of those now driving well over the existing limit of 80 is unlikely to be affected by lowering the limit. It is therefore assumed that casualty reductions resulting in the short term from reducing the limit will arise from reduction in accident involvement of drivers below or only somewhat above the current limit. (This is not to say that lowering the limit will never affect the amount of driving at higher BACs, but recognises that appreciable effects on such driving will come mainly through longer term changes in the culture of drinking and driving, leading to fewer people developing the habit of driving after heavy drinking). The following four ranges of BAC are therefore considered: 80–110, 50–80, 20–50, and below 20 but not effectively zero (in that they are so low that they are not necessarily related to drinking behaviour, and in any case there is no reason in terms of accident risk for seeking to change them).

For these four ranges, numbers killed per year in accidents in which a driver's BAC lies in each range are estimated from the total of 550 for which the BAC is over 80 using the distribution of BACs in car drivers killed in 1990–94 in Table 10 of Maycock's review. It is assumed that the distribution of BACs of drinking drivers involved in fatal accidents is estimated by that of the drinking drivers who were themselves killed. With access to the data on which Table 3h of *Road Casualties Great Britain 2006* and its predecessor tables are based, Maycock's Table 10 could be updated and replaced in the analysis reported here.

Because the numbers of drivers in the BAC intervals 41–80 and 81–120 in Table 10 are so nearly equal, it is assumed that drivers' BACs are uniformly distributed over the range 40–120. It is further assumed for purposes of calculation that BACs that are not effectively zero are uniformly distributed over the range 0–40 with the same density as between 40 and 120—a conservative estimate because more drivers would be expected at these lower BACs. It follows that the annual numbers of deaths in fatal accidents with a drinking driver in each of the four BAC ranges being considered are estimated to be as shown in Table 1.

The corresponding numbers seriously injured are estimated similarly from the total of 2,000 for which the drinking driver's BAC is over 80 using the distribution of breath alcohol concentrations in drivers involved in injury accidents in Table 8 of Maycock's review, after conversion to BACs. Whilst it is less clear than for Table 10 (relating to drivers killed) how representative the distribution in Table 8 is, it is the best available and was used by Maycock as such. Its use in relation to serious injuries is conservative in that it relates to all injury accidents, whereas the proportions of drivers with higher BACs would be expected to be greater among those involved in serious accidents only. The resulting estimates of the annual numbers seriously injured in accidents with a drinking driver in each of the four BAC ranges being considered are estimated to be as shown in Table 1.

Table 1

ESTIMATED ANNUAL NUMBERS KILLED AND SERIOUSLY INJURED IN ACCIDENTS WHERE A DRIVER HAS A BAC OF UP TO 110

BAC of drinking driver	*Number killed*	*Number seriously injured*
80–110	65	557
50–80	65	557
20–50	65	557
0–20 but not effectively zero	43	371

If drivers' BACs are influenced by reducing the legal limit, the effect on numbers killed or injured will be determined by the resulting changes in risk of accident involvement. Maycock estimated from his Tables 8 and 10 and the results of roadside surveys in 1988 ad 1990 of BACs of drivers in Britain that the risks of being killed and of involvement in an injury accident at a BAC of b were proportional to exp(0.032b) and exp(0.021b) respectively (after conversion from units of breath alcohol concentration). In line with previous assumptions, these relationships will be applied here to estimate changes in numbers killed and seriously injured respectively.

In doing so, two sets of assumptions, respectively pessimistic and optimistic in terms of casualty reduction, are made about how drivers will change their behaviour in response to reduction in the limit, in order to obtain lower and higher estimates of casualty reduction. These assumptions, set out in Table 2, are new to this process of estimation.

Table 2

ASSUMPTIONS ABOUT CHANGES IN DRIVER BEHAVIOUR IN RESPONSE TO REDUCTIONS IN THE LEGAL BAC LIMIT

Drivers' current BACs	*Assumption about altered BACs*	
	Pessimistic	*Optimistic*
	Limit reduced to 50	
80–110	Redistributed over 50–110 in the same order	All reduced by 30
50–80	Redistributed over 20–80 in the same order	All reduced by 30
20–50	Redistributed over 0–50 in the same order	Redistributed over 0–20 in the same order
0–20	Unchanged	Unchanged
	Limit reduced to 20	
80–110	Redistributed over 20–110 in the same order	All reduced by 60

Drivers' current BACs	*Assumption about altered BACs*	
	Pessimistic	*Optimistic*
50–80	Redistributed over 0–50 in the same order	Those over 60 reduced by 60; those 50–60 reduced to 0
20–50	Redistributed over 0–20 in the same order	Those over 30 reduced by 30; those 20–30 reduced to 0
0–20	Unchanged	Reduced to zero

The effects of these assumptions, together with the previous assumption that drivers are currently distributed uniformly over each of the four ranges being considered, upon numbers of deaths and seriously injured in accidents involving drivers currently in these four ranges can be derived by integration in the form of factors by which the numbers killed or seriously injured would be reduced, as set out in the Annex.

Estimated Reductions in Casualties

Applying the factors derived in the Appendix to the numbers in Table 1 yields the optimistic and pessimistic estimates of reductions in annual numbers killed or seriously injured set out in Table 3 for an existing situation in which the 550 are killed, 2,000 seriously injured and 12,000 slightly injured annually in accidents in which at least one driver's BAC exceeds 80. The estimates shown of the reduction in the number slightly injured are simply conservative estimates obtained by multiplying by six the estimated reductions in the number seriously injured.

Table 3

ESTIMATED ANNUAL REDUCTIONS IN CASUALTIES
RESULTING FROM REDUCING THE DRINK-DRIVE LIMIT TO 50 OR 20 MG/100ML

Drivers' current BACs	*Assumption about altered BACs*			
	Pessimistic		*Optimistic*	
	Killed	*Seriously injured*	*Killed*	*Seriously injured*
	Limit reduced to 50			
80–110	23	144	40	260
50–80	23	144	40	260
20–50	17	102	36	227
0–20	0	0	0	0
Total	63	390	116	747
Slightly injured		2,340		4,492
	Limit reduced to 20			
80–110	36	240	55	399
50–80	47	315	55	393
20–50	36	227	39	249
0–20	0	0	9	68
Total	119	782	159	1,109
Slightly injured		4,692		6,654

Estimated reductions corresponding to other current annual numbers killed or injured in such accidents can be obtained by prorating the estimates in Table 3. For example, estimated reductions of the year 2007, in which an estimated 410 were killed, 1,760 seriously injured and 11,850 slightly injured in such accidents can be obtained by multiplying the reductions in numbers killed by 410/550 = 0.75, the reductions in numbers seriously injured by 1,760/2,000 = 0.88, and the reductions in numbers slightly injured by 11,850/12,000 = 0.99.

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Annex

ESTIMATED EFFECTS OF ASSUMED ALTERATIONS IN DRIVERS' BACS UPON CASUALTY NUMBERS

The factors by which numbers of casualties will be multiplied under the assumptions in Table 2 are each estimated by use of one or two of the following four expressions, in which k = 0.032 for numbers killed and k = 0.021 for numbers seriously injured.

1 *All current BACs are reduced by r*

The number of casualties is multiplied by exp(–*kr*)

2 *BACs in the range (b,c) are redistributed over (a,c) in the same order, where a<b*

Each BAC *x* in this range is reduced by *(c–x)(b–a)/(c–b)* so the number of casualties is multiplied by $\int_b^c \exp[-k(c-x)(b-a)/(c-b)]/(c-b)dx = \{1-\exp[-k(b-a)]\}/k(b-a)$

3 *BACs in range (b,c) are redistributed over (0,b) in the same order*

Each BAC *x* in this range is reduced by $[b^2 + (c - 2b)x]/(c-b)$ so the number of casualties is multiplied by

$\int_b^c \exp\{-k[b^2 + (c-2b)x]/(c-b)\}/(c-b)dx = \{\exp[-k(c-b)] - \exp(-kb)\}/k(2b-c)$ Note:

In the singular case c=2b this expression reduces to expression (1).

4 All BACs in range (b,c) are reduced to zero

Each BAC *x* in this range is reduced by x so the number of casualties is multiplied by

$\int_b^c \exp(-kx)/(c-b)dx = \{\exp(-kb) - \exp(-kc)\}/k(c-b)$

These expressions yield the values shown in Table A1, which are independent of the numbers killed or injured in accidents in which at least one driver's BAC exceeds 80.

Table A1

FACTORS BY WHICH NUMBERS OF KILLED OR SERIOUSLY INJURED ARE ESTIMATED TO BE MULTIPLIED BY CHANGES IN BEHAVIOUR ASSUMED IN TABLE 2

Drivers' current BACs	*Assumption about altered BACs*			
	Pessimistic		*Optimistic*	
	Killed	*Seriously injured*	*Killed*	*Seriously injured*
	Limit reduced to 50			
80–110	.6428	.7419	.3829	.5326
50–80	.6428	.7419	.3829	.5326
20–50	.7386	.8166	.4512	.5926
0–20	1.0	1.0	1.0	1.0
	Limit reduced to 20			
80–110	.4445	.5685	.1466	.2837
50–80	.2828	.4349	.1553	.2943
20–50	.4512	.5926	.4056	.5526
0–20	1.0	1.0	.7386	.8165

Written evidence from the Association of Chief Police Officers (ACPO) (DDD 11)

1. *Should the permitted blood alcohol limit be reduced as proposed?*

1.1 Each year, around 450 people die in a road collision involving a drink driver. It is a contributory factor that is largely impervious to intervention and proving difficult to tackle. ACPO believes that in order to reduce the unacceptable toll of death and serious injuries on our roads, the Government must send a clear and unequivocal message to the public that drinking and driving is both socially and morally unacceptable. Even one drink can impair a person's ability to drive safely and the message that must be delivered consistently is that when people are drinking, they should leave the car behind.

1.2 The current alcohol limit of 80 mg per 100ml of blood is not consistent with that message. It creates the impression that there is an acceptable "quota" of alcohol consumption which some drivers then attempt to maximise through interpretations based on their own perceptions of what is an appropriate amount. This often leads to excess consumption or consumption at levels, which although not unlawful are unsafe for some drivers. ACPO supports the idea of a reduction in the drink drive limit to a level which is both safe and supports the message that drinking and driving do not mix. In an ideal world, the limit would be zero. However, we accept that this is not realistic given the presence in the body of naturally occurring alcohol and the residual effects of previous drinking.

1.3 We also accept that this would be unenforceable and have significant social implications that may not be acceptable to society as a whole. At this stage, we are not clear what constitutes an appropriate level. We are conscious that the majority of European countries now have a limit of 50mg per 100ml level or lower although this limit is usually associated with an administrative penalty not involving lengthy disqualification. Only at 80mg and above do penalties mirror our own. Drivers cross national borders on a regular basis and there is some merit in standardising limits for the sake of simplicity and clarity. There is some evidence to show that a reduction in the limit to 50mg per 100ml would save 64 lives a year. However, it is not clear what the impact of a reduction to 30mg or 40mg would be and whether this might produce proportionally greater benefits in terms of casualty reduction.

1.4 The recent introduction of roadside breath devices with a memory and data recording facility now provides a unique opportunity to gather the evidence that is necessary to enable an objective decision to be made. Initial figures gathered by the police indicate that 2% of drivers breath tested following a collision produce a result in the 50 to 80 range. A reduction in the limit will alter the behaviour of many drink drivers and will reduce drink drive casualties.

1.5 From now on data will be gathered which will enable a detailed analysis to be made of the impact of various levels of alcohol consumption on road casualties. This in turn will enable an objective assessment to be made to identify what is an appropriate limit. ACPO will offer the Government whatever support is necessary to facilitate this evaluation.

2. *If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?*

2.1 If a lower limit is ultimately introduced, ACPO would urge the Government to resist any pressure to introduce non-disqualification penalties for lower levels of offending. We believe that this would cause unnecessary complications and result in confusing and counter productive messages for the public. There may be a case for a shorter period of disqualification for low-end offenders of six months between 50 and 80.

3. *How severe is the problem of drug driving and what should be done to address it?*

3.1 There is no hard evidence relating to the scale of the problem of drug driving. Various surveys tend to suggest that a significant number of people have admitted to driving having taken drugs but the number of drug tests conducted on drivers does not give a significant result.

3.2 There are two reasons for this lack of evidence:

— A blood specimen is not routinely taken following a collision and only in majority of cases resulting in a fatality and then only from the deceased.

— The current legislation requires an officer to gather sufficient evidence to prove impairment and then a doctors confirmation of a condition due to a drug before a blood sample may be taken. This is a complex and time-consuming process, which may only be carried out by specially trained officers.

3.3 In terms of what should be done to address it: Currently the law requires proof of impairment to drive and proof that the impairment is due to either alcohol or a drug. The effect of this is that it is not an offence to drive with either alcohol or drugs in the body unless the substances are the cause of clear and explainable impairment to drive. This situation creates uncertainty, the user being unsure whether the effects will be sufficient to be determined as impairment to drive or not with many being prepared to take a chance. On the alcohol side, this has largely been addressed by the introduction of a statutory limit in 1967. Other drugs are by nature quite different with statutory limits being impossible to determine with the effect that the 1930 offence of impairment through drugs remains the only control in place. The offence is adequate in addressing the road safety issue but ineffective due to the Act's procedural process.

3.4 The Act requires that before an evidential specimen of blood or urine can be required from a suspect a medical practitioner has to confirm the presence of a condition due to a drug. The reason for this requirement is a mystery and the effect is serious. In some instances, doctors set the bar for deciding whether there is a condition far too high and fail to find one, many are confused and try proving impairment while in other areas securing the attendance of a doctor at a police station is difficult. This has the effect that during the wait the signs that would indicate the presence of a drug often disappear and a driver is released, as there is no condition found and therefore no futher authority for police to obtain a specimen.

3.5 For these reasons, officer confidence in the usability of the process is often very low with the effect that enforcement is considerably lower than it should be. Officers also frequently lack confidence in their ability to satisfy a court that a person was impaired to drive. Such opinions and decisions are very subjective, often fiercely contested and sometimes lost at court. To combat this officers are trained to carry out field impairment testing (FIT) (previously voluntary but now under section 6 of the Act which involves conducting a series of physical and mental assessments to help to identify and support impairment.

3.6 It is probably fair to say that officers can become disillusioned with what they perceive as barriers that are constantly placed in their way in their efforts to enforce the existing legislation and consequently shift their focus to other, more practically enforceable offences.

3.7 ACPO considers tackling drug driving to be a major issue in improving road safety. We believe that a significant improvement to the current system could be achieved simply by removing the requirement for the FME to confirm a condition due to a drug before the requirement for an evidential blood or urine specimen, especially as this would then mirror the law as it applies to impairment through alcohol. In the short term this can be facilitated in the worse cases by the introduction of drug screening technology (Home Office needs to provide a device specification for type approval of equipment) but as devices are still unreliable at the lower levels and very drug specific this could only help and will not solve the issue.

3.8 Therefore, we believe that firstly, the current legislation is in need of amendment due to the difficulties outlined above and secondly, consideration should also be given to the creation of new offence specifically targeting those drugs that are both illegal and which research has proved cause impairment to such an extent as to impact upon driving. These substances should be listed in a schedule where a person found driving etc whilst under the influence of such a drug would be guilty of an absolute offence—specifically without the additional need to also prove impairment. (This is a very long term solution and there will need to be much research and expert advice but, if we don't at least alter legislation and start the process we will never achieve the goal).

4. *What wider costs and benefits are likely to result from changes to drink and drug driving law?*

4.1 This will be clearly dependant on which changes are adopted.

4.2 *Reducing the drink drive limit:* The benefits will be many and varied. With some 64 lives a year to be saved, along with many serious injuries, there will be a significant reduction in the misery and hurt that comes with bereavement and life-changing injury. There is also the financial cost; the Government's own figures estimate £1.9 million per fatal collision and £188 thousand per serious collision. A reduction in collisions will obviously mean the police will have to spend less time dealing with them and congestion due to collisions will also be reduced.

4.3 *Removal of the statutory option:* ACPO strongly supports the removal of the statutory right to a blood or urine test as an alternative to the evidential breath test. Current technology has proven to be highly accurate and effective in its use. It has the confidence of the public and the criminal justice system and can now be relied on without the need for independent corroboration.

4.4 The continued retention of the statutory option simply allows drink drivers the opportunity to forestall the evidential test. This can often result in a reduced reading and in some marginal cases result in drivers avoiding prosecution even though a perfectly valid breath reading was obtained within minutes of a driver being brought to the police station. In addition, police officer time is unnecessarily wasted whilst waiting for doctors or nurses to attend and the process is medically invasive.

4.5 It is also worth considering that the removal of the statutory option for blood or urine would facilitate the introduction of roadside evidential testing which when used in conjunction with targeted checkpoint testing would be a significant enhancement in the options available to the police to tackle drink driving.

4.6 *Evidential roadside breath testing:* Once the technology is approved, we will fully support the introduction of evidential roadside breath testing. The current system of screening tests followed by an evidential test at the police station introduces a second tier of testing that would be unnecessary if roadside evidential testing was introduced. This would be doubly effective if the statutory option was removed. At present, following a screening test at the roadside, the driver is arrested and taken to a police station. If the custody suite is busy, it may be an hour or more before the prisoner is booked in and provides an evidential breath specimen. Should that come in at 50mg and the driver elect a statutory option, a doctor is called to take a blood sample, which may take another two hours, by which time the driver is below the legal limit, although he or she may have been significantly over the limit at the time they were driving.

4.7 This move will reduce the amount of time it takes an officer to process an offender, as it will remove from the system those who are over at the roadside but subsequently provide a negative evidential test. It will also prevent people who are over the limit at the time they are driving escaping justice when a much later evidential test shows them to be under the limit.

4.8 *Unrestricted power to test any person driving a motor vehicle:* ACPO wholeheartedly supports the introduction of a power to randomly check any driver. Putting conditions on when a breath test can be required simply supports the view that you can drink, drive and avoid prosecution by playing within the "rules", police have unrestricted powers to stop vehicles to check tyres, condition and the documents of a driver but are restricted when they can check for drink or drugs. A random power would support targeted checkpoint testing of drink drivers carried out now is some areas but requiring an element of consent. Random powers are supported, not necessarily because we believe that the existing powers are inadequate; rather, we believe that this simple measure, widely publicised, would increase the perception in the minds of drivers that if they do drink and drive they are likely to be caught and brought to justice at any time, anywhere.

4.9 We know, from practical experience, that there is a mindset amongst some drivers that if they avoid drawing attention to themselves (eg by causing an accident or committing a moving traffic offence) the police have no power to stop them. In truth, the reality is somewhat different. Under current legislation, a police officer can stop any vehicle without reason (using the road traffic act power not those under drink and drug driving) and having subsequently formed an opinion that the driver has been drinking (eg because the officer can smell drink) they can then require a breath test. However, many people do not believe that to be the case. In our view, this misconception perpetuates the attitude amongst a resilient hardcore of drink drivers that the risk is one that is worth taking. The message should be clear, don't drink and drive and if driving you can be tested anywhere, anytime.

4.10 *Allowing nurses also to take on the role currently fulfilled by the forensic physician in determining whether the drug driving suspect has "a condition which might be due to a drug":* This will have several benefits. In terms of financial savings, there will be a significant saving in not having to call out a Force Medical Examiner (FME) every time a suspect needs assessing. The availability and in many cases the presence of the nurse in the custody suite will mean that officer time is not wasted awaiting the arrival of the FME. Furthermore, the suspect will not evade justice as the impairing effect of the drug wears off prior to the arrival of the FME.

4.11 *Steps should be taken for the earliest practicable type approval and supply to police stations of preliminary drug screening devices:* if this proposal leads to the removal of any type of examination prior to the taking of a blood specimen then there may be benefits in terms of saving officer time and speeding up the administration of justice. Devices are currently somewhat inaccurate at the lower level but over time they will improve and eliminate many of those cases where the doctors attendance is necessary

4.12 *Setting a prescribed limit for drugs:* If the level can be scientifically linked to impairment, as is the case with alcohol it would be fair but would not result in any savings in terms of finance or officer time.

4.13 *Once preliminary drug screening devices have been type approved for use in police stations, the Government should continue to work on type approval of preliminary drug screening devices which are capable of being used at the roadside, drawing from overseas experience:* This will be extremely useful if it is intended to replace the current law that requires the evidence of unfitness to drive (impairment). The FIT assessment takes a minimum of 20 minutes to complete, whether it be positive or negative. It must be clear that as long as the need to prove impairment at the roadside remains, a device such as this would have no value.

4.14 *Should it prove beyond scientific reach to set specific levels of deemed impairment, the Government should consider whether a "zero tolerance" offence should be introduced in relation to a schedule of drugs known to have an impairing effect:* An absolute offence of driving with a drug known to have an impairing effect would simplify the application of the law at street level. It would remove the need for time-consuming impairment testing and the testing would not have to be carried out by specially trained officers. The time and cost savings due to this would be significant.

5. *What would be the implications of such changes for enforcement?*

5.1 Whilst it may be argued that a reduction in the drink drive limit may lead to more arrests and prosecutions for drink driving, we anticipate that this would be offset by the reduction in the time spent dealing with collisions caused by drink drivers.

5.2 The full benefit of the legislative changes will only be achieved if the full basket of drink driving proposals is adopted. Removing the statutory option will speed up the process and prevent offenders evading justice. Roadside evidential testing will have a similar effect. Both measures will result in a significant saving in officer time. The introduction of random testing will raise the public perception that they are likely to be detected and will facilitate more effective, targeted testing regimes which should lower the number of drivers prepared to risk capture and prosecution by driving after drinking or taking of drugs.

5.3 In terms of drug driving, the implications are equally positive. Simplification of the application of the law will result in a significant rise in testing by the police as no specialist training would be necessary and the current, unwieldy processes at the police station would be condensed greatly. As such they would be broadly welcomed.

August 2010

Written evidence from the RAC Foundation (DDD 12)

1. Introduction

1.1 The RAC Foundation is a charity which explores the economic, mobility, safety and environmental issues relating to roads and responsible road users. Independent and authoritative research, carried out for the public benefit, is central to the Foundation's activities.

1.2 The Foundation welcomes the Committee's inquiry into drink and drug driving, which is timely given the recent publication of the North Review. We broadly support lowering the permitted alcohol limit to 0.5mg/100ml blood and the development of a specific drug driving offence which focuses on drug consumption levels and measurable impairment. Increased traffic police enforcement is needed to achieve compliance with current and future drink and drug driving regulations.

2. Reducing the Permitted Blood Alcohol Limit

2.1 The RAC Foundation broadly supports reducing the permitted blood alcohol limit to 0.5mg/100ml, providing it is accompanied with increased enforcement. Reducing the limit to this level will lower the level of death and injury on the road and bring Great Britain in line with much of mainland Europe.

2.2 Calculations for Great Britain suggests that reducing the legal limit to 50mg per 100ml blood would save 65 lives per year and 230 people would be saved from serious injury (Allsop, 2005). More recent work looking at 2008 data has revised this figure to 43 deaths and 280 serious injuries (PACTS, 2010). Drivers with between 0.5–0.7mg/ml of alcohol in their blood have been found to be four to ten times more likely to be involved in a fatal crash than a driver with a zero blood alcohol content (BAC) (Fell and Voas, 2006).

2.3 The RAC Foundation is however cautious about the introduction of a new limit, as we remain unconvinced that the reduction will encourage a behavioural change amongst the 1% of excessive drinkers who account for 73% of all drink drive deaths (Allsop, 2005). In fact research indicates that a change in the BAC level may only affect the behaviour of roughly 2% of the driving population (Allsop, 2005). This is because 97% of the population already has a BAC lower than 50mg per 100ml when driving and 1% are so significantly above the current 80mg limit that any change in law is not expected to have an impact.

2.4 Finding a way to tackle the irresponsible minority, as recognised by the previous Government in both "A Safer Way…" and the "Road Safety Compliance consultation" should be given priority. Regardless of the BAC drink drive limit, more visible enforcement will be an important part of the solution.

