House of Commons

Transport Committee

Drink and drug driving law

First Report of Session 2010–11

Volume II

Additional written evidence

Ordered by the House of Commons
to be published 12 and 19 October 2010

Published on 2 December 2010
by authority of the House of Commons
London: The Stationery Office Limited

The Transport Committee

The Transport Committee is appointed by the House of Commons to examine the expenditure, administration and policy of the Department for Transport and its associated public bodies.

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List of additional written evidence

Written evidence

Written evidence from Steve Wilson (DDD 01)

In Summary

1. I am AGAINST the proposed change to the blood/alcohol legal limit in the driving legislation.
2. I am FOR the inclusion of drug testing in the driving legislation.

My Reasoning?

Although I have no firm evidence to support this view (by which I mean firm statistics and figures), as a publican running a busy high street venue I feel I am well placed to offer a balanced view? I say this because:

(1) With regard to the first point above: my view has nothing to do with any potential affect on my business, simply because I don't believe it will have any effect! I firmly believe that the current limit is about right, as it catches the habitual drink/driver but poses no risk to the "innocent" drink/driver? By "innocent", I mean those driving, for example, the day-after-the-night-before who may still have a traceable amount of alcohol in their blood but not at a level that seriously affects their driving? Reducing the legal limit will have absolutely no affect on the habitual drink/driver because they already, by definition, break the law and will continue to break the law, even if the limit was zero. In my own experience, drink/drivers do not even consider their actions until they've either been caught or involved in an accident (or both)? The only possible affects of a reduction, therefore, would be to increase convictions of people who probably don't need to be convicted? I have no idea how you have come up with the figure of potential lives saved of +300 but, I suspect, it is simply government doing their usual thing of stating an over-simplistic calculation that supports their case!

(2) With regard to the second point: this is a very sensible measure and drug takers have been getting away with driving under the influence for far too long. I see many people under the affect of drugs who habitually drive, in the mistaken belief that it's much better than drink/driving, but I can tell you that I'd much rather get in a car with someone who has had three pints (putting them over the legal limit) than with someone who has had three lines of coke (and are still perfectly legal to drive)!!

What I Believe you Should Do?

I believe the only way to properly reduce drink/driving is to introduce a higher limit BUT run it in conjunction with much more serious penalties? For example, an automatic jail sentence over a certain limit, regardless of the offender's position? I have absolutely no doubt you would see almost all the current habitual drink/drivers reassess their habits immediately!! Although even the most severe punishment will not stop all offenders, arbitrary limits and/or laws are not what prevents the law being broken, it is the penalty that has most effect.

July 2010

Memorandum from The Royal Standard of England (DDD 02)

Please do not change anything to do with limits over driving limits.

The pub in the country or village is the last piece of British culture that is only just surviving the current regulations and taxes.

The pub is the last bastion of British Culture and acts as the glue for social cohesion within communities, particularly in the country or village pub. Ask any visitor to the UK and they will want to visit a pub -the pub is an institution envied throughout the world.

Please ask your Tourist Board colleagues the figures for foreign visits to a pub to see the importance of supporting the pub.

For many communities the local pub is the only social life people have in their lives as the local high street shops have gone due to supermarket power. They are now being viewed as assets within the community.

Successive Governments have backed the supermarket lobbyists over the local high street shops this effects the cohesion of the local community.

Village shops and regional differences are disappearing through the power of the supermarkets and out of town shopping.

Supermarkets encourage promotions of cheap booze and take home convenience food. Britons stay at home and vegetate in front of the telly. Is this a Briton we want to live in, behind walls? Obesity has increased there is a link Government regulations and taxes have caused an underclass to grow, people that cannot develop any social skills and are a burden to the taxpayer.

The supermarkets have increased the nations alcohol consumption mainly by cheap wine and spirits sales. The pub gets battered again by the "Health Taliban" as one size fits all regulation or tax. Alcohol abuse is a burden to the taxpayer—not in my pub, it is the home drinkers. Kids drink in the streets with booze bought in from supermarkets/off licences not pubs.

Wine is imported and sold by supermarkets. Beer/Ale/cider is craft brewed locally in the UK and sold by local pubs—this is a no-brainer—support the UK local businesses.

Pubs do not fly in vegetables from overseas either, we use local produce. Supermarkets are too big to do this and where they do they are aggressive to local farmers. They are changing our quality of life through convenience.

Why do customers come by car? 95% of my customers come by car and most customers would love to walk down our lane but they are not safe,with cars going by, what else can they do?

Secondary to the drink drive limits is the safety of the roads for pedestrians on my local roads. There are no footpaths for walkers and there are no local buses. Where have the Green buses gone? There is no political will to redress this.

To lower the driving limit increases the cost of visiting the pub mini cabs are expensive and cost more than four pints.

Governments have made laws for large town pubs that have not been appropriate for the country or village pub.