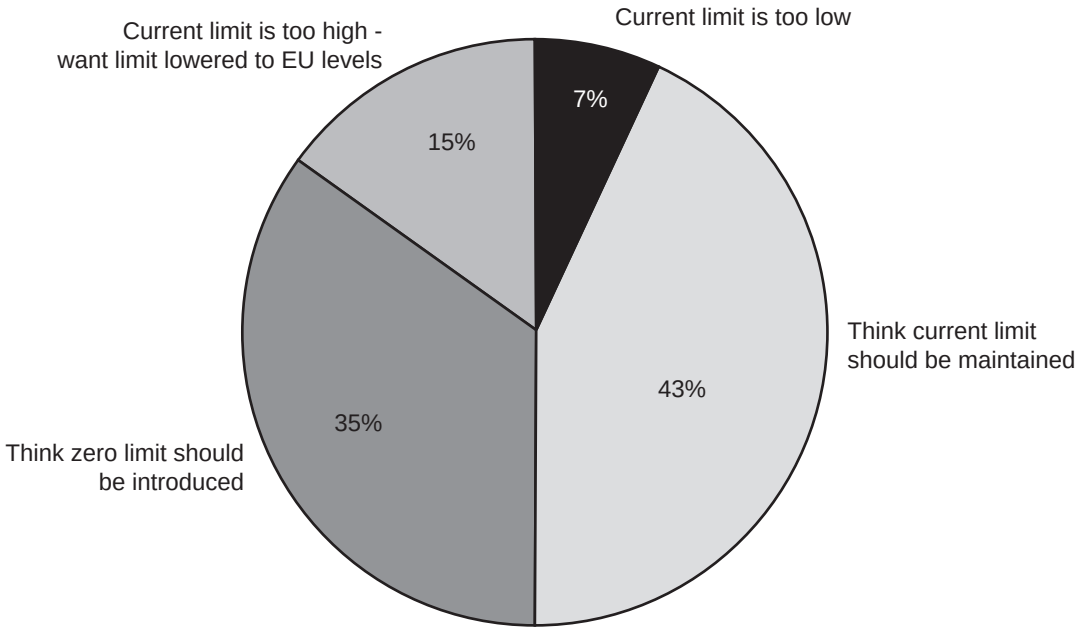
2.5 Despite these reservations, the RAC Foundation broadly supports a reduction in the BAC to 0.5mg/100ml for the role it will play in creating a "social norm" and culture against drink driving. Some education campaigns have a limited effect on public attitudes, but there is emerging evidence that education programmes have over many years helped to legitimise drink driving legislation and change attitudes (Box and McKenna, forthcoming). The future role of education in both drink and drug driving needs to be better understood and supported.

2.6 The RAC Motoring services also support a lowering of the limit to 0.5mg as they believe the level is easier to communicate to the public—in the main equating to one drink.

2.7 The public can be described as somewhat supportive of a change in the drink drive limit. The 2009 RAC Report on Motoring found that 15% would like to see the limit lowered to EU levels and 35% saying that a zero limit should be introduced. 43% would like to see the current limit maintained (See: Figure 1).

Figure 1

PUBLIC ATTITUDES TO THE DRINK DRIVE LIMIT



Source: RAC Report on Motoring 2009, p.40

2.8 The RAC Foundation is pleased that the North Review has not recommended imposing a lower limit of 0.2mg/100ml for different classes of drivers and riders. Although novice drivers and professional drivers are at a greater risk on the road the Foundation does not believe that this warrants a different limit for this group. The limit, whatever it is, should be simple, easy to understand and communicate. Setting a lower limit for novice drivers, only to raise it at a later point sends the wrong message and if a lower limit is revised in five years time as suggested by the North Review, research on the impact of the change would need to be conducted.

2.9 When asked about other approaches to reducing drink driving public support is highest for educational campaigns and longer sentences for drink driving. There is also a reasonably high level of support for random breath testing (71%) (See: RAC Report on Motoring 2009).

2.10 The motorists who risk drink driving often do so because they do not think they will get caught. Increasing traffic police is essential, not only to reduce drink driving, but also to deter other serious crimes.

2.11 To be effective drink driving limits need to be accompanied by appropriate deterrents. For this reason the RAC Foundation agrees with the conclusions of the North Review that *"the threat of a substantial period of mandatory disqualification has proved to be a potent weapon in combating drink driving"* and *"It would be a retrograde step to diminish the force of that weapon"*. If the 12 month driving ban is retained for the new lower level this will leave Great Britain with the toughest penalty regime of any EU country with a 50mg/100ml limit. Despite this the Foundation believes it is important that this penalty is retained to reinforce the anti-drink drive message.

3. Severity of Drug Driving and Possible Changes to the Law

3.1 The true extent of the drug driving problem is unknown. For this reason the Foundation supports the call for greater investigation of the presence of drugs in road fatalities and the wider driving community. Data collected from Field Impairment Tests (FIT) tests and other relevant sources should be collated and added to the published evidence base to improve understanding.

3.2 Current law on drug driving is found in the Road Traffic Act 1988 sections 4(1) and (2) which says that a person who, when driving or attempting to drive, or in charge of a mechanically propelled vehicle on a road or other public place, is unfit to drive through drink or drugs is guilty of an offence.

3.3 The law as it currently stands causes problems for enforcing drug driving as there is a need to prove that the driver has not only taken drugs but their driving is impaired as a result. There is no objective test for impairment, no legal definition of impairment in the Road Traffic Act, and no offence of driving in breach of a prescribed limit, as is the case for drink-driving. FITs used to assess drug impairment, which are effective overall, are only used by a limited number of trained officers.

3.4 The Foundation would support many of the suggestions made in the North Review on this subject. There is however a wider question to be answered about how drug driving and broader illegal drug laws are enforced. If, as it has been suggested, these issues remain separate the reasons for this decision need to be fully explained to the law abiding public.

3.5 The Foundation agrees with the North Report that a number of station test processes for drug driving could be sped up to improve the chances of conviction, such as allowing staff other than the Forensic Medical Examiner to take evidence samples at the station. Type approval of drug testing equipment for both at station and on road use should also be a priority and the Foundation supports the Government's commitment to have screening devices for a range of substances installed in every police station by 2012.

4. Implications of Changes to Drink and Drug Driving Law

4.1 Changes to drink and drug driving law as outlined above will have the benefit of reduced casualties, but implementing these changes will have resource implications for the police, courts and medical profession amongst others. The RAC Foundation does not have data on the extent of these resource implications.

4.2 Whether the drink and drug laws are changed or not, more visible enforcement is needed. More targeted breath testing for drink drivers would act as a strong deterrent to those who do not believe that they will get caught. This is particularly important as for some drivers the fear of being caught by the Police is more influential than the risk of injuring themselves or other road users.

4.3 A lack of funding and staff resources within the police force, alongside targets for other areas of enforcement acts as the main procedural barriers to deterring drink driving. Finances are understandably tight across all public services, but if Government wants to make this area a priority the subsequent funding needs to be available to support the activity.

References:

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August 2010

Written evidence from the British Beer & Pub Association (DDD 15)

The British Beer & Pub Association is the trade body representing brewing companies and their pub interests, and pub owning companies, accounting for 98% of beer production and just over half of the UK's 52,500 pubs. Over 80% of pubs are small businesses that are either leased/tenanted, or owned and run directly by their owners.

Introduction

1. The beer and pub sector is committed to helping to combat drink driving and is proud of the part that it has played over many years in helping to increase public awareness about the dangers of drink driving through its many initiatives and campaigns. The industry continues to support the Department for Transport's THINK campaign.

2. Pubs are now firmly part of the broader leisure and hospitality sector and food is as important an offer (if not more so) than the drinks offer. Food is consistently the top reason why people choose to visit the pub with over 1.1 billion meals served every year compared with 771 million in restaurants. Today's pub culture has become more family friendly, more focused on food and alternatives to alcoholic drinks, offering entertainment accompanied by drinks rather than the old-style drinks orientated public houses.

3. The value of the pub to the local economy should not be underestimated. Pubs are a major source of local jobs. The industry provides over half a million positions for management, bar and catering staff, and chefs, 60% of which offer part time or flexible patterns of working that enable people to juggle their home and work commitments. For every one job in hospitality, it is estimated that an additional 1.3 jobs are

created in the wider economy. Through their support of local businesses and local sourcing of goods and services, pubs also help to ensure that other small businesses thrive, securing more local employment. Pubs are a mainstay of rural community life, and play a crucial part in the sustainability of the rural economy.

4. There are an estimated 8,000 pubs in rural locations and a further 10,000 pubs in suburban or semi-rural locations which are vehicle-dependent. In villages and smaller towns there is often no public transport at all or a very restricted service in the evenings. Many pubs with large restaurant areas would not be sustainable if they relied on community trade alone. In total 18,000 pubs could therefore be particularly affected by a reduction in the current BAC limit.

Should the permitted blood alcohol limit be reduced as proposed?

5. Over the past two decades a mixture of improved enforcement, tougher penalties and a programme of publicity campaigns have significantly reduced the number of drink drive accidents. All the evidence gathered over many years indicates that drink/drive offenders have blood alcohol levels far in excess of the legal limit. The latest drink/drive figures[1] confirm this trend despite an ever increasing number of cars on the road and the number of miles driven. Britain's roads are already the safest of almost any developed country.

6. We believe that the current BAC limit of 80mg has the respect of the overwhelming majority of people in this country who believe the current limit to be fair. People are well aware of the consequences of exceeding the limit and have no sympathy for those that do. There is a real risk that lowering the limit would see a loss of that respect with a return to the "unlucky" tag resulting in more people taking the chance and not limiting their drinking at all. The current limit of 80mg has taken a long time to become established as the social norm. There is a danger that the message will lose credibility and cause confusion if it is changed after so many years of success.

7. A reduction in the current limit would also lead to more people being caught (this is likely to include more people who considered themselves responsible by drinking at home, or at a friend's house, but whose chances of being over the limit the next morning would be greatly increased). This would divert resource away from catching dangerous drivers who far exceed the current limit. The public may not look favourably either at the prospect of losing their licences as a result of a stricter limit being imposed after such a long period of time.

8. We do not believe that lowering the current limit will address the hard-core repeat offenders but will penalise the responsible majority. The industry supports the efforts of the authorities to enforce the law regarding drivers over the limit and, indeed, has long advocated the introduction of greater enforcement and random breath testing. We believe that these measures represent the best way of making further progress and should be allowed time to take effect before any consideration is given to lowering the BAC limit.

9. The North Report cites research contained in the "review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths", March 2010 (produced by the Centre for Public Health Excellence NICE). It should be noted that the evidence base for this report is derived mainly from the USA, Australia, New Zealand and other European countries where public attitudes, driving habits and drinking culture are all very different to that prevalent in the UK. We question the supposition that the benefits claimed in the report would be delivered by lowering the limit in the UK, where levels of enforcement, degrees of punishment and respect for the current limit are not compatible.

If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?

10. We believe that public opinion would rise against a reduction in the BAC limit if it were to carry the same penalties as currently exist for exceeding the 80mg limit. However, a two-tier penalty system would create enormous uncertainty and confusion and would give the wrong message about the consequences of drink/driving. We believe that retention of the existing 80mg limit, together with the associated severe penalties, would be the most sensible option.

11. A lower drink/drive limit with a more lenient penalty regime will not have any impact whatsoever on persistent core offenders.

How severe is the problem of drug driving and what should be done to address it?

12. The industry fully supports any measures taken by the Government to combat drug/driving. We are very concerned that the "the cocktail effect" of drug taking and drinking has the potential to be explosive. Drugs are frequently quoted as being a significant factor in other crimes and driving is no exception. The

[1] Department for Transport Reported Road Casualties in Great Britain: 2009 estimates for accidents involving illegal alcohol levels. Fatalities resulting from drink and drive accidents fell by 5% from 400 in 2008 to 380 in 2009, whilst seriously injured casualties fell by 9% from 1, 620 to 1,480. Slight casualties resulting from drink drive accidents fell by 8% from 10,960 to 10,130. Total casualties fell by 8% from 12,990 to 11,990.
Fatal accidents remained unchanged from 2008, remaining at 350 for the second year in a row. Overall drink and drive accidents fell by 7% from 8,620 to 8,050.

North Report acknowledges that where the Police suspect drugs have been involved, and evidence is found that the offender is over the drink driver limit, then a prosecution for drink/driving will be pursued and the drug issue ignored.

13. We believe this problem is becoming more and more prevalent and we fully support further Government action, including the creation of a new offence for driving whilst under the influence of illegal drugs and the development of new "drugalyser" equipment.

What wider costs and benefits are likely to result from changes to drink and drug driving law?

14. We do not believe that a stricter regime will do anything to reduce drink driving by hard-core offenders but will introduce the element of chance. Much greater enforcement of current laws is what is required.

15. Lowering the current BAC limit will have a significant impact on the viability of many rural and destination pubs. There will be a perception amongst law-abiding pub customers (and a fear-factor) that they cannot safely have even one drink. Despite the wide availability of alcohol-free drinks, customers will feel their dining experience is diminished if they can't have a good pint of beer or a nice glass of wine with their meal.

16. While we need to make it clear we would not wish to hinder any measure that would make a real improvement to road safety, we have a real concern that lowering the limit would not make a significant difference but it would most certainly have an undesirable effect on the hospitality and tourism industry throughout the country. Pubs operate from doing business themselves and are an important and integral part of the tourism industry. Many associated businesses, such as holiday home rentals, B&B's, historic sites and leisure facilities, rely on the location of a pub close to their business to attract visitors also looking for food and entertainment.

17. The tourism and hospitality industry has had to manage many legislative changes in recent years, much of which has added direct costs to business, and others which have had the effect of driving customers away from pubs. Notably, the smoking ban implemented on 1 July 2007 in England (earlier in other parts of the United Kingdom) resulted in reduced footfall affecting many pubs, particularly small community pubs and those which were constrained from adapting to the new situation. It is estimated that the industry invested around £100 million in outdoor areas but the loss of trade caused by the smoking ban has not been fully quantified. However the Valuation Office recently recognised the ban as a material factor in a number of successful rating appeals. (If a pub loses 10–20% of its trade, its viability is at risk). This is a prime example of the consequences that can arise as a result of legislative change. With 39 pubs closing each week any further economic damage will accelerate closures resulting in local unemployment. With each pub on average supporting six jobs another 1,500 pubs could be lost together with 9,000 jobs.

18. Having considered the likely impact of consumer behaviour we have made the following basic calculation of the effects a lowering of the BAC limit might have on the pub sector:

— Approximately 15 million people visit the pub each week.

— We estimate 1.5 million drivers make their journey to the pub in a vehicle (with passengers this number could potentially increase to 2.5 million pub visits each week).

— Estimated spend £20/person/visit = £50m/week.

— If one third of pub customers arriving by car no longer visited the pub there could potentially be a loss of £16.6 million each week (or approx £863 million per annum).

— The greater proportion of this loss will be from reduced food sales. This is approximately 4.5% of pub turnover.

19. The above estimate does not include other parts of the hospitality sector such as hotels and restaurants. We understand from the British Hospitality Association that the impact of a lower drink/drive limit is likely to reduce turnover in hotel and restaurants by £350 million a year and cost some 8,500 jobs.

What would be the implications of such changes for enforcement?

20. It could be argued that more police resource will be required to enforce a lower drink drive limit, and this may even be counter-productive as resources will be stretched more thinly than at present. With more people being caught exceeding a lower limit there could be considerable costs for the police and courts in dealing with such a big increase in offenders.

21. Those continuing to drink and drive way above the limit will continue to ignore the law and take the risk of evading detection.

SUMMARY

22. We believe that the existing drink/drive limit of 80mg/100ml of blood should be retained. It is tried and tested and has the respect of the vast majority of the population.

23. The Police should be given greater powers of enforcement including the introduction of random breath testing to enforce the existing limit. Sufficient time should be allowed for these measures to take effect before any further consideration is given to lowering the current limit.

24. The Government should target its resource at tackling the increasing problem of drug driving through improved detection and punishment.

August 2010

Supplementary written evidence from The British Beer & Pub Association (DDD 15a)

"[Re: Q194 about the number of pubs closing in rural and urban areas] Our source is CGA Strategy who have carried out independent assessment of pub closures over the past few years. During June–December 2009 CGA reported net pub closures per location across England, Wales and Scotland as: Rural (427), Suburban (272) and Urban (314)."

October 2010

Written evidence from the Parliamentary Advisory Council for Transport Safety (PACTS) (DDD 16)

The Parliamentary Advisory Council for Transport Safety (PACTS) is a registered charity and an associate Parliamentary Group. Its charitable objective is "To protect human life through the promotion of transport safety for the public benefit". Its aim is to advise and inform members of the House of Commons and of the House of Lords on air, rail and road safety issues.

(1) *Should the permitted blood alcohol limit be reduced as proposed?*

Yes. Although the evidence around drink-related road death and injury could be improved through more accurate data collection and use, there is a strong evidence base to support a reduction in the BAC limit from 80mg/100ml to 50mg/100ml. Drinking and driving is related to a significant number of deaths and injuries each year in Great Britain both above and below the current Blood Alcohol Content (BAC) Limit.

OVER THE CURRENT BAC LIMIT

Without factoring in the high level of underreporting which has been acknowledged by the Department for Transport (DfT)[2] and which may or may not be of greater importance with regards to illegal levels of alcohol in the blood whilst driving, a high number of road deaths and injuries occur when drivers have a BAC over the current limit. The most recently confirmed figures (2008) show that 400 people were killed and 1,620 people were seriously injured as a result of drink drive collisions.

The provisional estimates for 2009 show that road deaths resulting from drink and drive collisions fell by 5% from 400 in 2008 to 380 in 2009, whilst seriously injured casualties fell by 9% from 1,620 to 1,480. Slight casualties resulting from drink drive collisions fell by 8% from 10,960 to 10,130. The value of prevention of all casualties resulting from drink drive collisions in 2009 is provisionally estimated to be £1.1 billion.[3]

It is reassuring to see a 5% fall in the number of deaths and more than an 8% reduction in the number of serious injuries in collisions involving illegal alcohol levels from 2008 to 2009, particularly as the figures for 2009 show a consistency with the overall trend of significant reductions in death and injury on British roads.

The steady decrease since 2002 in numbers seriously injured in collisions involving illegal alcohol levels has continued for another year. A third successive year with around 400 deaths in collisions involving illegal alcohol levels confirms that such deaths are now clearly fewer than the numbers in the 500s that prevailed for a decade previously. However, these deaths fell by only 2.5% between 2007 and 2008 (final figures) and only 5% between 2008 and 2009 (provisional figure), whereas the corresponding falls in all road deaths were 14% and 12%. Road deaths involving illegal alcohol levels had leveled earlier in the decade at around 18% of all road deaths. The large reduction in alcohol-related deaths in 2007 brought the percentage down to 14, but small reductions in the last two years mean that illegal levels of alcohol featured in an estimated 17% of all road deaths in 2009. So deaths related to illegal drink driving once again represent a rising proportion of all road deaths.

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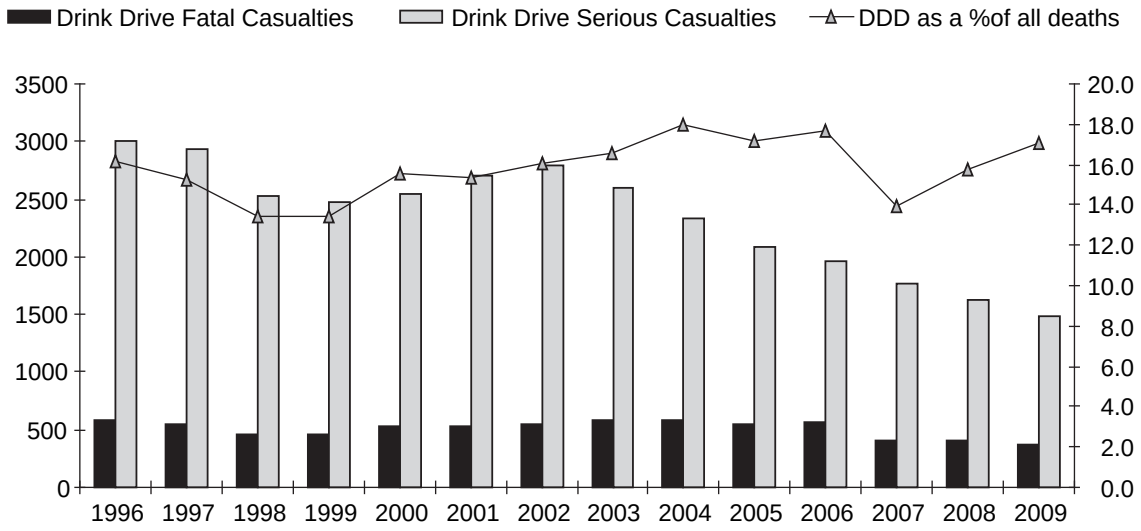
[2] http://www.dft.gov.uk/pgr/statistics/datatablespublications/accidents/casualtiesgbar/rrcgb2008

[3] Based on values provided by DfT in Reported Road Casualties 2008 http://www.dft.gov.uk/pgr/statistics/datatablespublications/accidents/casualtiesgbar/rrcgb2008

Estimated Alcohol-related Road Death and Serious Injury, Actual and as a % of Total Road Death



This rising proportion reinforces the importance of acting promptly and positively on the recommendations made in Sir Peter North's recently published report which recommended, among other things, a reduction in the current prescribed blood alcohol limit in section 11(2) of the Road Traffic Act 1988 of 80 mg of alcohol in 100 ml of blood to 50 mg of alcohol in 100 ml of blood and the equivalent amounts in breath and urine.

The provisional figures for 2009 underline the significant relationship between drink-drive and road death. It is vital that the government prioritizes a commitment to reducing levels of drinking and driving and thus levels of alcohol-related road death and injury as part of a wider commitment to improving road safety beyond 2010. However, some people driving within the current legal BAC limit also incur increased risk as a result of consuming alcohol.

Under the current BAC limit

In 1998, the DETR showed that between 50mg and 80 mg drivers are 2–2.5 times more likely to be involved in a collision than drivers with no alcohol, and up to 6 times more likely to be involved in a fatal crash.[4]

In 2005 PACTS asked Professor Richard Allsop to assess the potential casualty savings which would occur if the legal limit were reduced from 80mg/100ml to 50mg/100ml. His work explored both the likely behavioural elements of such a change based on a broad segmentation of drink-drive behaviours, and replicated the methodologies used by in Maycock in TRL Report 232 (1997) estimating that such a change would result in a reduction of 65 deaths and 230 serious injuries.

Professor Allsop updated these figures for the evidence which he submitted to Sir Peter North during his review of Drink and Drug Driving Law[5] again applying Maycock's exponential formulae for risk as a function of BAC to current DfT statistics on drink drive casualties, estimating that approximately 43 deaths and 280 serious injuries would be prevented each year if the BAC limit were today reduced as proposed.

In the 2005 briefing for PACTS, Allsop outlines three broad groups with regards to the drink drive behaviours of the British driving public:

Group one would never drive with a BAC of 50 or over. This majority group are aware of the message "do not drink and drive" and comply. There are few people in this group who would be affected by a reduction in the BAC limit.

Group two, estimated at 1% of drivers on weekend evenings and nights, already drive with a BAC well over 80 milligrammes. This group are responsible for over 70% of drink-drive deaths each year. Based on the behaviours already undertaken by this group, it is unlikely that a change in the BAC limit would be effective. Evidential roadside breath testing would have the greatest effect on this group and thus make the greatest reduction in numbers of KSI.

Group three, to whom a change in the limit is most relevant, are those people who try to stay within the limits (ie BAC of 30–100 milligrammes). This group make up around 2% of drivers on weekend evenings and nights.

[4] Combating Drink Driving: Next Steps: A Consultation Paper, DETR, 1998
[5] http://northreview.independent.gov.uk/

Allsop suggests therefore that a change in the BAC limit from 80mg/100ml to 50mg/100ml would be specifically relevant to group three in this segmentation. His casualty reduction estimates are as a result more conservative than those provided to the North review by researchers at Sheffield University[6] which additionally assume a behavioural change in other groups.

PACTS has been informed that Professor Allsop will be submitting evidence to the committee including a discussion about the variation in KSI reduction estimates which result from alternative methodologies. Even using this conservative estimate, it is clear that a reduction in the BAC limit to 50mg/100ml will bring about a substantial reduction in KSI each year. Both estimates indicate the significant potential of a change in legislation, with benefits far outweighing costs. The value of prevention of 43 lives and 280 serious injuries is estimated to be around £125 million per annum based on 2008 figures from DfT.[7] Additionally, in paragraphs 3.81 to 3.105 of *The North Report*, public support for a change in legislation is made evident.

(2) *If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?*

PACTS would be supportive of an identical punishment for those drivers caught at the new (lower) level.

Legislation-Education Gap:

Although the safety implications of drinking and driving are clear cut and comprehended in Britain and we have achieved a significant reduction in the occurrence of drink-drive death (all road death fell by around 50% whilst drink-drive road death fell by around 71% between 1980 and 2007,[8]) legislation does not support the educational and promotional messages.

The educational message is "don't drink and drive" and yet the legislation implies that some alcohol before driving is acceptable.

Great Britain continues to suffer from a significant number of drink-drive deaths and injuries each year (see response to question 1). Even with the reduced BAC limit, this firm penalty is appropriate to maximise public comprehension of the impact of behavioural choices surrounding drinking and driving.

There is no reason to suggest that the imposition of a lesser punishment for drivers found to be between 50mg/100ml and 80mg/100ml would be a positive step towards improving awareness, understanding, behaviours or risk around drinking and driving.

Further Evidence Identified in the North Review Process and Published in the North Report which Supports an Identical Punishment for those Drivers Caught at the New (Lower) Level

Paragraphs 3.65, 3.68, 3.113 and 4.19 of *The North Report* show a lack of public understanding about what the current BAC limit is, what amount of alcohol will result in that limit being reached and what the *morning after effect* is. Furthermore, these issues are shown in the same paragraphs to be better understood in neighboring European counties than they are in Britain. As such, those caught over the new limit must observe the same punishment as those above 80mg/100ml to ensure that behavioural messages are replicated by legislation and enforcement.

In paragraph 3.66 of *The North Report*, it is shown that group three drinkers (as identified in the PACTS response to question 1)[9] are likely to drink to achieve a desired state and then balance their consumption against its elimination. They drink and drive whilst aiming to stay within the legal limit using a habitual approach. As such, the habit will need to be altered to ensure that this group stays within the new law.

Habit creation/alteration is dependent on an integrated model which delivers educational and behavioural messages from a range of sources. It is therefore vital that the legislation matches the behavioural messages. Additionally, evidence from Sweden identified in paragraph 4.10 of *The North Report* shows that creating a two-tiered system of punishment for different levels of impairment has resulted in the lesser offence being treated by the public as a minor misdemeanor. Any similar outcome in the UK would simply undermine the message that drinking and driving kills.

(3) *How severe is the problem of drug driving and what should be done to address it?*

TRL report 495,[10] published in 2001, analyzed data collected between October 1996 and June 2000. The report showed that at least one medicinal or illicit drug was detected in 24.1% of the 1,184 casualties, increasing by a factor of around three since a similar study carried out during the 1980s. The report which offers some insight into drug consumption patterns and risk impact concluded that the increase in incidence of legal or illicit drugs in KSI casualties was an area of concern for road safety.

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[6] R Rafia, A Brennan. Modelling methods to estimate the potential impact of lowering the blood alcohol concentration limit from 80 mg/100 ml to 50 mg/100 ml in England and Wales. Report to the National Institute for Health and Clinical Excellence. School of Health and Related Research (ScHARR), University of Sheffield. 2010.38

[7] In 2008 figures as provided by DfTin RRCGB 2008 http://www.dft.gov.uk/pgr/statistics/datatablespublications/accidents/casualtiesgbar/

[8] Reporting inequality and external influences will have affected the reliability of these numbers. http://www.dft.gov.uk/pgr/statistics/datatablespublications/accidents/casualtiesgbar/

[9] This is not stated in The North Report but the characteristics of the two sets are similar.

[10] TRl Report 495 (2001) *The Incidence of Drugs and Alcohol in Road Accident Fatalities,* Prepared for the Road Safety Division, DETR, TRL, Crowthorne

The scale of the problem today is relatively unknown but it is likely to have grown in line with the general increase in the consumption of illicit drugs. As part of a wider approach to understand more about the severity and the implications of the problem of drug-driving we propose testing of all KSI casualties in combination with a coordinated research strategy which should be funded by Government.

Much closer working with the medical profession, locally and nationally, will improve our understanding of this area. Furthermore, it is essential that Great Britain is better represented in International research approaches such as the DRUID study which aimed to give scientific support to the EU transport policy by establishing guidelines and measures to combat impaired driving.[11]

The DRUID study aims include:

— conduct reference studies of the impact on fitness to drive for alcohol, illicit drugs and medicines and give new insights to the real degree of impairment caused by psychoactive substances and their actual impact on road safety,

— generate recommendations for the definition of analytical and risk thresholds,

— analyse the prevalence of alcohol and other psychoactive substances in accidents and in general driving, set up a comprehensive and efficient epidemiological database,

— evaluate "good practice" for detection and training measures for road traffic police allowing a legal monitoring of drivers,

— establish an appropriate classification system of medicines affecting driving ability, give recommendations for its implementation and create a framework to position medicines according to a labelling system,

— evaluate the efficiency of strategies of prevention, penalisation and rehabilitation, considering the difficulties of appropriate evaluation strategies for combined substance use and recommend "good practice",

— define strategies of driving bans, combining the road safety objectives with the individuaĺs need for mobility, and

— define the responsibility of health care professionals for patients consuming psychoactive substances and their impact on road safety, elaborate guidelines and make information available and applicable for all European countries.

DRUID Study Overview of international research: Only a few surveys have been carried out in Europe as well as in Australia regarding the prevalence of drugs in the driving population, one in Australia,[a] the other one in Germany.[b] Both studies are based on saliva samples and indicate similar results for passenger car drivers. About 1% took illicit drugs, primarily cannabis/ stimulants, and about 4–6% took licit drugs, primarily stimulants, hypnotic or anxiolytic drugs, or drugs without impairing effect. Recent studies have been carried out in Denmark,[c] the Netherlands and United Kingdom,[d] the latter two studies were part of the project IMMORTAL of 5th Framework Programme.

Some of the studies also aim at enlightening the problem of an increased risk for driving while impaired, despite the fact that calculations of accident risks are subject to great uncertainties.[e] These calculations indicate that the relative risk of being killed in a fatal accident is significantly increased for drug-impaired drivers compared to drug-free drivers, especially for drivers impaired both by drugs and alcohol.

In some countries a different approach to reveal the size of the problem has been taken. In Australia,[f] Belgium,[g] Spain[h] and Sweden[i] drivers have been interviewed at rest areas or emergency rooms about their drug consumption. Results indicate that 5–10% of the drivers admit use of drugs "hazardous" to road safety, primarily benzodiazepines, and 3–5% admit use of illicit drugs, primarily cannabis or amphetamines.

Even this short overview reveals that our knowledge about prevalence and risk is fragmentary. Neither the situation in each member country is known nor do we have information whether the problems and solutions can be generalised for other countries. The same holds true for legislative and preventive measures, established up to now. Some countries have introduced a zero tolerance law for illegal substances irrespective whether the impairing effect is known or unknown. Other countries pursue a clear impairment approach.

[a] Starmer, G A et al (1997). Drug Usage by Australian Drivers. Proceedings from the 14th International Conference on Alcohol, Drugs and Traffic Safety, Annecy 1997.

[b] Krüger H P, Schulz, E and Margerl, H (1995). The German Roadside Survey 1992–94. Saliva Analyses from an Unselected Driver Population. Licit and Illicit drugs. Proceedings from the 13th International Conference on Alcohol, Drugs and Traffic Safety, Adelaide 1995.

[c] Behrensdorff, I (2001). Medicin og narkotika blandt bilister. Report 3/2001. Danmarks TransportForskning. Kgs. Lyngby.

[11] http://www.druid-project.eu/cln_007/nn_112422/Druid/EN/partner/partner-node.html?__nnn=true

[d] IMMORTAL D-R4-2 (in press).

[e] Parliament of Victoria, Road safety Commission (1996). Effects of drugs other than alcohol on road safety in Victoria. Melbourne, Victoria.

[f] Starmer, G A et al (1997). Drug Usage by Australien Drivers. Proceedings from the 14th International Conference on Alcohol, Drugs and Traffic Safety, Annecy 1997.

[g] Belgian Toxicology and Trauma Study Research Group (1997). A study on alcohol, medication and illicit drugs in driver-victims of road traffic accidents.

[h] Rio, M C & Alvarez, F J (1995): Illegal drugs and driving. Journal of traffic medicine, Vol 23 No 1, 1–5.

[i] Törnros, J (1997). Benzodiazepiner, alcohol och trafiksäkerhet. Experimentelle studier—litteraturöversigt. Väg—och Transportforskningsinstituttet. VTI Meddelande nr. 805. Linköping

Enforcement of Drug Driving Offences should focus on identifying impairment, rather than identifying the presence of drugs in the body. A further simplification of the system could involve the carrying out of blood tests by nurses rather than requiring the often lengthy and costly presence of a doctor.

(4) *What wider costs and benefits are likely to result from changes to drink and drug driving law?*

The value of prevention of drink drive deaths and casualties which would be brought about by a reduction in the BAC limit to 50mg/100ml is considerable, even using the most conservative estimates. Based on estimates provided to the North review by Professor Allsop, the value of prevention of KSI as a result of the proposed reduction in the BAC limit would be around £125 million based on 2008 figures from DfT.

Wider benefits may include reductions in costs to employers based on the Driving for Better Business model,[12] plus wider health benefits associated with greater understanding about the effects of alcohol on the body which may come about.

As explored in our response to question 2 of this submission, The North Report identified high levels of misunderstanding and detachment about the current BAC limit and the relationship between drinking and driving. A change in legislation accompanied by ETP measures and adjustments to enforcement can be used to generate greater awareness about these issues and further communicate the drink-drive message.

Possible knock-on effects of a change in legislation include improved compliance of British citizens when travelling abroad, particularly within neighboring EU countries and improved understanding and control of wider alcohol-related problems in society.

Paragraph 3.133 of the North Report summarizes wider costs which may concern the drinks industry including loss of custom and thus loss of revenue. The evidence in this area is inadequate and would benefit from a monitored trial which took the full range of costs and benefits into account.

(5) *What would be the implications of such changes for enforcement?*

The proposed reduction has important implications for enforcement and will require a joined-up and strategic approach to improve knowledge, understanding and behaviours around drinking and driving.

Enforcement will need to be more vigorous in order to raise awareness about changes made and to ensure that public messages are backed up by activity. In order assist enforcement of this level, drink driving should be included among the "Offences Brought to Justice"[13] which police forces across England and Wales are required to report on.

The proposed change in legislation will require at least short-term and costly increases in visible enforcement of drinking and driving. However, the following actions could ease the additional burden to the Police:

(1) Drink driving should be included among the "Offences Brought to Justice"[14] which police forces across England and Wales are required to report on according to Recommendation (25) of the North Report.

(2) Completion of type approval of evidential roadside breath-testing equipment according to Recommendation (27) of the North Report.

(3) Removal of the statutory option for a blood or urine test where a recorded breath alcohol concentration is within a certain margin above the threshold for prosecution, according to Recommendation (11) of the North Report and the power to require anyone who is actually driving to cooperate with a preliminary breath test.

(4) Intelligence-led targeted breath testing should be made feasible by granting the police the power to require any driver to cooperate with a preliminary breath test.

[12] http://www.drivingforbetterbusiness.com/why/businesscase.aspx
[13] http://www.justice.gov.uk/docs/crim-stats-2007-tag.pdf
[14] http://www.justice.gov.uk/docs/crim-stats-2007-tag.pdf

(5) Wider investment in Field Impairment Testing (FIT) to ensure that all police forces have the required knowledge and equipment that will allow them to more effectively identify impairment.

August 2010

Written evidence from Brake (DDD 17)

About Brake

Brake is an independent road safety charity, dedicated to stopping death and injury on UK roads and caring for people bereaved and seriously injured in road crashes.

Brake carries out research into road users' attitudes on a range of road safety issues, including driver attitudes and behaviour; aspects of learning to drive; training and testing; traffic law and its enforcement; and charges and penalties for traffic offences.

Through trained volunteers, Brake delivers road safety education to thousands of people in their local communities each year. This allows the organisation to collate additional information on the attitudes and self-reported behaviour of drivers.

Brake also provides a range of services for road safety and fleet safety professionals. These include news bulletins and information sheets, workshops and conferences that disseminate international research and information on effective policies and best practice initiatives.

Summary of Brake Recommendations for Government Action

Brake recommends that the Government take the following steps to work towards stamping out casualties caused by drink and drug driving:

- The drink-drive limit to be cut to 20mg/100ml blood.
- A new law making it an offence to drive on illegal drugs without having to prove impairment.
- Random, targeted, and "blanket" testing for drink and drug driving, with more resources for traffic policing, ensuring we have sufficient numbers of officers to carry out a significantly higher number of tests.
- Approval of a roadside drug testing device, such as those already used by the police in Germany, Australia and Finland.
- Mandatory alcolocks for repeat drink-drive offenders, which requires them to pass a breath test before they can start their engine.
- Life-long driving bans for drink and drug drivers who have killed or maimed.
- Compulsory road safety education, delivered in schools, to 11–16 year olds outlining the horrific consequences of drink and drug driving.

Should the permitted blood alcohol limit be reduced as proposed?

Lowering the drink-drive limit would be a vital step in eliminating the unnecessary deaths and injuries caused each year by drink-drivers, and therefore in reducing the huge social and economic burden of road casualties.

Drink drivers (those who are over the current limit) still account for one in six road deaths in the UK. In 2009 there were 380 deaths and 1,480 serious injuries resulting from drink drive crashes.[15]

Brake believes that the blood alcohol limit should be reduced to 20mg alcohol per 100ml blood—a zero tolerance approach that allows for residual and naturally occurring alcohol in the body. This is in line with research showing that even small amounts of alcohol in the blood lengthen reaction times, impair judgment, and make you more susceptible to sleepiness. One recent academic study showed a significant deterioration in driving skills when drivers had 40mg alcohol per 100ml of blood.[16] A NICE review concluded that those with 20–50mg alcohol per 100ml of blood are at least three times more likely to die in a crash than those with no alcohol in their blood.[17]

Brake believes that a lower limit of 20mg would help to eliminate confusion among drivers about how much alcohol they can consume legally and safely if they are driving. The Government's own advice states that you should not drink any alcohol if you are driving, but our current limit is interpreted by many as meaning that one or two drinks before driving is safe and legal. Brake's 2010 survey of 800 drivers showed that many drivers don't understand that their driving will be affected after a very small amount of alcohol:

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[15] Reported Road Casualties in Great Britain: 2009 estimates for accidents involving illegal alcohol levels, Department for Transport, 2010

[16] Alcohol Consumption Impairs Detection of Performance Errors in Mediofrontal Cortex, The University of Leiden, 2002

[17] NICE Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths, 2010

31% thought their driving wouldn't be affected unless they drank two units of alcohol, while 14% thought their driving wouldn't be affected unless they drank three or four units.[18] Brake is concerned that this confusion would prevail if the limit was lowered to 50mg rather than 20mg.

Brake's 2010 survey of drivers on drink and drug driving also indicated that not only do the majority of drivers (71%) support a lower drink-drive limit, the majority of those would prefer a 20mg limit: of the 800 drivers we surveyed, 55% supported a 20mg limit, while 16% supported a 50mg limit.[19]

Research carried out by Sheffield University, which examined casualty trends in England and Wales against the success of lowering the limit in other European Countries and Australia, estimated that lowering the limit to 50mg would save in the region of 77–168 deaths each year in England and Wales alone.[20] Brake believes that lowering the limit to 20mg is likely prevent even more deaths, given the academic evidence showing the detrimental effects on driving of consuming less than 50mg of alcohol per 100ml of blood, and given the impact in other countries of lowering their drink-drive limits to 20mg. When Sweden lowered its drink-drive limit from 50mg to 20mg per 100ml of blood, drink-drive deaths fell by 10%.[21]

Evidence from other countries also suggests that lowering the drink drive limit is effective in reducing drink driving among those who exceed the limit by a larger margin, as well as those would otherwise be under the limit had it not been reduced. This found to be the case in the Australian Capital Territory when it reduced its limit from 80mg to 50mg per 100ml of blood in 1991.[22]

If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?

Brake believes that we should retain the mandatory driving ban for all drink drive offenders if a lower limit is imposed, and that this should be of *at least* one year for all offenders. This reflects the level of danger posed by those who drive after drinking even a small amount of alcohol, and sends a clear message to drivers that no level of drink driving will be tolerated. It is also in line with public opinion—64% of AA members surveyed earlier this year favoured a 12 month ban or more for all offenders if the drink drive limit is lowered to 50mg.[23]

Brake additionally recommends that this penalty (along with the other common consequences of drink driving, such as death and life-changing injury) should be publicised at the same time as bringing in a lower drink drive limit, to act as an effective deterrent.

Repeat offenders and drink-drivers who exceed the limit by a large margin are shown by research to be less responsive to a fine and driving ban alone.[24] Therefore Brake believes these offenders should also be given a driving ban of at least one year, but they should return to driving only following appropriate rehab courses and with alcohol locks fitted to their vehicle. This is a better long-term solution for these offenders as they are supported in altering their attitudes and behaviour at the same time as being prevented from driving if over the limit.

Research has shown that rehabilitation courses can be effective in reducing drink drive crashes, and that they are most likely to be effective with large margin offenders. Several studies have also shown that using alcolocks results in 65–90% less repeat offences than using a driving ban alone.[25] Following a review of research into what is most effective in tackling drink driving among these "high risk" offenders, the European Transport Safety Council recommended a combination of rehabilitation courses with use of alcolocks.

Brake also recommends life-long driving bans for drink or drug drivers who have killed or maimed. For many victims of drink and drug drivers, this is the only meaningful justice for offenders who have taken the decision to drive drunk or drugged and have caused such destruction.

How severe is the problem of drug driving and what should be done to address it?

Prevalence of drug driving, and effects of drug taking on driving:

Drugged driving is a widespread and often hidden menace in the UK. While not many drivers admit to it in surveys (for obvious reasons), research by TRL has found 17.7% of UK drivers who die in crashes have traces of illegal drugs in their system, a six fold increase from levels in the 1980s.[26]

A 2005 study carried out in the UK, Norway and the Netherlands estimated that 10.8% of drivers stopped at the roadside for testing were drug users.[27]

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[18] Fit to drive? Brake and Direct Line Report on Safe Driving Part Two, Brake, 2010
[19] Fit to drive? Brake and Direct Line Report on Safe Driving Part Two, Brake, 2010
[20] R Rafia, A Brennan, Modelling methods to estimate the potential impact of lowering the blood alcohol concentration limit from 80 mg/100 ml to 50 mg/100 ml in England and Wales, Report to the National Institute for Health and Clinical Excellence, School of Health and Related Research (ScHARR), University of Sheffield, 2010
[21] The Globe 2003 issue 2, Institute of Alcohol Studies, 2003
[22] Brooks C, Zaal D, Effects of a reduced alcohol limit for driving, Australia: Federal Office of Road Safety , 1993
[23] Populus survey of 20,417 AA members, February 2010
[24] Vehicle interlock programs: Protecting the community against the drunk driver, Marques, P R, Voas, R B, & Hodgins, D, Journal of Prevention and Intervention in the Community, 1998
[25] Drink Driving Recidivism Factsheet, European Transport Safety Council, December 2008
[26] Tunbridge, R J; Keigan, M; James, F J, The incidence of drugs and alcohol in road accident fatalities, TRL report 495, 2001
[27] Assum T, Mathijssen M P M, Houwing S, Buttress S C, Sexton B, Tunbridge R J and Oliver J, The prevalence of drug driving and relative risk estimations—a study conducted in The Netherlands, Norway and United Kingdom, IMMORTAL EU research project, 2005

A number of studies have demonstrated the effects of drugs on driving, including:

— The Universite Claude Bernard in France found that taking cannabis almost doubles the risk of being involved in a fatal car crash. The researchers studied the details of 10,748 fatal car crashes between 2001 and 2003 and concluded that even after accounting for other factors, 2.5% of the crashes were directly attributed to cannabis use.[28]

— Ultrecht University in the Netherlands concluded in a recent study that most "drugs of abuse" have a negative effect on driving performance, and that a substantial number of drug users are not aware that their driving is impaired. The study highlighted that drivers on cocaine, ecstasy and amphetamine often overestimate their driving skills, and that this combined with impaired decision making increases risk taking during driving.[29]

Brake's calls for Government action on drug driving:

Brake is calling for the law to be changed so drivers registering any level of illegal drugs in their blood stream can be found guilty of an offence of driving under the influence of drugs, whether or not it can be proven their driving was impaired.

More than nine out of 10 drivers (92%) surveyed by Brake and motor insurer Direct Line in 2009 stated that they would support the introduction of a new anti drug drive law to enable prosecution of anyone driving on illegal drugs, without the need to prove impairment.[30]

We also need urgent approval of roadside testing for drugs that can be used to carry out random and targeted checks on drivers at the roadside, and for procedures to be put in place to ensure evidential testing is carried out promptly following initial screening.

Brake is also calling for traffic policing to be made a national policing priority, and for greater investment in traffic policing so there are sufficient numbers of traffic police available to carry out appropriate numbers of roadside tests for both drink and drugs—so drivers understand that there is a significant chance of being caught if they do drive on drugs (see section below on implications for enforcement).

Finally, Brake would like to see greater investment in publicity campaigns on both drink and drug driving, particularly targeting young males. We are also calling for the Government to make road safety a compulsory part of the national curriculum, so all young people are given an understanding of the risks of driving on drink and drugs, information to help them make safe choices (such as the effects of different drugs on driving, and how long they stay in the body), and the opportunity to develop strategies for keeping safe in different scenarios where they may be tempted to drive on drink or drugs or get a lift with someone who has.

What wider costs and benefits are likely to result from changes to drink and drug driving law?

Road casualties are a huge social and economic burden. Each death on the road is estimated to cost society in the region of £1.7 million, due to costs to emergency and health services and other factors such as loss of earnings. The total annual cost of road deaths and injuries in Great Britain is estimated at £17.9 billion by the Department for Transport.[31] Using these figures, the annual cost of drink-drive deaths (caused by drivers over the current limit) alone is just under £640 million. Therefore any reduction in casualties not only reduces the trauma caused to those families directly affected, but also has a positive economic impact, which may be long-term as long as the lower casualty levels are maintained.

Evidence suggests that lowering the drink-drive limit to 50mg would prevent an estimated 77 to 168 deaths per year in England and Wales alone.[32] Taking the higher end figure, this would generate a financial saving of nearly £283 million per year, without taking into account the value of preventing injuries. Lowering the limit to 20mg is likely to prevent even more deaths (see arguments made above).

Other research has been carried out internationally into the cost-benefit ratio of implementing some of the specific measures recommended by Brake. The World Health Organisation has highlighted that for every $1 spent on random breath testing, cost savings of $19 are generated.[33]

Case studies from other countries offer evidence that the measures recommended by Brake would be effective in reducing road deaths and injuries:

— Drink-drive deaths fell in Austria, Belgium and France after lowering drink-drive limits. When Sweden lowered its drink-drive limit from 50mg to 20mg per 100ml of blood, drink-drive deaths fell by 10%.[34]

[28] Cannabis Doubles the Risk of Fatal Crashes, New Scientist, 2 December 2005
[29] Drugs of abuse, driving and traffic safety, Utrecht University, Netherlands, March 2010
[30] Fit to drive? Brake and Direct Line Report on Safe Driving Part Two, Brake, 2010
[31] Road Casualties Great Britain 2008, Department for Transport 2009
[32] R Rafia, A Brennan, Modelling methods to estimate the potential impact of lowering the blood alcohol concentration limit from 80 mg/100 ml to 50 mg/100 ml in England and Wales, Report to the National Institute for Health and Clinical Excellence. School of Health and Related Research (ScHARR), University of Sheffield, 2010
[33] Peden M, World Report on Road Traffic Injury Prevention, World Health Organization, 2004
[34] The Globe 2003 issue 2, Institute of Alcohol Studies, 2003

— In the Netherlands, the number of screening tests nearly doubled between 2000 and 2005. This increase was coupled with a publicity campaign and an increase in drink driving penalties. There was a marked drop in the number of drivers over the limit during weekend nights from 4.2% in 1999 to 2.8% in 2005.

— In 1982, police in New South Wales, Australia, introduced a programme of random breath testing. Highly visible checkpoints were established on main routes and vehicles were chosen at random and breath tested. Approximately one million tests were administered each year, to a driving population of about three million; to achieve this, police were taken off general patrol duties. By the fifth year of the system being in place, more than 50% of drivers in Sydney had been tested at least once and more than 80% had seen the system in operation. Extensive publicity was given to the programme from the start. The introduction of random breath testing saw a 22% drop in the total number of fatal crashes and a decline of about 36% in alcohol-related fatal crashes, based on the figures from the previous three years.[35] In 2005, 3.4 million breath tests were carried out across the state.[36]

— In New Zealand, police carry out about 1.5 million compulsory breath tests each year (where they stop every vehicle on a particular road), plus an additional 800,000 tests by mobile officers on drivers stopped as a result of poor driving. This represents about half of the country's population. Since the introduction of compulsory breath testing in the mid-1980s drink and drug drive deaths have fallen by 62%, from an average of 310 deaths per year in 1985–97, to an average of 118 deaths per year in 2005–07.[37]

— Police in North Rhine-Westfalia, Germany began using roadside sweat and saliva swabs to check for drug-impaired drivers in 2003. The roadside saliva swabs, coupled with new laws on drug-driving, have helped German police officers identify and catch drug drivers more quickly and easily. In 2007, 49,000 drivers were prosecuted for drug driving offences in Germany.[38]

What would be the implications of such changes for enforcement?

International evidence shows that when drivers know they are unlikely to "get away with it", they are much less likely to risk drink or drug driving.[39]

During 2008, there were 711,658 screening breath tests carried out in England and Wales. Breath test numbers fell dramatically during 1998–2002, and although they increased between 2003–08, they have not yet returned to the levels of the late 1990s. There is also a huge amount of variation between police force areas in numbers of breath tests carried out per 100,000 of the population, from 231 in West Midlands to 4,420 in North Wales.[40] A 2004 study concluded that only 3% of British drivers had been breath-tested in the previous three years—far below the European average.[41]

Brake believes that to effectively tackle drink and drug driving, we need far more enforcement checks to be carried out at the roadside—making it clear that drink and drug driving will not be tolerated, and there is a significant chance of being caught if you do break the law in this way. Brake wants traffic policing to be made a national policing priority, and for Government to work with police to ensure that sufficient resources are allocated to enable a significant increase in roadside enforcement checks.

National casualty statistics, and evidence from other countries, suggest that increasing the numbers of breath tests tends to result in a decrease in the number of drink drive casualties. Research in Queensland indicated that for every increase of 1,000 in daily breath tests, there was a 6% drop in serious crashes and a 19% drop in single vehicle night time crashes.[42]

Research and experience also indicate that to effectively deter and detect drink and drug driving, a combination of targeted breath testing and high-profile random or blanket testing should be carried out. Police therefore need to have sufficient powers to pull over drivers and breath test them without necessarily having reason to suspect that a driver has been drinking or committed another offence. Random testing is allowed in most EU countries, the only exceptions being the UK and Denmark.[43] In Australia and New Zealand, police frequently run enforcement campaigns where they pull over every driver (or one in every so many drivers) on a particular road for breath testing. Brake wants UK police to be given the resources and the powers to do the same in the UK. In 2004 the European Commission recommended that member states introduce random breath testing to complement enforcement based on suspicion, and ensure that random testing is regularly carried out in locations where and at times when drink driving is known to be common.

[35] Random Breath Testing in New South Wales, published in The Promise of Crime Prevention: Leading Crime Prevention Programmes, Grabosky, P & James M, 1995
[36] RTA New South Wales, www.rta.nsw.gov.au
[37] Motor Vehicle Crashes in New Zealand 2007 (NZ Ministry of Transport, 2008)
[38] Roadside Testing Devices: an objective approach to enforcing drug-drive laws', Chief Superintendent Georg Bartel, Ministry of the Interior, North Rhine-Westfalia, Germany. Member of TISPOL's Working Group on Alcohol and Drugs. Brake international conference on Drink and Drug Driving, 2009
[39] World Report on Road Traffic Injury Prevention, World Health Organization, 2004
[40] Police Powers and Procedures, England and Wales 2008–09, Home Office, 2009
[41] SARTRE European drivers and road risk, Part 1. Report on principal report and analyses, INRETS, Arcueil, 2004.
[42] J Henstridge, R Homel & P Mackay, The Long-Term Effects of Random Breath Testing in Four Australian States: A Time Series Analysis, Canberra: Federal Office of Road Safety, 1997
[43] Random Breath Testing Amendment to the Railways and Transport Safety Bill, PACTS, 2003

In addition to ensuring sufficient numbers of random and targeted tests are carried out at the roadside, it is also crucial that evidential testing is carried out promptly following a driver being stopped. Brake therefore believes the Government should introduce portable evidential testing devices as soon as possible, so that drink and drug drivers do not have time to sober up before evidential testing is carried out.

August 2010

Written evidence from the Association of British Drivers (ABD) (DDD 19)

SUMMARY

— The ABD supports the advice that drivers should not drink at all if they are planning to drive. Nevertheless, it would not support a reduction in the legal blood alcohol level, since there is little credible evidence that drivers with blood alcohol concentrations in the 50–80 mg range pose a significant risk. The greatest risk comes from drivers exceeding the current limit by a substantial margin, so better enforcement of the existing law would produce much greater safety dividends than reducing the limit.

— A reduced limit would also result in an increase in morning-after convictions, when drivers might be slightly over the limit but show little sign of impairment. There is evidence that impairment is less for a given blood alcohol concentration when the level is falling than when it is rising. Punishing otherwise responsible individuals for slightly exceeding a lower limit in these circumstances could create resentment and undermine the current support for drink driving legislation.

— If the legal limit were reduced, retaining the mandatory disqualification for drivers with a blood alcohol concentration between the new and old limits would be a disproportionate punishment. A flexible system of penalties would need to be introduced, as is the case in several other countries.

— The ABD recognises the difficulty of tackling drug driving, when there are so many substances involved and it may be hard to establish levels at which a driver becomes unfit to drive. Nevertheless, fair enforcement has to be based on impairment and the ABD would not support the creation of an absolute offence of driving with any trace of an illegal drug in the body, regardless of whether it affected a driver's ability. Efforts should be concentrated on producing more effective tests of impairment.

— A lower drink-drive limit could have social and economic consequences for rural communities, with the accelerating closure of public houses. More people could decide to drink cheap alcohol at home, increasing alcohol consumption overall.

— A reversal of the decline in police traffic patrols is needed in order to deter those who are tempted to drive while unfit through drink or drugs. There is no need for random testing, as this would waste police resources that should be targeted at those showing clear signs of impairment.

INTRODUCTION

1. The Association of British Drivers (ABD) was formed in 1992 to campaign for a better deal for Britain's motorists. The ABD believes that laws affecting drivers should be reasonable and enforcement of them should be fair and proportionate.

2. The ABD is a voluntary organisation funded by subscriptions and donations from its members and supporters. It receives no funds from public bodies or large corporate donors, so is truly independent. The ABD is a member of the Parliamentary Advisory Council for Transport Safety and the National Council of Voluntary Organisations.

3. Many of the ABD's active members are from professional or managerial backgrounds. Malcolm Heymer, who is submitting this evidence on behalf of the ABD, holds a master's degree in Transportation Engineering and has over 30 years' local government experience in the fields of transportation modelling, highway engineering, transport planning and traffic engineering. Mr Heymer is willing to give oral evidence to the Committee if requested.

4. The following sections of this submission address the questions raised in the call for evidence as a result of Sir Peter North's report.

PERMITTED BLOOD-ALCOHOL LIMIT FOR DRIVING

5. The ABD believes that the current limit of 80 mg of alcohol per 100 ml of blood is the best compromise between deterring irresponsible behaviour and unnecessarily penalising drivers who present a very low risk. The ABD does not condone drinking and driving, and supports the advice that ideally drivers should not drink at all if they plan to drive. The ABD opposes a reduction in the legal limit, however, partly because it would cause more responsible drivers to fall into the morning-after trap. The current limit also has widespread support, with little sympathy for those caught in excess of it. This could change if the limit were reduced.

6. In November 2008 the Department for Transport published a consultation on road safety compliance, which included a section on drink driving. Table 3.2 of the consultation paper (reproduced below) showed that just 1% of drivers and riders killed in road accidents had a blood-alcohol concentration (BAC) in the range 50–80 mg. The figure was 2% in the range 80–100 mg and rose substantially at higher levels. The fact that a driver had some alcohol in their system does not necessarily mean that this was the cause of their accident, since they could have been the innocent victim of another road user's error or bad driving. There is always more than one contributory factor in any accident.

Table 3.2

PERCENTAGE EXCEEDING VARIOUS BLOOD ALCOHOL LEVELS; AND PROPORTION OF FATALITIES EXCEEDING 80 ML/100ML BY TIME OF DAY

	Percentage blood alcohol levels (mg/100ml) in each band						*Percentage over 80mg/100ml at time shown*	
	200+	*150–200*	*100–150*	*80–100*	*50–80*	*Sample size*	*22:00–03:59*	*04:00–21:59*
Motorcycle riders	4	5	2	1	1	447	40	9
Cumulative	4	9	11	13	14			
Other vehicle drivers	11	8	6	2	1	848	53	17
Cumulative	11	19	25	26	28			

7. In February 1998 the former Department of the Environment, Transport and the Regions (DETR) published a consultation document on combating drink driving. In Annex 1 to that consultation, reference was made to roadside surveys conducted at various sites around Britain between 1988 and 1990. These showed that 2.3% of drivers tested (ie a sample of all drivers, not just those suspected of drinking) had a BAC in the 40–80 mg range. Reference was also made to a study of road accident victims attending the John Radcliffe Hospital, Oxford, during the same period. This showed that 2.1% of drivers treated had a BAC in the 50–80 mg range. These figures suggest that the proportion of drivers involved in accidents with a BAC level between 50 and 80 mg is much the same as that of the driving population as a whole, indicating that there is no perceptible increase in risk at this BAC level.

8. Since Table 3.2 shows rapidly growing percentages of drivers killed as BAC levels exceed 100 mg, there can be little doubt that alcohol is more likely to be the main contributory factor as BAC levels rise. The figures given in the earlier DETR consultation suggest there would be a negligible impact on accidents if the limit were reduced to 50 mg. The main problem is clearly caused by those who exceed the current limit by a substantial margin, so this is where action should be targeted.

9. The North Report (paragraphs 3.29 to 3.32) claims very high increases in the risk of being involved in a fatal accident at BAC levels well below the current legal limit: three times greater for a BAC in the 20–50 mg range compared with a driver with no alcohol and six times greater in the 50–80 mg range. These figures are derived from a 1991 study by the Transport Research Laboratory (TRL 232). As recognised in the North Report, this study had its limitations and was much smaller than the "Grand Rapids" 1964 study on which the current legal limit of 80 mg per 100 ml of blood was based. The latter showed a risk increase of no more than 1.5 times at the 80 mg level.

10. The very high risk factors quoted in the North Report are at odds with reported BAC levels in fatal accidents and are intuitively not credible, otherwise moderate drinkers would be more heavily represented in the accident figures. In practice, most responsible drivers do not attempt to drink up to the BAC limit, as they have no way of measuring their BAC and there are so many unknowns that affect the way an individual absorbs and processes alcohol. Consequently they leave a wide margin for error.

11. A lower limit would make responsible drivers more vulnerable to the morning-after trap, when they have avoided driving while drinking the night before but could still be over the limit the following day. There is evidence that, for a given BAC, a driver is more impaired when the level is rising than when it is falling. The following comes from *Loosening the Grip: A handbook of alcohol information* by Kinney and Leaton (ISBN 0-8016-2769-9, page 42 in the 1991 edition):

> "The neurophysiological basis for intoxication is not fully understood, but the intensity of the effect is directly related to the concentration of alcohol in the blood, and hence the brain. The degree of intoxication is also dependent on whether the blood alcohol level is rising, falling, or constant. It is known that the central nervous system and behavioural effects of a given blood alcohol concentration (BAC) are greater when it is rising. This is called the *Mellanby effect*. It is as if there were a small 'practice effect' or short-term adaptation by the nervous system to alcohol's presence. Thus for a given blood alcohol level, there is more impairment if the blood level is rising than is found with the same BAC when the level of alcohol in the blood is falling."

12. Consequently, a driver might feel, and be, safe to drive the next morning while still having an illegal level of alcohol in their blood. Drivers prosecuted for having a BAC in the 50–80 mg range in these circumstances might feel they have been treated unjustly, and this could weaken support for the drink-driving laws. While no fixed limit for BAC can ever exactly match the level at which significant impairment begins in different individuals, the current limit has the virtue of being based on a large-scale study in the 1960s and is generally accepted as reasonable. This is important and the current limit should not be reduced unless strong evidence emerges that a lower limit would prevent a significant number of accidents. No credible evidence to that effect appears to exist at present.

Punishment of Drivers with Low Blood-alcohol Levels

13. If the blood alcohol limit were reduced, which the ABD hopes will not happen, it would certainly be necessary to impose a lower penalty for drivers in the 50–80 mg range. Removal of the mandatory driving ban would be essential to avoid unduly harsh penalties for those representing very little risk. If the current mandatory one-year ban were retained for drivers with a BAC in this range, it would be disproportionate and at odds with the practice in most other European countries. The law could quickly fall into disrepute.

14. Some other countries operate a sliding scale of penalties according to the degree to which a driver exceeds the legal alcohol limit. This more flexible approach would be beneficial in the UK, especially if the blood alcohol limit were lowered. It is right that extreme offenders should be treated severely, but those posing little risk should face lower penalties.

The Problem of Drug Driving

15. The ABD accepts that drug driving is a more difficult problem to tackle than drink driving, since many substances, both legal and illegal, may be involved and taken singly or in combination. The existing law may be difficult to enforce, therefore, on the basis of subjective tests of impairment.

16. It would not be acceptable, however, in the interests of securing easy convictions, to introduce a law that made it an absolute offence to drive with any trace whatsoever of an illegal drug, if there was no evidence of actual or likely impairment at the measured blood level. Traces of some drugs, notably cannabis, can be detected long after any impairment effects have disappeared. While the use of illegal drugs should be discouraged, this worthy aim must not be pursued by punishing drivers who are not causing actual danger.

17. Given the speed with which new "designer" drugs can be developed, a list of proscribed drugs will quickly become out of date. Efforts should be concentrated, therefore, on developing better ways of assessing impairment at the roadside or in a police station to enable those who present a real danger to be dealt with effectively.

Costs and Benefits of Changes to Drink and Drug Driving Law

18. As explained above, the ABD considers there would be very little benefit from a reduction in the legal blood-alcohol level for driving, since it would be unlikely to have a significant effect on casualties. It would, however, be likely to lead to more convictions of responsible individuals caught in the morning-after trap, which would cause resentment and bring the law into disrepute.

19. The wider implications would most probably include an accelerated rate of closure of public houses in rural areas, with detrimental economic and social consequences for those communities. Paradoxically, rather than reduce drinking overall, a lower limit could cause more people to stay at home and drink cheap alcohol from supermarkets rather than drink responsibly in the more controlled environment of public houses.

20. The development of better impairment tests for drivers suspected of drug-driving could help address this apparently growing problem, especially among the young. The creation of new, absolute offences, however, could lead to needless and unfair prosecutions, undermining respect for the law.

Implications for Enforcement

21. Whether drink and drug laws are changed or not, there needs to be a sufficient police presence on the roads to act as a deterrent, which is more important than detecting offences once they are committed. The ABD believes the police have adequate powers to stop anyone they suspect of drink or drug driving, so there is no need for a specific power to carry out random testing. Indeed, if random testing were allowed, it is likely that police resources would be wasted in carrying out tests on innocent drivers when they should be targeting those showing clear signs of impairment.

22. Police patrols have been reduced in many parts of the country in recent years, as the number of speed cameras has increased. Cameras cannot, of course, detect drink or drug driving (or many other driving offences), so there is an increased perception by those tempted to flout the law that they are unlikely to be apprehended. With the current constraints on public spending, it is increasingly important that available

resources are targeted to greatest effect. There are welcome signs that many local authorities are reducing their expenditure on camera enforcement, which has mainly detected technical offences, so it is to be hoped that the tide is turning in favour of a greater police presence to tackle behaviour that is actually dangerous.

August 2010

Written evidence from Concateno (DDD 21)

INTRODUCTION

1. Concateno welcomes the Transport Select Committee's Inquiry into Drink and Drug Driving Law. Below, Concateno responds to the call for evidence with information about drug driving based on our significant experience of roadside testing overseas, combined with our extensive expertise in drug testing in the UK.

CONCATENO—IN BRIEF

2. Concateno (www.concateno.com) is Europe's most experienced provider of drug and alcohol testing. It is a long-standing supplier of drug testing solutions to UK government, the wider public sector and the private sector as well as internationally—including:

- Active roadside testing for drug driving in countries such as Australia, Croatia, Italy and Spain using an onsite, portable saliva testing solution—the UK-manufactured Cozart® DDS®
- Home Office Drug Intervention Programme (DIP)—the programme that uses the DDS in police custody suites for testing arrestees and that recently carried out its millionth test
- HM Prison Service's Mandatory and Voluntary Drug Testing programmes
- More than 85 percent of UK police forces use Concateno's solutions for forensic, employment and pre-employment testing

DRUG DRIVING—THE FACTS

3. According to the Royal Society for the Prevention of Accidents, around 18 percent of people killed in road accidents have traces of illegal drugs in their blood—a six-fold increase since the mid 1980s.[44]

4. The worst offenders for driving under the influence of drugs are those aged 25–34, with some nine percent of this group admitting to such activity. Meanwhile, a quarter of 17–24 year olds claim to have been in a car when they believed the driver to be under the influence of drugs, according to the RAC.[45]

5. When considering drug driving, the broader context of UK drug use is insightful. Based on findings from the latest British Crime Survey, around one in 20 people had used illicit drugs in the last month.[46] With potentially more than 43 million drivers on UK roads, according to DVLA figures,[47] it could be inferred that up to 200,000 drivers could also be regular drug users.

6. While such evidence of drug driving is indicative of a real problem in the UK, there is a significant lack of any *substantial* data on its prevalence—particularly when compared to the statistical data available for drink driving.

7. There is an urgent need for the UK to better understand how many drug users go on to drive while under the influence of drugs, and for more action to tackle the danger and improve road safety.

8. When it comes to testing for drug driving in the UK, findings from a YouGov poll commissioned by Concateno[48] showed that:

- More than nine out of ten (92%) people agree with the statement that drug driving is as socially unacceptable as drink driving.
- 91% support drug testing at the roadside and would not object to being tested for drugs.

CONCATENO'S CURRENT DRUG DRIVING TESTING DEVICE

9. Concateno provides an onsite, portable saliva testing solution—the Cozart® DDS®—that is currently being used for roadside testing programmes in various countries including Australia, Croatia, Italy and Spain.

10. Using the DDS, police can detect up to six different drugs from a single oral fluid sample in a matter of minutes.

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[44] Royal Society for the Prevention of Accidents: Drink, Drugs and Driving, http://www.rospa.com/roadsafety/citizenship/drink_drugs.pdf
[45] RAC Report on Motoring 2009
[46] Home Office Statistical Bulletin, Drug Misuse Declared: Findings from the 2008/09 British Crime Survey
[47] DVLA, Driver and Vehicle Statistics, Drivers Statistics at a Glance, http://www.dft.gov.uk/dvla/pressoffice/media/doc/press_stats/drivers_aag.ashx
[48] YouGov:Concateno survey conducted online between 17–19 November 2009. All figures from YouGov Plc

11. Sampling takes approximately 30 seconds, results for the presence of six drugs are displayed in five minutes, and two drugs in 90 seconds, with both options being significantly quicker than the Field Impairment Test currently used by police in this country as the initial means of assessing whether someone is driving under the influence of drugs.

12. While not used at the roadside in the UK, the DDS is used in police custody suites as part of the Home Office's Drug Intervention Programme (DIP), running since 2003, which tests individuals arrested for trigger offences—such as burglary—for opiate and cocaine use. The DDS is currently used in 174 police custody suites in England and Wales as part of the DIP to carry out 240,000 tests annually

Italy and Concateno: testing for drug driving

13. Concateno has sold over 200 DDS units to Italian police forces, including Milan, Naples, the Piedmont region and Rome. In total, the Carabinieri use the DDS in seven different cities.

14. Rome City Hall approached Concateno recently for the provision of 750 tests to support a three-month drug driving test trial starting July 2010. Rome is considering issuing a tender for all 23 Roman municipalities to be supplied with mobile drug testing kits for suspected drug driving offenders.

15. In a separate development to this, the central Italian Government is considering a trial of four drug testing devices including the Cozart DDS to be carried out later in 2010. The purpose will be to establish a standard device for police forces across Italy.

16. The Italian police experience demonstrates satisfaction with the DDS device as an effective deterrent against drug driving.

Australia and Concateno: Testing for Drug Driving

17. Concateno has been providing random roadside drug testing for the Australian police since 2004. The State of Victoria, which is at the forefront of the country's road safety initiatives, was the first in the world to effect a change in legislation and allow random testing. Other Australian states have subsequently followed, including Queensland, New South Wales, Western Australia, South Australia and Tasmania.

18. Since the introduction of this testing regime, a clear trend has been seen in the State of Victoria, with incidences of drivers detected with illicit drugs present halved over a five-year period, from one driver in 44 to one driver in 94, and a reduction in the involvement of illicit drug in road trauma has occurred. This means that fewer drivers are driving while taking drugs, indicating that a regime such as the one adopted by Australia is effective in reducing drug driving and contributing to safer roads. Concateno believes that this significant impact has been due to the combination of an effective, highly visible roadside enforcement process with driver awareness media campaigns.

19. Australia's head of roadside testing for the *State of Victoria Police*, Inspector Martin Boorman, said: "In Australia, the use of roadside drug testing technology has proved extremely successful and has certainly helped to make our roads safer. Roadside drug testing, much like the roadside alcohol screening test, acts as a deterrent, but also provides the police with a quick and effective means to help catch those people who drive while using illegal substances. This technology, used in conjunction with a widespread educational campaign, has and continues to be extremely successful."[49]

Field Impairment Tests—Low Uptake for Testing for Drug Driving

20. Current law in this country states that:

- A person who, when driving or attempting to drive a motor vehicle on a road or other public place, is unfit to drive through drink or drugs is guilty of an offence.
- A person shall be taken to be unfit to drive if his ability to drive properly is for the time being impaired.[50]

21. Although the offence is very clear, this question of impairment means it can be difficult for police to enforce. Currently the best available method of detecting drug use at the roadside is the Field Impairment Test (FIT), which relies on specially trained traffic officers observing an individual's performance in physical and mental skills tests and other elements (eg pupil dilation).

22. Yet FIT tests are not currently used consistently as a matter of course by all UK police forces. The statistics highlight a huge difference between the numbers of tests conducted for drug driving compared to those for drink driving. They also show that a proportionately higher number of drivers tested positive for drugs than for alcohol.

23. According to the national Association of Chief Police Officers, figures from the 2009 Christmas drink and drug driving campaign[51] show that:

- Police conducted 223,423 breathalyser tests for alcohol—three percent were positive, failed or refused.

[49] Concateno press release 20th August 2010: Oslo: Concateno to preview new drug testing device at ICADTS
[50] Road Safety Act 1988, Sections 4(1) and (5)
[51] http://www.acpo.police.uk/pressrelease.asp?PR_GUID={7F46F85D-50B5-44BE-AFE6-5F6CB2191659}

— In comparison, just 489 Field Impairment Tests were carried out for drug driving—with 18% arrested.

— The total number of drink driving tests was up by almost 22%.

— This compares to less than a two percent increase in drug driving tests.

What Concateno Advocates

24. Concateno's recommendations to help Government in this country make Britain's roads the safest in the world would be:

— Evolve current UK law by changing the emphasis from impairment to showing the presence of a drug over a certain level.

— The introduction of a specification document that lists the technical requirements of a device that can measure the presence of drugs.

— A type approval process that evaluates devices against the technical specification.

25. Enforcement practices such as testing are just one instrument in combatting drug driving, and that the combined impact of running awareness campaigns alongside the raised profile that roadside testing brings, can make a significant improvement to road safety. We draw attention to some hard hitting campaigns by UK Police Forces on similar issues—such as Gwent Police's COW[52] film, about a teenage girl from a Gwent valleys family who kills four people on the road because she used her mobile and lost her concentration for a few seconds. It is an extraordinarily graphic film produced with the help of schoolchildren. Similarly on drug driving issues, Australia has produced a number of adverts in conjunction with roadside test programmes that provide a similarly hard hitting message—such as a recent one from Victoria's Transport Accident Commission.[53]

26. Concateno is aware of the North Review recommendations to introduce drug testing for drivers at the police station initially, following an indication of impairment through means of the Field Impairment Test. We have experience in both installing drug testing technology in custody suites and training operatives to carry out the tests as a result of Concateno's tests being the chosen method for drug testing in custody suites as part of the Home Office's Drug Interventions Programme, since the initial pilot in 2001. To date over a million tests have been carried out.

Concateno and Other Safety Initiatives

27. Although Concateno is not involved in current roadside drug testing practices in the UK, we provide drug testing products and related services for a number of other transport sectors and therefore have direct experience of how others are helping to make travelling safer through drug testing:

— We work with transport and logistics companies, testing drivers to ensure that they are free from alcohol and drugs.

— We test train drivers and trackside operators so that organisations comply with the rail industry's regulations.

— We test airline pilots and cabin crew.

— We test taxi drivers as part of the licensing procedure.

28. We are also aware of other initiatives that are using testing, for example the DVLA tests persistent offenders before re-issuing their licence.

How Concateno can Help

29. Concateno welcomes the Transport Select Committee's recognition of drug driving as a serious issue, and is committed to improving road user safety in the UK by helping to reduce death and injury. We would feel privileged to assist the Committee and its Inquiry with the provision of further evidence of our drug driving/screening experience overseas, and to support any pilot initiatives in the future. If there is a requirement to learn from international police forces to gauge best practice, Concateno would be able to facilitate a meeting between the UK and international stakeholders.

Concateno—Global Drug Testing Services

Informed testing for informed decisions, when it matters most

30. Concateno (www.concateno.com) brings together Europe's strongest and most experienced drug and alcohol testing organisations and over 60 years of collected expertise. It offers an unparalleled breadth of advisory services and testing capabilities—spanning laboratory, point of care tests and all sample types for any biological specimen, including urine, oral fluids, hair and sweat.

[52] http://www.youtube.com/watch?v=vMNx0Q8t9so
[53] 10 http://www.youtube.com/profile?user=TACVictoria#p/u/49/n4X2lbxc5O4

31. Concateno's 400 employees perform and deliver more than 10 million tests annually, supported by a global network of 600 sample collection officers, trained in-house in chain-of-custody procedures. Together, they conduct testing for approximately 8,500 clients in 130 countries around the world across all industries, healthcare and government bodies. Concateno's dedicated divisions specialise in: Child Protection, Clinical Diagnostics, Criminal Justice, Employee Services, Healthcare and Maritime.

32. Quality is assured by the highest levels of accreditation, supported by expert and responsive customer service. Concateno's three UK laboratories are audited and accredited by the United Kingdom Accreditation Service (UKAS) to the international standard ISO/IEC 17025 for the testing for substance misuse in hair, oral fluids and urine, respectively. Laboratory products and point of care test products are manufactured within ISO 9001:2008 and ISO 13485:2003 certified facilities. The company is also subject to a range of external quality assurance programmes, including UKNEQAS, IIP and CAP (US scheme).

33. In August 2009, Concateno became a subsidiary of Alere Inc., formerly known as Inverness Medical Innovations, Inc. (NYSE: ALR).

August 2010

Written evidence from The Automobile Association (AA) (DDD 29)

SUMMARY

The AA is delighted that the Transport Committee has decided to look at this important area of road safety law and practice. We welcomed the North review and would support the introduction of the vast majority of its recommendations.

The AA would support a cut in the drink drive limit from the current 80mg/100 millilitres of blood to 50 mg/100 millilitres of blood. We would also welcome wider powers to conduct breath tests.

Retention of the existing minimum penalty of one year's disqualification is supported by AA members and would be supported by the AA. Consequential changes should be made to the "sliding scale" of penalties that exists above this minimum.

Drugs and driving are a major concern, even though the scale of the problem is not well understood. Steps need to be taken to improve this understanding. At the same time there is no doubt that drug driving is costing lives, and that the difficulty and complexity of enforcement is hindering adequate deterrence.

There is scope for using modern technology to assist enforcement of drug driving law. The ideal road safety law is based on proven impairment of driving and the AA would favour a system that was based on impairment. However dealing with the issue may mean that a less desirable system based on the presence of drugs is necessary to save lives on the road.

The AA has long been concerned at the low level of traffic enforcement. Being seen to realistically tackle drug driving must require more resources, and the reduction of the legal alcohol limit will also require this. If enforcement concentrates on enforcing the law on those between 50 and 80, and the drug driving law, it could make high level offenders less likely to be caught and reduce deterrence among this, the most dangerous group. At the moment there are some indications that the future will see less, rather than more police activity and if this is the case there may be little scope for changing the existing law while maintaining pressure on the most high risk group

Should the permitted blood alcohol limit be reduced as proposed?

The AA supports a reduction.

66 % of respondents to an AA Populus poll thought this should be the case. The sample size for that poll (in April/May 2008) was 17,481. Expert opinion is also convinced that this would lead to a significant reduction in drink drive deaths—the North Review suggesting between 43 and 168 in the first year after a change, rising to over 300 by year six.

However, we continue to be concerned that there is a major problem with those that totally disregard and drive way above the current limit. This "hard-core" are disproportionately represented in drink drive casualties and therefore should be targeted as a priority. We also support the wider use of drink drive re-habilitation courses and medical interventions to target those with drink problems.

There has to be a concern about the level of resources available to the police to enforce any new legal limit and to create an atmosphere where drivers exceeding the new limit feel at risk of apprehension. This must be done at the same time as continuing to catch and deter the hard core drink drivers responsible for so much of the current problem. It can be argued that hand held mobile phone use continues because drivers do not feel at risk of apprehension, and it is vital that changing the drink drive law does not lead to drivers thinking the same way. If it does there is again the risk that higher risk drivers will also feel a reduction in the risk of being caught.

It does not seem that, in the current economic circumstances, police will be able to increase drink drive enforcement resources—in fact there is a risk that they may be reduced. If this is the case careful consideration will have to be given to the timing of a reduction in the limit to ensure that over-the-new-limit drivers do feel at risk of apprehension and that this perception is not gained at the expense of enforcement against high risk drink drivers

The AA does not favour further reductions in the legal limit for specific groups of drivers (young, vocational) in the short term. If the overall limit is to be cut the accompanying publicity needs to be clear and introducing different limits would confuse this. Lower limits for vocational drivers and novice drivers should be considered in the longer term, but vocational driving limits should only apply when they are using vehicles that need vocational licences, not their private cars.

The main message to drivers about the 50 limit would have to be about driving after drinking. Lower limits would need the message to major on how long would have to elapse after drinking before driving. It would be hard to communicate both messages together.

If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?

Knowing that differential penalties are used abroad, and to some extent in the UK the AA has considered this carefully. Members opinions were sought at the time of the 1998 consultation on reducing the legal limit, and these suggested that the minimum penalty should remain the same.

At the request of the North Review, the February 2010 AA/Populus study included the question:

> *The current blood-alcohol limit for drivers is 80 milligrammes in 100 millilitres of blood. Those caught driving with alcohol levels above this limit are banned from driving for 12 months.*
>
> *If the limit was reduced to 50 milligrammes in 100 millilitres of blood, should there be…?*

The headline results are in the table below:

A lower disqualification period of six months	3,550	17
The same disqualification period of 12 months	9,916	49
A higher disqualification period of more than 12 months	3,062	15
No disqualification, but penalty points instead	2,641	13
I don't know	1,206	6

There were 20,129 respondents.

This confirms the AA's view that breaking the drink drive law should result in disqualification with only 13% voting for a lesser penalty. With 64% voting for disqualification for at least as long under the new law as under the old, the AA would support the retention of the minimum one year disqualification for this offence. We would also accept a corresponding increase in the length of disqualifications on the magistrates' sliding scale to reflect higher alcohol levels.

Generally public opinion supports tougher penalties against drink drivers. Whether this is because of the public's abhorrence of drink driving, or because the vast majority of those that take part in surveys cannot see themselves drinking and driving, is open to debate.

How severe is the problem of drug driving and what should be done to address it?

The true magnitude of the drug driving problem is hard to establish and there is a great need for it to be better quantified. Some steps to do this would be relatively simple. Random roadside research to establish the prevalence of drug driving could be carried out, as it was for alcohol in the 80s and 90s. Coroners should be asked to test all people killed on the roads for drugs.

Once the magnitude of the problem had been established it would be much easier to discuss whether there is a need to change the law or even the principles of road safety law because of the need to take swift action against drug drivers. Certainly there is public support for allowing the police to stop drivers to test for drugs and drink at any time and the AA would support such a change. But it seems a more drastic change is needed.

Procedurally the present system is difficult and tends to discourage use. A "legal limit" approach would be ideal, but may not be feasible, especially not in the short—to medium—term. In the interim there seem good arguments that failing a field impairment test, and testing positive for drugs should amount to proof of an offence. It should be possible for saliva testing machines to be used to test for the presence of drugs. If any type of medical practitioner (doctor, nurse) is involved in the testing perhaps their view on impairment could be used to corroborate that of the officer conducting the field impairment test. More thought also needs to be given to people who look impaired but pass breath tests—this could be a sign that both drugs and drink have been taken.

Also in the short term, more training of more police officers in the field impairment test is necessary. Confidence in the field impairment test among the police is vital, and more training develops this confidence. Police officers who are not confident with the test are less likely to use it.

In the long term there is a necessity for a "legal limit" approach, as used with drink, to be adopted. It would make enforcement more effective by streamlining the procedure by which drivers could be convicted. There would be many difficulties, not least in setting the different levels for different drugs, and measuring when it was exceeded. One of the questions is whether the limit should be one where impairment can be proved (as with drink) or a zero limit, making it an offence to drive with any illegal substance in the body regardless of impairment. The second option is acceptable to 75% of members (although 100% favour a rule that includes impairment) but becomes problematic when it is accepted that there are drugs that leave traces in the body days or even weeks after its impairing effects have worn off.

At the moment the basic principle of motoring law is that it tackles behaviour that has been shown to make a collision more likely to happen. Moving to a zero limit for drugs would not do this, and the AA feels that this would be a major change that should not be taken lightly.

While the AA believes that road safety measures should be applied in proportion to the problem, there is an argument that drug driving, although unquantified, needs more enforcement effort than there is at the moment. Some of this is due to there not being enough police officers to enforce the law properly. But much is down to the difficulty of enforcing the law.

As is the case with drink driving there will be a need for the existing "impairment" law to remain even if a legal limit approach is used. It will be needed to deal with medicinal drugs.

What wider costs and benefits are likely to result from changes to drink and drug driving law?

The AA can really only ask questions about health effects and those on wider aspects of life. Among these are:

- Could it lead to a cut in alcohol consumption and benefits to health? Could it deter more people from use of drugs?
- Could it push people who currently use cannabis (which can remain in the body for a long time) into using "harder" drugs (which remain in the body for a shorter period)?
- Will more social drinkers walk or get lifts and drink more, increasing the alcohol problem?
- Many pubs are rural and do rely on people driving to them. Many village dwellers may be keen to see tougher rules on drinking drivers, but they may be more concerned about the risk of their village pub closing.
- Are more people who live in urban areas concerned about personal safety and antisocial behaviour near home and may therefore not walk, again damaging the pub industry?
- Will more people drink more at home?

What would be the implications of such changes for enforcement?

Recent years appear to have confirmed the view that there is a relationship between increased enforcement effort and reduced drink drive deaths.

As has already been stated, the AA believes that there will be problems if a lower drink driving limit is not introduced in conjunction with a major enforcement initiative which convinces people that those breaking the new law will be caught. At the same time any such campaign must not diminish the pressure on those who break the current law. While lack of enforcement seems to have allowed substantial numbers of drivers to ignore the mobile phone law, this cannot be allowed to be the case for the drink driving law, where there is a risk that non compliance with the lower limit could spread to non compliance with the law as a whole.

Similarly, a new drug driving law will need high profile enforcement. A tougher law will be no use if drug drivers do not believe they will be caught. Again the police will need to devote more resources to road policing during the early stages of the law and again the penalty for not doing so may be the existence of a law that is not respected.

Currently it looks doubtful whether road policing will be maintained at present levels in coming years, and there seems little hope of more resources becoming available. This poses a major obstacle to creating a tougher framework for the laws surrounding impaired driving.

Additional Points

Disqualification is the main penalty for both forms of impaired driving. At the moment annual findings of guilt for driving while disqualified currently run at about one quarter of the number of drivers disqualified. Drivers should not be able to dodge their punishment and severe penalties are needed for those who try.

An AA Populus poll showed that 66% of respondents found acceptable the immediate disqualification of drivers who failed an evidential breath test, even before they appeared in court. The AA would therefore be happy with a similar change.

The AA would also be happy with the removal of the option to take a blood test. However care must be taken to ensure that changes to the way breath testing is conducted can be carried out without compromising public confidence, especially as powers already exist for the introduction of evidential testing at the roadside. Some back up system is necessary at times of change to retain public confidence.

Increased enforcement of the drug driving laws will require the development of a parallel scheme to the high risk offenders scheme used for drink drivers, especially for repeat offenders. It would not be right if repeat drug offenders did not have to follow a similar procedure to repeat drink offenders.

August 2010

Written evidence from the British Medical Association (BMA) (DDD 32)

The British Medical Association (BMA) welcomes the opportunity to submit evidence to the Committee's inquiry into drink and drug driving law. As doctors, we witness first hand the catastrophic impact of road traffic crashes. While considerable progress has been made in reducing the number of deaths and serious injuries on Britain's roads, the BMA believes that further measures are necessary to reduce the levels of drink and drug driving.

The BMA's submission to the North Review of Drink and Drug Driving Law has been used to inform our responses to this inquiry and we welcome the opportunity to expand further on our attached submission.

EXECUTIVE SUMMARY

— The BMA believes that lowering the prescribed alcohol limit for driving should be given a high priority. There is considerable evidence that driving impairment and crash risk increase exponentially with increasing blood alcohol content (BAC) levels, and that lowering the prescribed limit changes driver behaviour and results in fewer serious and fatal crashes. A reduction in the BAC limit to 50mg/100ml would bring the UK in line with most other European countries, and would be in agreement with the best available evidence on the effects of alcohol on driving impairment. The use of a fixed penalty (namely 12 months mandatory disqualification) at a BAC limit of 50/mg/100ml is appropriate.

— There are very limited scientific data on the levels of drug driving. Front line experience of BMA members attending patients indicates that it is an increasing problem difficult to quantify because of the lack of simple reliable quantitative field testing equipment. Enforcing the current legislation on drug driving is complicated by the lack of distinction between drink and drug driving in the Road Traffic Act 1988, and the difficulty in detecting impairment resulting from drug use. In addressing the problem of drug driving, as recommended in the North Review, in the short-term, there should be a focus on developing preliminary drug screening tests for use in police stations, capable of detecting controlled drugs which are known to be commonly used by drivers. In the longer term, a new offence should be introduced making it unlawful to drive under the influence of specific drugs which are deemed to impair driving ability.

— In relation to prescribed and over-the-counter medications, where these are included in any new offence, there are a number of important considerations. Individuals can respond differently to certain prescribed drugs and there would need to be a distinction between prescribed medications which may impair driving ability on their own and where impairment results from interactions with other drugs. The introduction of any new or amended legislation would also need to be accompanied by clear information for prescribers, pharmacists and patients on which drugs are proscribed for driving, and with a programme to raise awareness among the general public.

— Lowering the BAC limit and the introduction of new measures to improve the process of detecting and deterring drug driving would reduce the number of drink and drug driving-related road traffic crashes, and associated mortality and morbidity. The lowering of the BAC limit with a mandatory 12 months disqualification for driving at or above that level is likely to provide a strong deterrent effect, as has been found to occur at the higher BAC limit.

— The BMA supports the recommendation in the North Review to provide a general and unrestricted power to require anyone who is driving a motor vehicle to cooperate with a preliminary breath test.

— The BMA believes that forensic physicians should be legally empowered to take blood samples for testing for alcohol and drug levels without consent from a driver without capacity after a road traffic accident, and that testing should occur later only with the consent of the driver. Other than in the strict circumstances laid down in the legislation, the BMA is opposed to doctors (other than forensic physicians) being involved in non-consensual testing of drivers involved in crashes for evidential purposes.

About the BMA

1. The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine throughout the UK. With a membership of over 140,000 worldwide, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

2. The BMA welcomes the opportunity to contribute to this inquiry. As doctors, we witness first hand the catastrophic impact of road traffic crashes. While considerable progress has been made in reducing the number of deaths and serious injuries on Britain's roads, the BMA believes that further measures are necessary to reduce the levels of drink and drug driving.

3. The BMA's submission to the North Review of Drink and Drug Driving Law has been used to inform our responses to this inquiry, which are outlined below.

Should the permitted blood alcohol Limit be reduced as proposed?

4. Yes. Lowering the prescribed alcohol limit for driving should be given a high priority. The BMA has a long history supporting a reduction in the legal alcohol limit for drivers from 80mg/100ml to 50mg/100ml, and first called for a lowering of the permitted blood alcohol content (BAC) level in 1990. This was reaffirmed at the 2010 BMA Annual Representative Meeting (ARM) where members unanimously supported Sir Peter North's recommendation to lower the BAC limit to 50mg/100ml.

5. There is considerable evidence that driving impairment and crash risk increase exponentially with increasing BAC levels, and that lowering the prescribed limit changes driver behaviour and results in fewer serious and fatal crashes. Driving performance deteriorates significantly between a BAC of 50mg and 80mg/100ml, and crash risk increases.[1,2] The relative crash risk of drivers with a BAC of 50mg/100ml is double that for a person with a zero BAC; the risk rises to 10 times for a BAC of 80mg/100ml.[3,4,5]

6. Modelling studies predict that lowering the BAC limit to 50mg/100ml would reduce serious and fatal crashes, and could expect to save 65 lives and prevent 250 serious injuries per year in the UK.[6] A 2010 review by the National Institute for Health and Clinical Excellence (NICE) of effectiveness of drink driving legislation estimated that lowering the BAC limit to 50mg/100ml would reduce road fatalities by up to 13.8% and injuries by 1% within six years of implementation. This would prevent 70 to 144 fatal, 139 to 323 serious and 1,121 to 2,606 minor injuries in the first year of implementation, increasing to 158 to 303 fatal, 274 to 708 serious and 2,213 to 5,715 minor injuries prevented annually by the sixth year of implementation.[7]

7. A reduction in the BAC limit to 50mg/100ml would bring the UK in line with most other European countries, and would be in agreement with the best available evidence on the effects of alcohol on driving impairment.

8. There is widespread support from the public and key stakeholders to reduce the BAC limit to 50mg/100ml. In March 2008, the BMA Board of Science hosted a "stop drink-driving" stakeholder event with representatives from the Medical Royal Colleges, the police and the hospitality trade, and organisations such as Alcohol Concern and the Institute of Alcohol Studies. Following the event, letters of support from the various stakeholder organisations were forwarded to the Department for Transport (DfT) calling for the drink-drive limit to be lowered to 50mg/100ml.

9. In relation to a lower limit for certain categories of driver, the BMA believes there should be consideration for further reductions below 50mg/100ml for all newly qualified drivers, and supports Sir Peter North's recommendation to review the impact of a new prescribed limit of 50mg/100ml on young and novice drivers over the five years following implementation and consider further reductions at that stage.

If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?

10. Yes. The use of a fixed penalty (namely 12 months mandatory disqualification) at a BAC limit of 50/mg/100ml is appropriate. As noted in the North Review, it would be a retrograde step to lessen the deterrent effect of mandatory disqualification. The 2010 NICE review found that driving licence suspension or revocation is an effective deterrent for drink driving, influences driver behaviour and results in fewer alcohol-related road crashes.8 The introduction of a graduated scale of penalties may also lead to an increase in the acceptability of drink driving and create a mixed road safety message.

How severe is the problem of drug driving and what should be done to address it?

11. There are very limited scientific data on the levels of drug driving. Front line experience of BMA members attending patients indicates that it is an increasing problem difficult to quantify because of the lack of simple reliable quantitative field testing equipment. Evidence indicates that drug use and the prevalence of drug driving have increased in recent years in the UK.[9] In a survey of club-goers in Scotland, 69% had taken cannabis and 85% had at some time driven after using illegal drugs.[10] The survey also identified common attitudes among drug users: many were not aware of drug driving legislation, ignored anti-drug campaigns, and did not believe that cannabis impairs driving ability.

12. The wider implications of this behaviour are beginning to emerge. Research from 2000 indicates an increasing incidence of road traffic crashes where individuals have tested positive for drugs, and where drugs may have been a contributory factor to the cause of the crash.[11] A study by the Transport Research Laboratory (TRL) of fatal collisions between 1985 and 1987, and between 1996 and 1999 found that the incidence of medicinal drugs and alcohol in road collisions casualties remained stable over this period. Drug taking overall increased by a factor of three, and the proportion of those testing positive for multiple drugs increased dramatically, from 5% in 1985–87 to 26% in 1996–99. Further research into the levels of drug driving, the dual use of alcohol and drugs while driving, and the associated impact on road safety is essential.

13. Enforcing the current legislation on drug driving is complicated by the lack of distinction between drink and drug driving in the Road Traffic Act 1988, and the difficulty in detecting impairment resulting from drug use. Detection relies on demonstrating impairment through physical examination in a controlled environment, which can lead to delays in taking blood samples. The procedure for testing at the police station is still too variable, and is interpreted differently by individual forensic physicians. In particular, the identification of a condition that may be due to a drug is very broad-based and can lead to false positives and false negative results. Thus, in cases where both drugs and alcohol are suspected, it is therefore common practice not to pursue enquiries about driver impairment as a result of drug use. It is much simpler to prove the same offence with BAC evidence linked to alcohol use.

14. The BMA does not support Sir Peter North's recommendation to amend the Road Traffic Act 1988 to allow nurses to also take on the role currently fulfilled by the forensic physician in determining whether a drug driving suspect has a condition which might be due to a drug. Nurses do not have the relevant training, experience and expertise to undertake this role. Determining whether a suspect has a condition which might be due to a drug requires clinical judgement of an order only likely to be available to someone trained from first principles in pathophysiology and pharmacology, and who has an understanding of neurology and psychiatry.

15. In addressing the problem of drug driving, as recommended in the North Review, in the short-term, there should be a focus on developing preliminary drug screening tests for use in police stations, capable of detecting controlled drugs which are known to be commonly used by drivers. This would remove the need for a forensic physician to investigate whether the suspect has a condition which might be due to drug use. In the longer term, a new offence should be introduced making it unlawful to drive under the influence of specific drugs which are deemed to impair driving ability. This requires research, and agreement upon, levels at which controlled drugs which are prevalent among drivers could be deemed to be impairing, and the establishment of a list of which drugs, the presence of which was banned in drivers at or above the specified levels.

16. In relation to prescribed and over-the-counter medications, where these are included in any new offence, there are a number of important considerations. Individuals can respond differently to certain prescribed drugs and there would need to be a distinction between prescribed medications which may impair driving ability on their own and where impairment results from interactions with other drugs (eg opiate derived analgesics and sedative antihistamines). There are also conditions where drug testing will be inherently complex such as hypoglycaemic reactions that can be caused by prescribed drugs or other circumstances such as nutritional status. Consideration would need to be given to the fact that many currently prescribed medicines could become unusable for drivers, and the impact this may have on prescribing patterns and compliance with treatment regimes. In issuing penalties for driving under the influence of a prescribed drug, consideration would need to be given to ensuring any action is proportionate in relation to the driver's medical condition.

17. The introduction of any new or amended legislation would also need to be accompanied by clear information for prescribers, pharmacists and patients on which drugs are proscribed for driving, and with a programme to raise awareness among the general public.

18. The existing offence of driving while impaired by drugs in the Road Traffic Act 1988 should be maintained to cover those drugs (including prescribed and over-the-counter drugs) not listed in any new offence, as recommended in the North Review.

What wider costs and benefits are likely to result from changes to drink and drug driving law?

19. Lowering the BAC limit and the introduction of new measures to improve the process of detecting and deterring drug driving would reduce the number of drink and drug driving-related road traffic crashes, and associated mortality and morbidity. As noted previously, it has been estimated that reducing the BAC limit from 80 to 50mg/100ml would save 65 lives and prevent 250 serious injuries per year in the UK.[6] This would in turn reduce the burden of drink-drive related mortality, morbidity and disability on public healthcare services, and productivity and profitability in the workplace (absenteeism and lost working days).

What would be the implications of such changes for enforcement?

20. The lowering of the BAC limit with a mandatory 12 months disqualification for driving at or above that level is likely to provide a strong deterrent effect, as has been found to occur at the higher BAC limit.[8] It is unclear what effect this would have on the number of offenders and resource demands on the police services. As the North Review highlights, international evidence indicates that drivers modify their drink

driving behaviour in response to a change in the legal BAC limit, where the percentage of people driving at every BAC level, including in drivers who drink heavily, decreases following a change in legislation. With appropriate public awareness and communications, the number of drink driving convictions would not be expected to increase substantially if the BAC limit were lowered. The implementation of Sir Peter North's recommendations to increase the policing priority for drink and drug driving, as well as the development of roadside and evidential screening devices should improve the ability of the police to enforce the law and secure convictions in the longer term.

21. The following provides information on BMA policy in relation to a number of other areas considered in the North Review.

Random and selective breath testing

22. The BMA supports the recommendation in the North Review to provide a general and unrestricted power to require anyone who is driving a motor vehicle to cooperate with a preliminary breath test.

23. As highlighted in the 2008 BMA Board of Science report *Alcohol misuse: tackling the UK epidemic*, the BMA believes that the use of highly visible police enforcement and non-selective random roadside breath testing measures (without the need for prior suspicion of intoxification) are key components of effective enforcement of drink-drive legislation.[12]

24. Under current regulations, enforcement is operated through selective breath testing that requires police to have judged that a motorist has consumed alcohol before implementing the test. Non-selective random roadside breath testing is an advantageous approach as motorists are unable to influence the likelihood of being tested and there will be a perceived increased risk of detection. Research from Northern Ireland, Scotland and England indicate public support for these policies.[13,14,15]

25. With the exception of the UK, non-selective breath testing is permitted throughout the European Union (EU).[16] Research in Australia has found that highly visible, non-selective testing can have a sustained and significant effect in reducing levels of drink driving, alcohol-related road traffic crashes and associated injuries and fatalities.[17,18,19] One study found non-selective testing to be twice as effective as selective testing, with a reduction in fatal crashes of 35% and 15% respectively.[19]

Compulsory testing

26. The BMA believes that forensic physicians should be legally empowered to take blood samples for testing for alcohol and drug levels without consent from a driver without capacity after a road traffic accident, and that testing should occur later only with the consent of the driver. Other than in the strict circumstances laid down in the legislation, the BMA is opposed to doctors (other than forensic physicians) being involved in non-consensual testing of drivers involved in crashes for evidential purposes. The BMA publication Medical Ethics Today provides the following guidance in relation to drivers who are temporarily incapacitated either because of the crash or because of the effects of drug or alcohol consumption:

> "A blood specimen may be taken for future testing for alcohol or other drugs from a person who has been involved in an accident and is unable to give consent where:
>
> — a police constable has assessed the person's capacity and found the person to be incapable of giving valid consent due to medical reasons; and
>
> — the forensic physician taking the specimen is satisfied, at the time the sample is requested, that the person is not able to give valid consent (for whatever reason); and
>
> — the person does not object to or resist the specimen being taken and has not refused consent to the sample being taken before losing competence; and
>
> — in the view of the doctor in immediate charge of the patient's care, taking the specimen would not be prejudicial to the proper care and treatment of the patient.
>
> The specimen is not tested until the person regains competence and gives valid consent for it to be tested. If doctors follow the advice in this summary they will fulfil both legal and ethical requirements."

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August 2010

Written evidence from Dtec International Ltd (DDD 34)

UK agent for Securetec "DrugWipe" global leaders in road side drug driver screening, helping save lives since 1996.

SUMMARY

Sir Peter North Review was long over due and tried to focus on a particular set of problems highlighted by this committee in 2006 and 2008.

In my view having been involved in this industry in the UK and abroad for 15 years, North Review does a fair amount to high light the failings and inadequacies of the current UK system with regards drink and drug driving and offers some credible suggestions as to effective solutions.

When looking at other countries, I believe it is not acceptable for our Government to say we are better, or they have more to do to match us. Other countries may be coming from behind as far as over all fatalities and seriously injured, but importantly, they are doing more on drug driving and saving lives that could just as easily be saved here. That is, given suitable political will to make hard decisions, and very importantly, a more positive attitude from the Home Office and Department for Transport, especially when the rest of Europe and Australia is proving how effective currently available solutions are.

My expertise is in reducing drug driving so I will focus on that and let others advise on the drink drive situation.

It must be remembered that changing the law, or not, on drink drive, does not preclude law changes on drug driving and vice versa. If the public sees the alcohol limit remain at 80ng/ml, they will have an opinion some positive and some negative. If Government introduces changes or new laws to reduce drug driving, by far the vast majority of innocent public will agree with its introduction and more importantly be safer on the roads for it.

Drug Driving

The North Review highlights a number of significant improvements that can be made to the procedural side of apprehending and successfully prosecuting drug drivers. How ever, to make a step change and save a significant number of lives and reduce the harm (and reduce cost to NHS) of the 100 fold more significant injuries, we need to look no further than what has proven successful in Europe and Australia. The UK is now behind a dozen other countries, yet this successful and available solution could be implemented in the UK in as little as 3 to 6 months.

Key Points

Step Change

Germany successfully prosecuted 34,500 drug drivers in 2009. England and Wales only managed a couple of thousand. Yet the UK is Europe's largest consumer of drugs. The UK once lead this field with the worlds largest trial in the late 1990's and suggested the modification of road side screeners to what is used now. Yet the UK is significantly behind and has been for 10 years. The positive side is that a step change in saving lives and reducing injury can be achieved and not in two or three years, it can be done with what is successful and available now.

DRUID (DRiving Under the Influence of Drugs)

No country from England, Scotland, Wales or Northern Ireland took part in the pinnacle of world research into drug driving performed in 18 countries. Why? The DRUID results, based on work done at the road side in 2008 and 2009 was unavailable to the UK as North Review closed because we were not a part of it. But DRUID and all its positives were made public before North was released. So we didn't take part in DRUID and didn't use its wealth of results in North.

Benchmark

Has North benchmarked the UK against any other countries? There is passing remarks to what is being achieved else where, but North should be shouting out that with political will and departmental positive mental attitude, the same can be achieved here.

Field Impairment Testing (FIT) is not infallible.

The UK is currently relying on Field Impairment Testing because the law requires proof of impairment. DRUID shows FIT is only 13% effective and even when the suspect tells the officer what drug they have just taken, the FIT is still only 33% effective!

FIT is good to raise the knowledge and competence level of officers and can work in extreme cases of impairment with current "Driving whilst Impaired" laws. I believe the current law should remain. (see later) How ever, with a Zero Tolerance law, as in other countries, officers are trained to use some of the FIT type tests to realise that they need to use a road side screener.

HO vs DfT

Department for Transport has ownership of Road Safety and the Fatal/Serious performance figures, but Home Office has the manpower element in the police and the Type Approval authority for any equipment used.

The previous Government's politicians appear to have allowed these departments to put effort into effectively "not finding a solution". In my view this Government should make the political decision to solve the drug driving situation as best they can now. This instruction should be driven through both the DfT and HO departments and a step change achieved in half a year.

Momentum will help drive development of better equipment and procedures and the UK can benefit from input and experience of a dozen other countries that already screen effectively at the road side.

Type Approval

The Railways and Transport Safety Act 2003 Permitted police to use Home Office Approved road side screening devices. To be HO approved, any device has to pass a Type Approval. The specification of the Type Approval has been in several stages of Draft for 7 years now. Each successive one was slightly less demanding than previous, but still far too restrictive to accept any current device, or device likely for the next few years.

Type Approval is necessary, but it should not preclude equipment that can significantly achieve what society wants, that is to SCREEN for the drug user and identify them for further steps towards successful prosecution.

Current draft Type Approval specification asks for detection levels that are too low, and then sets Yes/No cut offs either side of that level that are neither necessary nor achievable.

This set of cut offs was chosen arbitrarily by a committee of experts in the UK who have not taken part in any of the European or Australasian trials or successful implementations.

We are talking about a "screener", not a full blown laboratory analysis machine.

The road side screener is successful, reliable and available now.

North hopes that one day a road side evidential device will be available.

Perhaps but it is many years off before a suitable device could be built to both identify and to quantify in whole blood at the road side Should we delay and see people die and be seriously injured while we wait for the perfect solution?

The UK introduced breath screening 43 years ago with glass tubes and blow in the bag. Technology stepped on every 10 years through electronic testers to the imminent arrival of evidential road side testers. What if Government had not had the courage to start back then, how many deaths and injuries would those 43 years have given us?

The myth of "Anyone who ever takes Cannabis will not be able to drive!"

If we take the urban myth of "You can detect Cannabis use for a month, so I will never be able to drive" being the topic hit upon by most ill informed journalists to deliberately sensationalise the issue of drug driver screening.

Screeners look for THC in saliva not for the long term metabolite THC-COOH. THC-COOH is a metabolite of THC. It is distributed via the blood into the body's fatty tissue, where upon it is slowly re-released over a period of several days or weeks into all the body's tissues and fluids. It is thereby also deposited on the skin in sweat but mainly detectable for many weeks in the urine.

THC is the ingredient in Cannabis that causes impairment, not THC-COOH. THC is present in the saliva for a short period of time. Drug driver screening uses saliva at the road side to detect THC (not THC-COOH). THC in the blood is used for confirmation and prosecution.

The lower we chase the detection levels of THC, the longer we can see back in time and the more people we will catch. Detection levels are available now that will catch the majority of users who have just smoked and importantly, **are likely still impaired.**

The UK's proposed list of 7 drugs to be screened for

If we go with the most successful method found in Europe and Australia, we will screen at the road side for a list of the most common problem drugs.

This is from the list of Cannabis(THC), Cocaine (and Crack), Heroin, Amphetamine and Methamphetamine.

Benzodiazepines are screened for in some countries making a total list of 6 drugs.

Methadone is not screened for in any country that performs road side screening. This is because it is relatively insignificant due to Heroin addicts having sold their car to buy drugs, Methadone users also take a range of other drugs and would show up on the list of 6. This was confirmed in studies from the UK some years ago.

New drugs and illegally used medicines will I believe require the current Section 4 impairment law to remain in place.

Roadside vs at Police station

"Catch your fish then fry them" is the motto used by the global leader in road side drug screening Securetec.

The true effect of drug driver legislation is deterrent. The best deterrent is a credible one and that means drug users being caught whilst driving. Hence screening has to take place at the road side.

Then a positive screen means a rapid and priority processing to obtain a blood sample for detailed and exact laboratory testing.

The current system is ineffective for a number of reasons but principally because of the time delay between seeing bad driving, performing a FIT, calling for suspect transport to the station, queuing at the desk, waiting for a Doctor, then the Doctor assessment and finally a blood sample. The majority of drugs are fast acting and fast clearing, this Home Office measured delay was reported by Jerry Moore Police Liaison at the DfT Road Safety as averaging at $2\frac{1}{2}$ hours by which time, most fast acting drugs are out of the suspects system.

Many other countries will screen at the road side and take blood as quickly as possible either in a Drug/Alcohol bus or taken to a technician to extract the blood sample.

Screening in the station is discussed by North as "a step" to take. Why? No other country performing drug driver screening does it at the station, it is ineffective. Screening at the station does nothing to help the officer at the road side to decide who they should arrest, it will not speed up the transport to the station, it will not prioritise the driver in the queue at the station desk, nor will it aid in the availability of a Doctor or technician to the station to take the sample of blood.

I believe station screening was mooted by several companies that cannot successfully operate their devices at the road side as they require a stable environment to work. The device chosen by the majority of countries has been show to match or out perform the electronic station based reader devices, and can be used where it has the most effect.

The bottom line is that the deterrent has to be maximised and that deterrent is the fear of being screened and found positive at the road side. Then prioritise them to rapidly have blood taken and sent to the lab for confirmation.

Conclusion.

Please consider why do a dozen other countries use currently available equipment and are benefiting by saving lives and reducing injury, yet the UK is not?

Also consider why the Transport Select Committee reviews of 2006 highlighted the problem of lack of cooperation and lack of results on drug driving, then 2008 pushed again for action, yet two years on, the matter is not resolved and is still in discussion. Meanwhile, another half dozen countries have started roadside drug screening!

Government should in my view make sure the real effort is put positively into making an accepted road side screening system work. Improve in the future but start saving lives now.

August 2010

North Review Recommendations Drug Driving Section by Point

R1.

The correct statistics MUST be recorded and that will show the magnitude of the problem. Do not wait to see this before taking action. Every one involved knows the problem is there and needs sorting now, not after two years of benchmarking statistics.

R2.

Yes, commission research, any changes should be monitored and researched, but not at the expense or delay of actually getting on with solving the problem!

R3.

Detailing Field Impairment Test (FIT) information will help highlight drug driving as a priority and show officers that they will be supported for taking the time to do it. It will also high light the forces that are not doing enough. This is apparent with the percentages of breath tests post RTC when analysed by force.

R4.

As above. If an officer stopped a car suspected of impaired driving, and only breathalysed, and the breath test is negative make the officer explain why they did not consider drugs and why they did not perform FIT or screen the driver.

R5.

CPS to rely more on trained officers observations of impairment.

R6.

It is unbelievable that a stolen Kit Kat is a recordable offence yet drink or drug driving is not. This is a simple solution which would have great effect in this world of targets and performance monitoring.

R7.

The officer saw bad driving, trust them, take the blood as quickly as possible. Let the lab decide if illegal drugs are there. When Government considers changing the law for zero tolerance, they should allow for the option that one day in the future, technology could provide an officer with the capability to take a blood sample immediately at the road side? Most diabetics take samples daily.

R8 & R9.

This is also so the health care professional knows they are not being asked to prosecute and remove the driving license of an individual, just to understand they are there to take a blood sample. Many Doctors have taken this view in the past.

R10.

Proper paperwork.

R11.

Earliest practical type approval, but this should be at the road side. Not seeing DRUID results meant North fell back on a supposed safe option that will not give a step change in deterrent or prosecutions. As for two years, the European system could be ready by the time the House passes legislation, which, with the right political will could be 6 months. In our view, the list does not require Methadone, but could be optional test.

R12 & R23.

This research will be nigh on impossible for different people have different tolerances. Also the UK is a massive poly drug using community. Different drugs taken at different times for different effects. Then throw Alcohol into the mix. DfT's own research tried to show the additive effect of a small amount of alcohol on the impairment levels of a cannabis user. Don't let this research be a red herring and a substantial and costly delay to saving lives.

R13.

As above. Impossible and time consuming.

Other countries have variously set either low levels from current research, to low levels as detectable by the global leader in road side screening, or, have set no levels at all. A simple test of if a drug from the list is detected at the laboratory (by what ever technique is used) this will be considered positive should be the aim.

Put the effort into the confirmation accuracy, not the screener that just finds then and deters them.

R14 & R21 & R22.

Medical advice should include training Doctors to take responsibly for the advice they should give to patients about driving on medication. The simple "do not drive if affected" is not good enough from the Doctor, the Pharmacist or the Pharmaceutical industry. The traffic light system has been discussed for 10 years but there is no universal agreement.

R15.

The light of day, don't wait for almost impossible research. Set a Zero Tolerance on the list of 6 drugs.

R16.

Sec4 RTAct1988 should stay for medicines, medicines Over the Counter, medicines self prescribed, legal highs and anything else.

R17.

Why wait, this step of screen at the road side can and is being done in a dozen countries now. This is because it is the only real true deterrent.

R18.

Evidential will come, but don't wait until then! (See previous comments)

R19 & R20.

High Risk Offenders loose their licence permanently in some countries. Germany, they need to attend specialist and prove over a period that they are reformed before a licence is re issued.

Written evidence from Dr Rob Tunbridge (DDD 36)

Independent Alcohol, Drug Driving and Driver Impairment Consultant

N.B. The following are strictly my personal views and mine only.

1. Reduction of the Permitted Blood Alcohol Limit

In my view reduction of the GB Drink Drive limit is a relatively low priority.

GB *currently* has nearly the best, if not the best, drink drive record in the world, as measured by unbiased BAC levels in driver fatalities.

This is because it is the only jurisdiction, bar Victoria (Australia), that takes away a drivers licence for 1 year on a 1st offence, irrespective of BAC.

For example, France, like the majority of other EU countries has a 50mg limit, but does not impose a 1 year ban until the BAC reaches 200mg.

In GB such a BAC limit warrants a 3 year ban and medical intervention.

France consequently has a worse drink drive record than Britain.

It should be remembered that the average drink driver's BAC is c. 150mg/100 ml in blood! Almost twice the drink drive limit.

Bringing down the limit would be beneficial, but only if enforcement levels were maintained and a lower penalty for a lower drink drive level (below 80) was NOT introduced.

This would give entirely the wrong mixed message on the seriousness of drink driving.

The current law should be enforced more rigorously with more breath tests!

In recent years roadside breath tests have dropped from 800,000 to around 600,000 per year. The introduction of roadside evidential breath testing would greatly assist this.

Roadside Evidential Breath Testing (As allowed under the Serious Organised Crime & Police Act 2005) should be introduced speedily!

There is no excuse for the continued delay in type approving existing devices which meet all current international scientific standards and are in daily use in many other countries.

Roadside testing would eliminate the sometimes substantial delay in obtaining an evidential test at a police station. A study by Sussex police in 2001 estimated that around 25% of cases were lost due to time delays in testing drivers, who would have been over the limit at the roadside!

The universal measure of the percentage of drivers killed in accidents who are over the limit has been clearly shown to be inversely proportional to the number of tests carried out. Greater enforcement is a great deterrent.

As stated above, I believe the one year minimum ban is a good deterrent and should be retained, not weakened by shorter disqualifications or fines.

Targetted, rather than random, tests should be introduced. Police generally know where people drink and the "type" of driver likely to offend.

Targetted checkpoints and testing of Individuals assisted by ANPR should be introduced.

Police currently have powers to stop for any reason. If they suspect alcohol they may then test for it. Targeting drinking locations would improve detection of drink driving.

A lower limit for novice drivers, in my view, gives the wrong message. It implies once you get more driving experience you are allowed to drink more!

If a 50 mg limit is brought in it should be quickly and also apply to professional drivers. Fitting of driver interlocks should also be considered for this latter group.

2. The Problem of Drug Driving

At present, information to throw light on the above is limited. The last time a thorough study was undertaken into the incidence of drugs in road fatalities (Tunbridge, R.J. et al. (2001) *The Incidence of Drugs and Alcohol in Road Accident Fatalities.* TRL Report 495 available online at www.trl.co.uk/store/report_list.asp)

It was found that 18% of drivers had at least one illicit drug and 6% had medicinal drugs.

The former had shown a massive increase (from 3%) since the 1980s when a previous study was conducted (TRL, Research Report 202, 1989). Medicinal drug incidence had remained unchanged at 6%. These results prompted the DfT to conduct an extensive programme of research on drug driving in the early 2000's.

Data on non-fatally injured drivers is much more limited. This is because drug analysis is very expensive (compared to alcohol testing); in excess of £500 for a screening and confirmation. It is therefore only carried out when a police officer has evidence of major impairment, often after a negative breath test.

DfT figures for 2007 show that drug impairment was a measured contributory factor in only 685 accidents compared to 16,585 for alcohol (Road Accidents GB, (2008), DfT). This figure however by no means gives an accurate assessment as the vast majority of drivers suspected of impairment are not tested for drugs, especially if they give a positive roadside breath test.

A new offence of driving with the presence of a proscribed drug would be greatly aided by the introduction of roadside drug screening. This would be carried out if an officer suspected impairment and if positive would give strong support to the officer's suspicion.

A confirmatory test would still need to be taken at a police station before any action against the driver could be taken!

Evidence from a limited number of studies shows that incidence of drugs in non accident involved drivers may be quite high. Samples of saliva taken at random from over 1000 motorists in Glasgow in 2004 showed around 10% were positive for an illicit drug (IMMORTAL study www.immortal.or.au).

Until a much wider screening programme is carried out, it is not possible to say whether this figure is typical of GB as a whole, but almost certainly the number of drug drivers being detected at the moment is just the "Tip of the Iceberg" A study conducted by the Forensic Science Service (FSS) in 1995 of those drivers stopped and tested on suspicion of drug impairment showed over 90% to be positive, many for more than one drug.

GB has the most serious illicit drug use problem in the EU it would be surprising if this were not reflected in drug driving figures.

The current law regarding drug driving is clearly ineffective.

Section 4 of the Road Traffic Act 1988 (RTA) requires it to be demonstrated that a driver is unfit to drive if his ability to drive properly is for the time being impaired. But, nowhere is the term unfit or impaired defined and thereby lies the serious difficulty.

It has been known since the 1920's that alcohol seriously affects a persons ability to drive, but it was not until the Grand Rapids Study of 1962 that proved a clear correlation between Blood Alcohol Concentration (BAC) and accident risk, not impairment!, that legislation under the Road Traffic Act 1967 brought in a Per Se limit for drink driving. There is a clear assumed relationship here between impairment and accident risk, but this has never been clearly scientifically established, even for alcohol. The situation with the myriad of drugs which may cause impairment is an order of magnitude more complex.

What we do know is that in excess of 600,000 roadside breath tests are carried out each year in GB of which around 100,000 are positive for alcohol above the legal limit. Studies at TRL have shown that over 50% of these tests relate to drivers under suspicion of impairment. There are therefore in excess of 250,000 drivers stopped at the roadside per year initially suspected of impaired driving who are below the legal alcohol limit. Data from the Forensic Science Service (FSS) suggest that less than 3000 of these are successfully pursued and prosecuted for drug driving! The number of detected drug drivers is therefore almost certainly "The Tip of the Iceberg"

Furthermore, analyses carried out by laboratories authorised to carry out road traffic case drug analysis suggest that the number of successful cases has not increased since the Mandatory application of the Preliminary Impairment Tests (FIT) in 2004.

3. Changing Drug Driving Law

The North Report suggested a variety of possible changes to drug driving Law.

One mentions the possibility of creating a new "Zero Tolerance" offence of driving with an illicit drug in the body.

I certainly welcome the exploration of such an offence; I broached this issue in a paper to a PACTS conference in November 2002.

The difficulties surround two issues: identifying the drugs to which the law might apply and deciding on what concentrations of drugs are evidence for a drugs presence. The later is relatively straightforward, at least for evidential samples. There are acres of toxicological data on this.

More difficult is the identification of drugs of interest.

However, if we stick to the premise that our only concern is with drugs which might impair driving; in my view the task is not too difficult.

What we need to concentrate on is drugs which have the ability to impair driving; then as with alcohol, impairment relates to accident risk and therefore a road safety concern. If the drugs don't cause accidents then we need not worry about them!

Fortunately, All evidence suggests that 95% of the problem is with drugs producing impairment relates to illicit drugs, principally cannabis, opiates, amphetamines and cocaine. However, also a significant problem relates to benzodiazepines, which may be legally prescribed, but are widely abused.

There is very little evidence that other prescribed drugs eg antidepressants or antihistamines administered to legitimate patients at therapeutic levels present a road safety problem!

I would therefore suggest that any legislation relates principally to these 5 groups of drugs. These cover 95% of drugs likely to cause impairment; most of the rest would be made up by LSD, GHB and Ketamine. All other illicits are hardly ever used.

Secondly we need to consider Enforcement. The following comments apply equally whether there are moves to bring in a new Zero Tolerance or we retain the requirement to demonstrate that the driver was impaired (possibly due to a drug).

My own view, as has ever been, is that we need to bring in Roadside drug screening for drugs; As soon as practicably possible!

A major point of issue in the original DfT consultation of 2008/9 and the suggestion carried forward in the North report is where best to carry an initial drug screening. The consultation and North suggest screening at a police station!

But, All the advantages of screening come from doing this at the roadside!

If the suspect drug driver needs to be taken back to a police station for a test, large amounts of police time will be wasted to no good purpose.

Furthermore, in order to do this the officer will need to have more than a reasonable suspicion that the driver is impaired. If this is the case, the officer could go straight to an Evidential blood sample at the police station. What value would an additional screening test add?

It is a little known fact that, although such rarely happens, the police are allowed to require an evidential sample currently, for alcohol, without offering a screening test!!

We therefore have the precedent in current drink driving law.

The benefit of roadside screening for drugs is that it is likely to detect more than 90–95% of drugs of concern with greater than 90% accuracy.

Up until the very recent introduction of digital roadside breath screening devices, roadside screening for alcohol has been no more accurate than this and yet it has driven forward successful enforcement of drink driving for more than 40 years!!

Furthermore, A roadside screener would practically allow the police to test the driver, even if there was only minimal evidence of impairment, without risk of wasted time if the screening test later proved negative (Probable minimum of half hour, more likely at least an hour, plus the tie up of staff resources) of returning to a police station.

Meanwhile resources would still be available for roadside enforcement if necessary.

These are the major salient points as I see them.

October 2010

Written evidence from the National Institute for Health and Clinical Excellence (NICE) (DDD 37)

Summary of Key Points

1. Overall, the evidence indicates that lowering the UK BAC limit from 0.08 to 0.05 is likely to reduce the number of alcohol-related deaths and injuries.

2. It could have an impact on the drink-driving behaviour of everyone who drinks alcohol—including those who tend to drink well above the current limit before driving. However, the effect of lowering the BAC limit (in terms of scale and sustainability) is likely to be dependent on increasing the public's awareness and understanding of BAC limits and the rigour of enforcement strategies. Currently, the actual—and perceived—risk of being detected and sanctioned for drink-driving (in the context of the BAC 0.08 limit) is low, and therefore does not act as a sufficiently strong deterrent.

3. The effect is also likely to be dependent on the precise combination of measures (including sanctions) targeting specific groups of drink-drivers, particularly those who drink and drive persistently above the limit.

4. Specific additional measures used in combination with a lower BAC limit are likely to enhance the effect. Administrative licence suspensions have proved an effective deterrent as they are employed immediately after the offence. Zero tolerance laws and graduated licensing systems for young drivers have also proved effective.

5. The NICE review is based on a rigorous review of the best available evidence. However much of this evidence is from the USA, Australia, and other European countries. The precise impact of these measures in the UK is uncertain, given differences in the context. Nevertheless the review findings provide an important basis for informing the government's policy considerations on changes in drink driving legislation.

6. NICE would be happy to make on oral submission of the evidence if requested.

About NICE

7. NICE is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE produces guidance mainly in three areas of health: public health (guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector), health technologies, and clinical practice. NICE guidance helps to improve the public's health and makes access to healthcare more equitable across the country.

Introduction

8. The Centre for Public Health Excellence at NICE conducted a review of the evidence relating to drink driving (NICE 2010).[54] This review was commissioned by the Department for Transport. It was considered by Sir Peter North as part of his independent Review of Drink and Drug Driving law (June 2010).

9. This submission is based primarily on the executive summary that sets out the findings of the NICE review. It addresses the first of the issues the Committee is interested in: Should the permitted blood alcohol limit be reduced from 80mg/100ml to 50mg/100ml?

Review of the Evidence—Approach

10. The review aimed to assess how effective the blood alcohol concentration (BAC) laws are at reducing road traffic injuries and deaths. It also assessed the potential impact of lowering the BAC limit from 0.08 to 0.05.[55] The findings will support the national road safety strategy for 2010 onwards for England and Wales.

11. The review examined:

- drink-driving patterns and the associated risk of being injured or killed in a road traffic accident
- how BAC limits and related legislative measures have changed drink-drinking behaviour and helped reduce alcohol-related road traffic injuries and deaths
- models estimating the potential impact of lowering the BAC limit from 0.08 to 0.05 in England and Wales
- lessons from other countries on using BAC laws as part of overall alcohol control and road safety policies.

12. The review was conducted in accordance with the methods outlined in NICE's "Methods for development of NICE public health guidance (second edition, 2009)" available from www.nice.org.uk/phmethods

Quality of the Evidence

13. The evidence comes primarily from the US, Australia, New Zealand and other European countries (mostly Scandinavia) and it is difficult to determine how applicable the findings are to the UK. There are marked historical, institutional, social and cultural differences between countries, as well as different political and policy priorities in relation to traffic safety, alcohol consumption and drink-driving.

14. Any evaluation of the effectiveness of BAC laws and related measures has certain limitations. In part, this is due to the complex nature of such interventions. It is also due to the methodological difficulties involved in conducting rigorous evaluations of the impact of legislative measures on a population. As a result, it is difficult to attribute precisely reductions in alcohol-related injuries and deaths to changes in BAC limits.

15. The quality of studies is also variable. The best available evidence is provided by time series studies (examining weather an "effect" was observed from date of policy change) and multivariate regression analyses, a statistical method that attempts to control for confounding factors. These factors include underlying trends in alcohol consumption and economic and social changes, as well as other alcohol control and road safety policies.

Findings of the Review

16. The main findings of the review are presented below.

Drink-driving and the risk of a road traffic accident

There is strong evidence that someone's ability to drive is affected if they have any alcohol in their blood. Drivers with a BAC of between 0.02 and 0.05 have at least a three times greater risk of dying in a vehicle crash than drivers with no alcohol in their blood. This risk increases to at least six times with a BAC between 0.05 and 0.08, and to 11 times with a BAC between 0.08 and 0.10.

17. Studies consistently demonstrate that the risk of having an accident increases exponentially as more alcohol is consumed.

18. Younger drivers are particularly at risk of crashing whenever they have consumed alcohol—whatever their BAC level—because they are less experienced drivers, are immature and have a lower tolerance to the effects of alcohol than older people.

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[54] NICE 2010 Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. This was supported by the report: Modelling the impact of a blood alcohol concentration limit of 50mg/100ml in England and Wales (ScHARR 2010)

[55] This review draws on a wide range of studies that used a variety of units to define BAC levels—such as milligrams of alcohol per 100 millilitres of blood (50mg/100ml or 80mg/100ml). In this review report we have not sought to standardise the terminology, but in summary sections the shorthand of 0.05 or 0.08 is used.

19. Younger drivers may also be predisposed to risk-taking—regardless of whether or not they have drunk alcohol.

Effectiveness of BAC laws

Overall, there is sufficiently strong evidence to indicate that lowering the legal BAC limit for drivers does help reduce road traffic injuries and deaths in certain contexts.

20. A number of studies indicate that lowering the BAC limit from 0.10 to 0.08 reduces road traffic injuries and fatalities, although the scale of effect varies. They include high quality review evidence (Shults et al. 2001). The effect is independent of other control measures (in particular, administrative licence suspension or revocation, which involves immediate revocation or suspension of the driver's driving licence upon failure of a breath test)..

21. Other studies indicate that reducing the BAC limit from 0.08 to 0.05 is effective. In what is the most recent and relevant high quality study, the adoption of a 0.05 BAC driving limit reduced alcohol-related driving death rates by 11.5% among young people aged 18–25 (Albalate 2006). It also reduced driving fatalities among men of all ages by 5.7%, and among men in urban areas there was a 9.2% reduction. The analysis, which covered 15 European countries, took account of a large number of factors which could have affected the results, including related policies and enforcement such as minimum legal driving age, points-based licensing and random checks.

22. There were reductions in deaths or injuries among the population as a whole but this was not statistically significant when other concurrent policies and infrastructure quality were taken into account.

23. The lowering of the BAC limit from 0.08 to 0.05 also led to a significant reduction in fatal accidents in Australia, specifically, an 18% reduction in Queensland and 8% reduction in New South Wales (Henstridge et al. 2004).

24. There is insufficient evidence to judge what level of effect might be sustained by lowering the BAC limit, although certain studies indicate that there could be positive, long-term gains (Albalate 2006; Eisenberg 2003).

Public awareness and enforcement of BAC laws

There is sufficiently strong evidence to indicate that publicity and visible, rapid enforcement is needed if BAC laws are to be effective. Drivers need to be aware of—and understand—the law. They also need to believe they are likely to be detected and punished for breaking the law.

25. Sobriety checkpoints (ie random and selective breath testing without the need for the police to have grounds for suspecting drink-driving) can help reduce road traffic injuries and deaths, according to two high-quality reviews (Peek-Asa 1999; Shults et al. 2001). In addition, random breath testing (RBT) had an immediate, substantial and permanent impact on accidents in three out of the four states studied in an Australian study (Henstridge et al. 1997). A further study showed that sobriety checkpoints in US states helped enforce the 0.08 law (Tippetts et al. 2005).High quality review evidence also shows that mass-media campaigns can reduce alcohol-impaired driving and alcohol-related crashes (Elder et al. 2004).

BAC laws and changes in drink-driving behaviour

There is sufficiently strong evidence to indicate that lowering the BAC limit changes the drink-driving behaviour of drivers at all BAC levels.

The BAC law appears to act as a general deterrent and the beneficial effects are not just restricted to the drivers at the BAC levels involved.

26. Five studies (included in a systematic review) showed that the introduction of a 0.08 BAC legal limit reduced the number of alcohol-related deaths involving drivers with a BAC of 0.10 or higher (Shults et al. 2001).

27. Another study showed that it had a differential impact according to age, with the highest reductions in deaths among younger drivers (14% reduction among 18–20 years, 9.7% among 21–24 years and 6.7% among those aged 25 and older) (Dee 2001).

28. Other studies have shown that reducing BAC limits to 0.05 or lower has an impact on drivers who drink heavily. For example, in 1991 when the BAC limit was lowered from 0.08 to 0.05 in the Australian Capital Territory, it reduced the incidence of drink-driving with a BAC well above the original 0.08 limit (Brooks and Zaal 1993).

29. In addition, analysis of six roadside surveys conducted between 1987 and 1997 in Adelaide, South Australia, found that the percentage of people driving at night with a BAC at or above 0.01, 0.05 and 0.08 decreased at an almost uniform rate (Kloeden and McLean 1997).

30. Although these studies show reductions in drink driving among those with high BAC levels, the precise mechanisms that influence their willingness and capacity to change their drink-driving behaviour are unclear.

31. A pan-European study reported that the 0.05 BAC limit had a statistically significant effect on younger drivers, men, and men in urban areas (Albalate 2006).

Administrative licence suspension or revocation

There is sufficiently strong evidence from good and high quality studies to show that administrative licence suspension can help reduce road traffic injuries and deaths.

32. This effect pre-supposes that a BAC limit is in place.

33. According to one study, such a policy (which involves an immediate sanction) can reduce the likelihood of being involved in a fatal, alcohol-related crash by 5%. It affected drivers at all BAC levels. Laws mandating licence suspension penalties after conviction had little effect, and did not appear to be an effective deterrent (Wagenaar and Maldonado-Molina 2007).

34. Another study (Villaveces et al 2003) showed that administrative licence revocation laws were associated with a 5% reduction in overall mortality and a 5% reduction in alcohol-related crash fatalities. A further study reported that administrative licence revocation was associated with an 8.6% and 10.6% reduction in alcohol-related fatal accidents (Kaplan and Prato 2006).

35. A model of the effect of administrative licence revocation legislation, taking into account variables for the business cycle, mileage travelled and demographic characteristics, also showed significant reductions in alcohol-related crash fatalities (Freeman 2007). However, administrative licence revocation usually has a BAC limit as a criterion, so the author says the results should be "properly interpreted as a partial effect conditioned on the existence of a BAC law".

Young drivers: zero tolerance laws and graduated licensing schemes

There is sufficiently strong evidence to indicate that zero tolerance laws and graduated licensing can help reduce alcohol-related injuries and deaths.

36. Zero tolerance laws (where the legal BAC limit is zero or close to zero for particular categories of driver, such as young and probationary drivers) and graduated licensing schemes (where young or novice drivers get more driving privileges as they mature or their driving skills increase) can help reduce alcohol-related injuries and deaths. One systematic review reported a 9–24% reduction in crash fatalities, while another reported reductions in the range of 11–33% (Shults et al. 2001; Zwerling and Jones 2001).

37. Additional evidence is provided by primary evaluation studies of high or good quality.

38. One study found that zero tolerance laws, combined with administrative licence revocation, led to a 4.5% reduction in fatal crashes among young drivers (Eisenberg 2003). Another showed that zero tolerance laws reduced the proportion of deaths among underage drink-drivers by 24.4% (Voas et al 2003). A further study linked zero tolerance laws to a 12% reduction in alcohol-related fatalities and a 4% reduction in overall crash fatalities (Villacaves et al. 2003).

39. Three US studies showed that zero tolerance laws changed the pattern of alcohol consumption and the drink-driving behaviour of young people overall ((Wagenaar et al Carpenter 2004 Liang and Huang 2008).

40. Good quality evidence shows that graduated driver licensing restrictions help reduce crashes among young drivers (Hartling et al.2004).

41. A study of the impact of graduated driver licence restrictions on young drivers in New Zealand showed that crashes involving those on a restricted licence were less likely to have occurred at night—and less likely to have involved passengers. In addition, the driver was less likely to have been suspected of drinking alcohol, compared with crashes involving a driver licensed under the old system (Begg et al 2001).

Modelling the impact of a 0.05 BAC limit

For the NICE review, a range of estimates were produced for the number of alcohol-related driving casualties that would be avoided in England and Wales from introducing a 0.05 BAC limit, according to different assumptions.

Assuming the policy produces the same relative effect on the BAC distribution in the driver population of England and Wales as observed in Australia, 144 deaths and 2929 injuries were estimated to be avoidable.

Assuming the policy produces the same relative effect on accidents as observed in other European countries, 77–168 deaths and 3611–15832 injuries were estimated to be avoidable.

42. A model was developed for NICE which used the best evidence identified during the systematic review to estimate what impact lowering the BAC limit to 0.05 would have on the number of alcohol-related deaths and injuries in England and Wales (ScHARR 2010).

43. A number of estimates were made, based on an extrapolation of the effect of lowering the BAC limit from 0.08 to 0.05 in other countries. The predictions also take into account the ongoing shift in the distribution of BAC levels in the driving population (that is, the amount that people are drinking before driving). Given the many uncertainties related to the data and the assumptions used in the modelling, the figures should be interpreted with considerable caution.

44. There was limited evidence on the pattern of drink-driving in the UK, as measured by BAC levels among the driving population. There was also a lack of UK evidence on how reducing the legal limit might change drink-driving behaviour and the associated risk of casualties, particularly among those drinking above the current 0.08 BAC limit. Consequently, unknown parameters had to be calibrated or estimated from the international literature.

International Lessons

45. It is generally accepted internationally that reducing the legal BAC driving limit is an effective drink-driving deterrent and there is a clear trend, especially in Europe, towards introducing a 0.05 limit.

46. Other interventions that are being introduced to support this policy include lower BAC limits for young, learner, probationary and professional drivers (ie zero tolerance laws), and a range of enforcement measures, particularly random breath testing but also alcohol ignition interlock devices and more consistent and intensive enforcement in general.

47. European citizens (including drivers) appear to support drink-driving policies already in force, as well as proposals to extend them. The same is true of UK citizens. However, UK citizens are less likely than other Europeans to know what the legal BAC limit is, and are among the least likely to have had their BAC level checked. In common with drivers in other countries that do not permit random breath testing, UK drivers are likely to think that they will never be checked.

48. The quality, comprehensiveness, and reliability of data in international reviews of measures against drink-driving are variable. Also, there is a lack of information about contextual factors that might be important in explaining differences in outcomes. General conclusions about the impact of interventions may not be a reliable guide for policymakers in any particular country.

August 2010

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Supplementary written evidence from The National Institute for Health and Clinical Excellence (NICE) (DDD 37a)

I would like to reiterate key messages from the Study by Albalate.

Alabalate has studied in detail the fatality figures from 15 countries in Europe over the years 1991 to 2003 during which 9 of those 15 countries shifted from a .08 to .05 limit. Several statistical models were fitted which adjusted for many factors including country, trends in fatalities, employment levels, economic growth, level of motorisation, kilometres driven, education levels, road infrastructure such as motorway and national roads, legal age, whether points are given for punishment, levels of random checks. Having adjusted for all these factors the study found that the average independent effect of changing from .08 to .05 was a reduction in fatalities of between -3.39% and -7.43% depending on the statistical model fitted. Applying these reductions to England gives the Sheffield figures of 77 to 168 fatalities avoided per annum.

These estimates do not depend on any specific assumptions about behaviour across different bands or the use of Australian evidence. They are the average effects achieved across EU countries in the recent past ie some countries will have achieved slightly more effect and others slightly lower, but represent a best guess at an effect for England if one accepts that the changes seen in 9 other European countries would be representative of England.

Albalate also analyses time lag effects, concluding that these estimated effects improve over a time horizon of 3 to 6 years.

The study also finds that random testing interacted with moving to.05 produced statistically significant reductions at population level.

Finally, if there were one scientific study that I would recommend the committee to read it directly for themselves rather than reading reports summarising evidence it would be the Albalate study.

October 2010

Written evidence from The Association of Licensed Multiple Retailers (ALMR) (DDD 39)

1. The Association of Licensed Multiple Retailers (*ALMR*) welcomes the opportunity to submit written evidence as part of the above inquiry. As the only national trade body dedicated solely to representing the needs and concerns of pub and bar operators, the Association is well placed to comment on the potential impact of any changes in the law on the sector.

2. The *ALMR* represents neither brewing nor property owning interests and instead provides a voice for those running licensed retail outlets on a day-to-day basis. Between them our 74 member companies operate just over 7,000 pubs, clubs, bars and restaurants. Two-thirds of members are small independent companies operating 50 pubs or fewer under their own branding, predominantly suburban community outlets.

3. The credit crunch, economic downturn and a series of regulatory burdens have combined to create a perfect storm which continues to threaten many of the UK's pubs and bars. The outlets which have been hardest hit have been the traditional suburban community or neighbourhood pubs of the type operated by our members. These pubs are valuable social and economic assets—community centres, social spaces, tourist attractions and significant revenue generators—as well as providing a well regulated and controlled environment for people to enjoy alcohol responsibly and socially.

4. The sector clearly has the potential to help drive forward the private sector recovery—in the early part of this decade it was responsible for creating 1 in 5 new jobs. An early return to growth for pubs and bars will not only help the economy as a whole but also the delivery of a successful Olympics in 2012. In order to deliver that however, pubs and bars need a supportive regulatory and economic environment.

OVERVIEW

5. This is a fragile industry already under strain and we are concerned that precipitate change in the drink driving law could have a detrimental impact on it—a point readily acknowledged by the North Review. It will reinforce the impression left by a diverse range of public policies that drinking should be done at home, rather than as part of a social outing. Consumption in a well regulated environment ensures that it is both monitored and managed. Pubs and bars have played and continue to have a key role in the successful delivery of existing drink drive policy, and this should be applauded not undermined.

6. Recent Government policy on taxation, health and law and order has significantly increased the price to consumers of alcohol sold through the pubs and bars. At the same time, licensing policy has deregulated the sale of alcohol through the off-trade and supermarkets. This has fuelled a price differential which has actively encouraged consumption at home. Coupled with the introduction of a ban on smoking in public places in 2007, the net effect of public policy has been to create a disincentive to visit licensed premises.

7. We are also concerned to ensure that any changes in driving legislation should be proportionate and directed at those offender groups or types of driving which give rise to the highest number of deaths or fatalities. We are concerned that the proposals in the North Review, focused as they are on a whole population approach, are not the most effective means of delivering the public policy objective of reducing road casualties and fatalities. More importantly, as a reduction in the BAC level overall will target the responsible majority rather than those of greatest concern—young drinkers and those drinking well in excess of the current level—such a change may undermine existing support for the policy and respect for the law. This would be a retrograde step.

Should the BAC level be Reduced?

8. Drink driving policy and legislation is an area of conspicuous public policy success. From a peak in 1966 when drink driving was responsible for over a quarter of all fatalities, it now accounts for just fewer than 15%—and this despite a significant increase on traffic and passenger numbers. Since 2001, when drink drive policy was last reviewed, road deaths attributable to drink driving have declined by 6% on average each year. This is faster than the decrease in road deaths caused by other factors over the same period. The latest Department of Transport statistics reveal that in 2009 deaths from drink driving dropped by 5% to below 400 per annum for the first time. Serious casualties and slight casualties are both down by 8–9% year on year.

9. We now have amongst the lowest road deaths in Europe and Britain's roads are also amongst the safest in the world. It is also worth noting in this context that we also have a very different legal and enforcement framework to other countries. We may have one of the highest BAC levels in law, but we also have some of the toughest penalties and stringent enforcement. Countries with lower limits also have lower penalties and drink driving is seen as a relatively minor misdemeanour.

10. The existing policy framework is demonstrably working, not just in reducing deaths and fatalities but in delivering a significant cultural shift which stigmatises the practice of drinking and driving. The message of not driving if you have had anything at all to drink is patently getting through to the responsible majority. Pubs and bars have played a significant role in that through designated driver schemes and contribution to public education campaigns.

11. We do not believe that the current BAC limit should be changed whilst the overall policy framework within which it sits is still successfully delivering a reduction in casualty and fatality numbers. We also question whether sufficient evidence has been provided to demonstrate that a lower limit would of itself reduce the figures still further.

12. The North Review itself acknowledges the difficulties in modelling and the uncertainty surrounding any change in the current law. We wish to draw attention to the following points made in the Report and believe that these are the key points of consideration in the current inquiry:

a. *Will a change in the BAC be effective?* Evidence from both NICE and European Studies suggests that reducing the limit will not necessarily influence behaviour across the whole population and will not be effective in all cases. It suggests that the UK's existing approach of high visibility, mass media campaigns and prompt enforcement intervention are more effective. A lowering of the BAC on its own will not be effective in reducing fatality and casualty numbers.

   A whole population approach is also likely to be ineffective at tackling those drivers who continue to be immune to existing limit; a reduction in the BAC will do nothing to reverse this. Whilst the majority of people have readily accepted the "do not drink and drive" message, a hard core of offenders continue to drink well in excess of the BAC—90% of those drink drive fatalities have a BAC in excess of 100mg. There is also a serious problem of non-compliance amongst younger drivers. This suggests that it would be more effective to focus attention towards targeted enforcement against these offenders rather than create a new BAC to enforce.

   The North Review itself identifies that the effectiveness of the proposed change is questionable. It notes that a reduction in the BAC level would have no impact on statistics in Scotland, which make up over 7% of total drink drive related fatalities. Evidence from Canada and America from earlier this decade also suggests that a reduction would have little, if any, effect.

b. *Will it impact on support for the law?* Whilst the existing drink drive regime is by no means perfect, it is well understood by the population as a whole and is respected. This is perhaps in contrast to other public health messages and limits for alcohol. It is a particular measure of its success that the BAC is now no longer viewed as a safe limit at which to drive but rather an indicative level at which penalties will be applied. It is this which is key to the public support for the existing BAC and there is a very real risk that any changes to it could result in a weakening of that; for example if the new limit is seen as unrealistic or penalties disproportionate.

The high level of public support is acknowledged by the North Review, as is the uncertain impact of any change, and the potentially detrimental impact of change should not be under-estimated. As noted previously, countries with a 50mg limit or lower have correspondingly lower penalties and drink driving is often seen as a minor misdemeanour. On the other hand the continued application of stringent penalties for a perceived lower level offence risks bringing the regime into disrepute in the eyes of the general public and undermining the stigma currently associated with a drink drive offence. The existing public policy success could quickly unravel as a result.

We are also concerned that any public messaging around a reduction in the BAC could inadvertently give the impression of an indicative level of safety or reintroduce the concept that there is a limit you can drink to safely before driving. Evidence from NICE clearly shows that the consumption of any alcohol impairs ability and the suggestion of a safe level would be a retrograde step.

c. *Will it impact on the hospitality industry?* The North Review acknowledges the difficulties inherent in any cost benefit analysis and that the modelling of the impact on the industry was uncertain. The report acknowledges that the change could have a detrimental impact on pub trade but suggests that the industry could do much to protect itself against this—for example through designated driver schemes and lower priced soft drinks. This fails to acknowledge the existing investment and support for such schemes already in place in the industry. We do not believe there is anything additional or significantly different that pubs and bars etc could do to insulate against the likely downturn in trade resulting from a change to the BAC level.

The North Review is equally dismissive of the likely economic impact on an industry already under strain. The pub trade has faced severe pressures since 2007 as a result of the credit crunch and subsequent recession. Pubs have been closing in record numbers since then—industry estimates suggest 39 per week—and new pub openings have declined by some 60%. A change of this nature which could further affect trade in a vital sector of the economy should not be under-estimated. Pubs are already facing increasing operating costs—those directly attributable to legislation increased by 20% in the last year alone—and a resulting pressure on margins. There is simply no slack with which to insulate themselves against a further downturn in custom.

The proposed change also needs to be seen in the context of the wider public policy environment. The net effect of recent Government taxation and law and order policies has been to significantly increase the cost of alcohol sold in pubs as compared with that sold through supermarkets. During the 1990s, beer was on average 3 times more expensive in a pub than in a supermarket: it is now more than 10 times as expensive. The total deregulation of alcohol sales through the off trade as part of the Licensing Act 2003 has fuelled the use of alcohol as a loss leader by the major supermarkets and aggressive price promotions coupled with the introduction of a ban on smoking in public places have resulted in over 70% of alcohol now being consumed at home.

The policies of the previous Government have resulted in a legislative disincentive to drink in a social, well-regulated environment. The reduction of the BAC and associated messaging will simply serve to reinforce this.

13. All of the above make it uncertain that a change to the BAC level at this point in time will deliver the public policy objective of reduced fatalities and casualties and the wider costs and benefits outlined in the report.

Pub Trade Recommendations

14. At a time of limited resources at both a central, local and police level, it is vital that any reform in this area is focused on delivering the greatest reduction in fatality and casualty figures most effectively. We question whether a focus on reducing the BAC and a whole population approach will deliver that.

15. In the first instance, measures to further reduce drink driving statistics needs to be put in the context of overall fatalities and casualties. There are many causes of death on the roads and measures to tackle them must be prioritized accordingly. In particular, as the North Review notes, driving under the influence of drugs is a serious cause of death and casualties on the road which is, as yet, not being tackled in any meaningful way. A short and long term strategy to address the problem of drugs and driving is needed as a matter of urgency and may deliver a greater reduction in fatalities and casualties than an adjustment in the BAC. There is considerable overlap between alcohol and soft drug use which means that action to tackle the latter could also reduce drink drive statistics.

16. Looking specifically at measures to reduce drink drive fatalities and casualties, evidence from NICE and other countries suggests that this is best achieved by means of public education and enforcement. Efforts to target young drivers and existing persistent non-compliance should be stepped up; over 90% of those dying on the roads are well above the existing BAC level. It is worth noting in this context that publicizing the change in the limit and educating people about its implications would divert valuable resources away from enhanced enforcement. More can and should be done to enforce the existing limit before measures are taken to reduce it further. We would support increased levels of random breath testing and visible and rapid enforcement.

Conclusion

17. In summary, therefore, we believe that changes in driving legislation should be proportionate and directed at those offender groups or types of driving which give rise to the highest number of deaths or fatalities. Moreover, controls and costs should be targeted specifically at the irresponsible minority rather than penalising the responsible majority. The proposals outlined in the North Review fail these tests and, more importantly, could undermine existing respect for the regime and its effectiveness. We question whether the benefits of a small reduction in casualty figures justified the social and opportunity costs in terms of support and impact on the hospitality industry.

September 2010

Written evidence from the Department for Transport (DDD 41)

1. Introduction

1.1 This evidence is submitted for the Transport Committee inquiry into drink and drug driving law, following the independent report submitted by Sir Peter North CBE QC.

1.2 As suggested by the Committee, this Memorandum addresses five issues identified in the invitation to submit evidence—

a. Should the permitted blood alcohol limit be reduced as proposed?

b. If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?

c. How severe is the problem of drug driving and what should be done to address it?

d. What wider costs and benefits are likely to result from changes to drink and drug driving law?

e. What would be the implications of such changes for enforcement?

1.3 Sir Peter North's review was commissioned by the then Secretary of State in December 2009. His report covers a wide range of issues. The Government is considering carefully the 51 detailed recommendations. In doing so, it is important that we fully investigate the economic and public service resource impact of any suggested changes to the law, taking account of the current financial and economic situation.

1.4 The Government will follow with interest the evidence which is given to the Committee, and will take account of the Committee's report before a response to Sir Peter's report is finalised and published. The Secretary of State has indicated to the Committee (in oral evidence on 26 July) that he expects this to be achieved by the end of the year.

1.5 The Department will be pleased to assist the Committee in any way it can, and to give oral evidence if that would be helpful. However, this Memorandum does not offer substantive comment on the individual recommendations; and we will not be in a position to do so until a formal response is ready at the end of year, when we will be in a position to draw on the Committee's recommendations.

2. Background Information

2.1 The Department publishes National Statistics on reported road casualties in Great Britain. The annual report routinely includes an article on drink-driving. The most recent in this series was published in September 2009;[56] and the next one is scheduled for publication on 23 September.

2.2 In the meantime, on 5 August 2010, the Department published provisional statistics on road accidents reported to police involving drinking and driving in Great Britain in 2009.[57] Figures show that fatalities resulting from drink and drive accidents fell by 5% from 400 in 2008 to 380 in 2009, whilst seriously injured casualties fell by 9% from 1, 620 to 1,480. Slight casualties resulting from drink drive accidents fell by 8% from 10,960 to 10,130. Total casualties fell by 8% from 12,990 to 11,990. Fatal accidents remained unchanged from 2008, remaining at 350 for the second year in a row. Overall drink and drive casualty accidents fell by 7% from 8,620 to 8,050.

2.3 The Department's statistics do not include equivalent figures for casualties or offenders related to drug-driving. However, the Ministry of Justice publish statistics which cover proceedings, convictions and disposals for drink driving as well as drug driving.[58]

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[56] http://www.dft.gov.uk/adobepdf/162469/221412/221549/227755/rrcgb2008articles.pdf
[57] http://www.dft.gov.uk/adobepdf/162469/221412/221549/399405/rcgb09drinkdrive.pdf
[58] Available on-line at—http://www.justice.gov.uk/publications/motoringoffences.htm

3. Should the Permitted Blood Alcohol Limit be Reduced as Proposed?

3.1 The Government will announce a conclusion on this question in due course in its response to Sir Peter's report. His terms of reference required an examination of the evidence not only on the involvement of alcohol in road fatalities/accidents; but also the impacts of any change in the blood-alcohol limit on health outcomes, businesses and on the economy more widely. The report has only limited coverage of these latter questions, and does not include an impact assessment, or consideration of the public sector resource and enforcement implications of his proposals.

3.2 It is important that the Department should fully investigate the economic and public service resource impact of any suggested changes to the law, taking account of the current financial and economic situation. A related issue is the extent to which the estimates of casualty reductions are attributable to a lower drink drive limits per se or to increased enforcement and related measures. Much of the evidence comes from countries where there were effects from changes in the enforcement regime and publicity at the same time as they changed the limit. We are undertaking further work to this end, which will inform the Government's decision.

3.3 The Department will consider any evidence the Committee is able to identify on these matters.

4. If so, is the Mandatory One Year Driving Ban Appropriate for Less Severe Offenders, at the New (Lower) Level?

4.1 The present penalty regime for drink and drug drive offenders includes a minimum one year disqualification for the main offences. This simple, tough and unambiguous disqualification has been regarded as an important element of the deterrent against these offences. As Sir Peter's report notes this might be lost if offenders perceived a chance of less severe penalties.

4.2 Most other European countries that have a lower prescribed alcohol limit have adopted graduated penalties. In some cases, it is considered to be a criminal offence only to exceed a limit at—or, in some cases, above—the prescribed limit applied in this country.

4.3 The EC 6th Framework Programme supported a project, Police Enforcement Policy and Programmes on European Roads (PEPPER), which included, as Deliverable 6, a report produced in 2008 entitled "Comparison and analysis of traffic enforcement chains across EU Member States and in relation to EU policies".[59] This report has a table comparing the prescribed limits in various EC countries, and the associated penalties. This shows a number of examples where penalty points and modest fines are used for offences below the UK prescribed limit. In some cases—for example, Spain and Portugal, the limit above which a criminal offence is committed is reported to be higher than the UK limit. In Canada, the federal limit is the same as in the UK, although the Provinces impose short-term licence suspensions for exceeding a lower limit.

4.4 The Department has not researched the reasons for these graduated regimes; nor is it aware of research into the impact of reducing penalties in this way. It may be intended among other things to reduce the burden on criminal justice systems of processing additional offenders. The UK's current record on drink drive casualties compares very well with other EU countries which do have graduated penalties and, in many cases, there is no correlation between casualty figures and a lower blood alcohol limit.

4.5 We are not aware of similar evidence of graduated penalties for drug-driving.

5. How Severe is the Problem of Drug Driving and what Should be Done to Address It?

5.1 The Government is committed to introducing preliminary testing devices to assess suspected drug driving. The next step is for the Home Office to publish a final draft specification for the type-approval of such devices, which they aim to achieve in September 2010. It will then be for manufacturers to submit devices for assessment and trialling. We expect that these devices will be available initially for use in police stations, in place of assessments by forensic medical examiners.

5.2 Sir Peter North has reviewed the available evidence on the prevalence of drug-driving in some detail. It is widely acknowledged that this is a difficult exercise, and the Department will welcome any additional information the Committee is able to identify. Much of the detailed information on drink-driving is obtained from routine testing not only of offenders, but also from post mortems. The Department's published statistics on drink-driving are drawn from a combination of police accident reports and post mortem information, and there is at present no equivalent for drug-driving.

5.3 Sir Peter has made proposals for increasing the available data, and we are considering what is practical with other Departments. We have a research project almost completed, which has looked at available information about the prevalence of driving impaired by drugs. This has considered in particular information that might be obtainable from investigations by Coroners. We will take this work into account in finalising a response to Sir Peter's report.

[59] http://www.pepper-eu.org/docs/pepper_documents/PEPPER_D6_WP1_20080821.pdf

6. What Wider Costs and Benefits are Likely to Result from Changes to Drink and Drug Driving Law?

6.1 As explained in paragraph 3.2 above, it is important to investigate as fully as possible the economic and public service resource impact of any suggested changes to the prescribed alcohol limit for driving to the law, taking account of the current financial and economic situation. We are undertaking further detailed work on these impacts before responding to the report.

6.2 It is very difficult to assess the benefits of changes in the law on drug-driving when so little is known about the present scale of the problem, and how much it might be abated by any given measure.

6.3 Estimates of the casualty reduction potential of changes in the law on drink-driving depend upon assumptions about the way offenders—and drivers in general—may change their behaviour, and what if any changes are made to the enforcement regime. Since they account for the bulk of the numbers, any major reduction in drink-drive related casualties is likely to depend upon significant changes by a large proportion of those prepared to drive after drinking well above the current legal limit, whose offending behaviour is entrenched. The wider impacts of any new measures are not confined to those whose present behaviour is dangerous and illegal; casualty savings among other drivers might prove to be modest, but an assessment has also to be made of the wider potential effect of changes in behaviour by the driving population at large. Those with blood alcohol between 50 and 80 mg/100ml make up only 2% of driver and rider fatalities.

6.4 The key potential benefit from lowering the drink drive limit would be any reduction in fatalities and injuries, assuming that it resulted in a positive change in driver behaviour, and there were not perverse effects such as an increased willingness to flout a lower limit. This benefit includes avoiding the loss in economic output; and the health and other emergency service costs, and the very high social and human costs from the suffering caused by deaths and injuries. There would be further economic benefits from the reduction in damage only collisions; and congestion benefits from the reduction in collisions. The latter could be significant for trunk roads and non-urban roads, though less so for urban areas—as traffic can more easily divert to other roads.

6.5 The key economic costs from lowering the blood alcohol limit would include any additional enforcement costs, court costs and prison costs, although this depends on how the police enforce any new limit and how drivers react. There would be economic costs arising from any increase in drink-driving offences—for example, if more people lose their licence this potentially means more people are out of work. There would be an impact on the drinks, rural pubs and restaurants and wider services industries from any reduction in alcohol consumption. There might potentially be a more significant reduction in custom if people decided no longer to go to a pub or restaurant if they are worried about any curtailment of drinking alcohol beverages. Money not spent in say rural pubs might theoretically be spent on other activity not involving alcohol consumption, which could mitigate some of the economic impacts; but there would still be adverse consequences for those sectors which were affected.

6.6 The benefits described in paragraph 6.3 will continue to accrue from reductions in drink-driving over the years; and will do as a result of any further measures which have that effect, not all of which incur the range of costs discussed in paragraph 6.4.

6.7 The Department will consider any evidence the Committee is able to identify on these matters.

7. What Would be the Implications of Such Changes for Enforcement?

7.1 Sir Peter's report does not answer this question, except to say that drink and drug driving should have more priority. This necessarily raises questions about the deployment of police resource, and demands on the criminal justice system. We have to assume that changes to the law have potential to increase the number of offenders apprehended, and there is potential for a significant impact to the criminal justice system. The assessment described in paragraph 3.3 has to look at this issue; and similar work is also needed in relation to changes relating to drug-driving.

7.2 Sir Peter has discussed a range of measures to make the apprehension and processing of offenders more efficient. These include –

- removing the "statutory option" which allows certain drivers apprehended for drink-driving to replace evidential breath samples with a blood sample;
- commencing a provision in the Road Safety Act 2006 which closes a loophole in the High Risk Offender regime;
- introducing portable evidential breath-testing equipment, which would remove the need for drink drivers to be taken to the police station for further tests;
- random breath-testing;
- introducing preliminary drug-testing devices;
- delegating to custody nurses the role of forensic medical examiners in relation to the processing of suspected drug-drivers.

7.3 Some of these measures have potential to reduce administrative burdens significantly, and to improve the efficiency with which the current law can be enforced. The Department is considering each of these proposals, and will welcome the Committee's assessment of them.

7.4 The Government has a commitment to issue a specification for preliminary drug testing devices—so that manufacturers can submit devices for the necessary type approval. It will then be for police forces to purchase devices and introduce them to operational use. The Home Office aims to issue a final draft specification by the end of September.

September 2010

Further written evidence from the Department for Transport (DDD 41a)

Thank you for your letter of 19 October asking a series of supplementary questions for your Committee's inquiry into Sir Peter North's report on drink and drug driving.

TYPE-APPROVAL

Some of your questions relate to the requirements for type-approval of equipment used by the police for enforcing road traffic law. As you will know, this is a matter for the Home Office. They have provided the attached note which deals with the technicalities of type-approval, and the some of the legal issues which explain why we may not be in the same place as some other Continental countries.

It may assist the Committee if I add to this note an explanation of how we are trying to make the process of catching drug-drivers work more effectively. The challenge the police face under the system we have now in securing a conviction for driving unfit through drugs is to prove that –

i) the offender was driving;

ii) the offender was impaired so as to be unfit to drive; and

iii) the impairment was caused by drugs.

The police may arrest where there is evidence of i) and ii), and the officer has reasonable grounds (not necessarily a test result) to suspect iii). In the case of drink-driving, the breath test has supplied a simple fail safe answer for iii); and the prescribed limit offence has removed ii) altogether, because no evidence of impairment is required. So the drink-driving procedure has been simplified—with very beneficial effect.

But all three tests remain for drug-driving. We know there is a problem with getting the evidence that the impairment is caused by drugs. Invasive samples are required, and getting these depends on uncertain procedures involving forensic medical examiners. The devices we are committed to providing to the police will solve this problem—because drivers who fail preliminary tests will be required to give the blood samples required. As the Home Office note explains, we envisage devices that can be used in a police station or at the roadside.

It is important that the devices are not open to challenge—we cannot afford to lose cases because offenders argue that blood was improperly taken. That is why it is a priority to issue a type-approval specification and get the devices into use by the police.

The Committee may find—as Sir Peter North did—that this is not the only problem we have to overcome. It is not necessarily straightforward to collect and prove the required evidence of impairment. Your question about other countries suggests that the Committee may have identified differences in their offences and judicial processes. I am sure we would consider carefully any recommendations you make on these issues.

RESEARCH

You have asked why the Government did not participate in the EU DRUID or OECD research projects, and to what extent the decisions may have been due to human rights concerns. You also asked to what extent we intend to become more closely involved with current or future international research programmes on drug-driving.

You will appreciate that the decisions about which you ask were taken under the previous Administration. I understand that the choice not to participate fully from the outset in the DRUID project arose from a combination of competing priorities for limited research resources and the likely limitations of any UK sample due to difficulties we would face in replicating methodologies used by other member countries. We were clear, however, that we would have full access to the results of both projects, and would therefore be able to learn from other countries.

The department has had a long-standing programme of research into road safety which has included research on drinking and driving and drugs and driving. This has involved both national studies and contributions to international studies. These contributions have required the use of funds, and staff resource, and access to available data from this country. In the case of DRUID and the OECD study, I understand that resource considerations determined the contribution the Department was able to make. However, in both cases, we responded fully to requests for information about available UK data.

In addition, experience of involvement in a previous EU study (IMMORTAL) identified that other countries had been able collect samples from fatally and non-fatally injured drivers. However, it was not possible to get ethical approval to collect unbiased samples for non-fatally injured drivers in the UK. The UK case sample therefore consisted only of fatally injured drivers from post mortem records. This limited the conclusions that could be drawn from the UK samples. Given this experience, it was felt that the results from other countries would provide better evidence on the risks of drug driving than we could collect ourselves.

The Department was one of 12 countries that contributed to the assessment by the DRUID team of drink drive rehabilitation courses. This was based on work by TRL Ltd commissioned by the Department to co-ordinate a survey of a sample of drink drive rehabilitation course providers and attendees. This data was submitted to the DRUID team in 2008 and used for analysis reported in Validation of Existing driver rehabilitation measures (2009) at—

http://www.druid-project.eu/cln_007/nn_107534/Druid/EN/deliverales-list/downloads/Deliverable__5__2__4,templateId=raw,property=publicationFile.pdf/Deliverable_5_2_4.pdf

We were not able to participate in the OECD expert working group on drugs and driving for want of staff resources and competing priorities, but the report from this project included our contribution to national surveys of data and evidence on drugs and driving, which enabled the report to include a cross country comparison of this issue. The Department has also provided feedback to early drafts of the report. I understand that the report of this expert group, "Drugs in Traffic", is scheduled to be published by the OECD shortly.

The Department continues to keep a watching brief on the outcome of the DRUID project and will consider future international collaborations on a case by case basis, subject to Departmental resources and priorities.

November 2010

Note by Home Office

Type-Approval Process for Drug-Testing Devices

"Why does type-approval for drug-testing devices in the UK need to be more stringent than in other countries?"

1. The Home Office is developing type approval arrangements for drug testing devices for use by the police in relation to drug driving. Initially, it is intended that such devices will be installed at police stations. We have issued a draft specification for comment by the manufacturers, which we are now considering. In parallel, we are exploring the requirement for a drug testing device at the roadside, and the type approval specification which would be needed. It will only be possible to judge how stringent the Home Office requirements are in practice when the type-approval specification has been finalised, and devices have been submitted and assessed.

2. We have a legal requirement in primary legislation that any drug screening device for use in suspected drug driving cases must be specifically type approved by the Secretary of State (the Home Secretary). This is the same requirement as has long applied to screening and evidential breath test instruments, speed and red light cameras, and other devices.

3. Type-approval has been developed as a rigorous process for police equipment to overcome the scope our Courts allow offenders to challenge process. Road traffic law against drink-driving, speeding, and some other offences, has been beset by successful challenges on the basis that something was wrong—or unproven—about the equipment the police used to detect the offence. These challenges are not confined to equipment used for evidential purposes: questions about screening equipment have also derailed cases.

4. The answer—first adopted for breath testing equipment—is to provide in law that, if a device the police has used is of a type that has been approved, and has been used properly, its use and results cannot be challenged. This concept has then been built into subsequent legislation to avoid the risks of successful challenges against speed and other camera equipment. The fact that type approvals for various equipment has been subjected to rigour tests sets the standard of stringency for any further equipment—such as drug screening devices. Otherwise, there is a risk of compromise of the principle of type-approval.

5. The purpose of this type approval system is to ensure that the courts can have confidence in the results the devices produce and in actions based on those results, because the devices have been proved to be reliable, consistent, accurate and precise. Without type approval, it is likely that scientific evidence on the device's performance would have to be given separately in every case, with consequent heavy demands on the police, police suppliers and the criminal justice system.

6. If the Courts are to accept this degree of constraint, and the type-approval is not itself to be open to legal challenge by way of judicial review, specifications have to be stringent. Equipment must be reliable, consistent, accurate, and precise; working to standards that have been endorsed on an objective basis by relevant experts. This includes operational and laboratory tests. For example, a device which produces a high rate of false negatives (so that drivers who have taken drugs are not caught by the device) has the virtue that it catches some offenders; but they can be expected to win challenges in our Courts on the grounds that other, equally impaired, drivers are getting off because the testing device is not consistent or reliable. Besides,

if a large number of drug users are known to be avoiding getting caught then an approach could lose credibility. Conversely a high number of false positives (where the kit find drivers as having a drug present, which is then not confirmed by the evidential blood test) this could lead to legal challenges over false arrests. If a high standard is not set, the type-approval itself could also be subject to judicial review.

7. Type approving devices without requiring them to meet the strict requirements proposed would be liable to judicial review as being irrational and distorting the market by unfairly favouring manufacturers whose existing devices could not meet the requirements over those whose future devices might. It could also lead to repeated court challenges, eg on the grounds that there was no justification for the police action in requiring a blood specimen and that other equally impaired drivers were not being prosecuted because of a negative reading. Challenges against drug screeners would also be likely to bring the entire type approval procedure into disrepute and lead to challenges against other type approved devices, with a very significant effect on other police enforcement operations. Repeated challenges in the courts would have very considerable resource implications for the police and court system. Most cases are heard in the magistrates' courts, so a decision in one case is not binding in any other: so that winning one case would set no precedent that could be relied on against further challenges to the police.

8. Police operational requirements are different in other countries and significantly not all countries have a type-approval system like ours; nor do they have the same judicial system and the opportunities our legal process offers to defendants. Other countries do not offer the same opportunities for judicial review or for challenges to prosecutions based not on disproving the accusation but demonstrating that there were insufficient grounds for the prosecution, or that prosecution was unjustified because arbitrary. In this country, challenges have regularly been made against both screening and evidential breath test devices but have consistently been unsuccessful because of the rigid type approval regime that applies here.

How does the Government respond to the view that the types of preliminary roadside drug screening devices used in other countries are sufficient for UK roadside screening/because they are screening devices and not evidential?

9. It is significant that our current law requires proof of impairment from any drug, not proof of the presence of a drug. A drug may be present but not causing impairment because of the time since it was taken, or the subject's level of tolerance, or other conditions. Some countries where drug screening devices are used have an absolute offence of driving with a specified drug in the body- whether there is any evidence that it is impairing the driver or not. A screener therefore has only to detect that drug, even at levels which might not be impairing.

10. As previously explained, it may not be helpful to cite foreign comparisons where there is a different judicial context—and even a different offence. In this country, devices must be properly type approved, and the police need to be able to demonstrate that they are acting legally in requiring someone to take a test using it.

November 2010

Supplementary written evidence from Sir Peter North (DDD 42)

Thank you for inviting me to give evidence at your hearing on 14th September. There was one point which arose which I felt I ought to clarify.

You asked me about the derivation of data on both risk of driving with alcohol in the system and the estimated reduction in casualties from a lower UK limit. As I explained, the estimates of reductions in casualties by the NICE rely on the experience of other nations (Australia and in Europe) in reducing their blood-alcohol limit. However, I fear that I might have left you with the impression that this was also true of the research and statistics on the risk of dying or injury with various blood alcohol concentrations in the system.

In fact, these statistics are derived from GB coroners' data on blood alcohol concentration of those drivers who are killed as compared with those who have drunk nothing. This is set out more fully in paragraphs 3.29 to 3.32 of my report, which sets out the risk of a driver with a blood-alcohol concentration of between 50mg and 80mg/100ml dying in an accident as being six times that of a driver who has consumed no alcohol.

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