We had better a transport network and a more cohesive social structure in the past and this has been legislated away since 1947?

We need national foot paths and bicycle paths along side our country roads.

Those that break the limits will always break the limit, not those who do not. Most customers have learnt what they can drink (two pints of ale below 4% over an hour) within the current limits and to change it will mean confusion to drinkers and a loss of sales and more pubs shutting. A loss to local economies.

Not all pubs can convert to being a restaurant and subsequent loss of pub culture.

Common sense please.

July 2010

Memorandum from The Richardsons Group (DDD 03)

We all deeply sympathise with families who lose their loved ones as a result of other people's anti-social behavior. Unless we have experienced it, we can only imagine the heart ache and grief that follows the injury or death of a loved one in a car accident.

I still write however to object to the proposed law change, that will reduce the legal limit from 80mg to 50mg of alcohol per 100ml of blood.

We are told that this move will save 100–300 lives per year. There seems to be no good evidence to support this claim, and in any event, road fatalities in England are currently lower than almost anywhere in Europe.

What is certain however, is that responsible social drinking by the vast majority, and the viability of pubs,will be needlessly jeopardized if not decimated.

I am opposed to the destruction of our social fabric, by the elimination of reasonable social drinking. I do not believe that someone with 75 mg of alcohol in their blood, is a menace on the roads.

How extraordinary that having not vigorously enforced the current limit, that it is thought by the authorities that there is a need to reduce it.

Most alcohol related accidents, involve drivers who are well over the 80mg limit, sometimes by as much as two or three times. These are the people that should be targeted.

If there is a strong desire to reduce the number of road deaths by 100–300 per annum, instead of decimating responsible social drinking, our social fabric and the pub trade, I suggest the implementation of some of the following measures.

1. Enforce the current 80mg limit.
2. Ban drivers who are involved in divorce proceedings because they are distracted.
3. Ban drivers who are planning weddings for the same reason.
4. Ban drivers who are travelling with an argumentative spouse for the same reason.
5. Ban drivers who are travelling with badly behaved children for the same reason.
6. Ban drivers who are listening to Sport Radio (the respected Transport Research Laboratory claims that these people have a significantly worse reaction time than people who have 80 mg of alcohol per 100ml of blood).

7. Ban drivers who are tired.
8. Ban drivers who are using medication that effects the central nervous system.
9. Ban drivers from drinking and driving if they are under 21 years.

I realize that some of these suggestions are impossible to enforce, but they are in fact the causes of many hundreds if not thousands of road deaths.

It is a bad law that when introduced, is regarded as neither fair nor reasonable. It is for this reason that I urge you to leave the current arrangements in place.

If the desire to save lives needs to be satisfied, energy and resources could be spent in the following areas:

— Up to 4,000 deaths occur annually in our hospitals as a result of the *Clostridium Difficile* superbug.

— Up to 7,000 premature deaths are caused per year by the harmful trans fats that are present in a wide range of cheap foods.

— The fact that the NHS spends £7 billion a year on the obesity problem.

— About 1,200 babies are born each year in England alone, who are addicted to drugs such as heroin. This figure has almost doubled in the last 10 years.

Thank you for the opportunity to express my views.

August 2010

Memorandum from Joseph Holt Limited (DDD 04)

Drink Drive Limit

We wanted to write and express our views on the proposed review of the Drink Drive laws.

We are a company which owns and manages 130 pubs and supply 200 free trade accounts in the North West of England. We operate a brewery in Manchester and in total employ 1,361 people. We would submit that to reduce the limit from 80mg to 50mg would penalise a lot of our sensible law abiding customers unnecessarily, as it would restrict the number of visits they make to a pub. The consequences for us as a business, which has already suffered a considerable fall in trade from both the recent increases in beer duty and also from the current recession, would be severe.

We suggest instead that efforts be directed towards a greater enforcement against the minority of prople who currently abuse the Drink Drive laws and that also curbs should be made against drug related driving incidents.

Simply to lower the limit now from 80mg to 50mg would be a heavy handed way of dealing with this issue and would lead to harsh restrictions for our customers and to a further downturn in our business.

Pubs are a very important part of the community and there is no doubt that the current alarming rate of closures would be exacerbated by these proposals.

It is worth considering if the limit is dropped to 50mg, how many drivers in future would not risk going to the pub at all who currently enjoy visiting their local quite safely.

August 2010

Memorandum from Mike Rawson (DDD 06)

1. The Committee might consider the following points when making its recommendation to Government as to whether the current permitted blood alcohol limit be lowered.

2. Sir Peter North's report highlights the dramatic decrease in road traffic fatalities between 1979 and 2009. A reduction from 1,640 to 410 is welcome but the drink/drive laws are only part of the reason. A high compliance with the seat belt legislation and huge improvements in vehicle design, with the accent on safety and survivability, are of equal importance.

3. When looking at statistics relating to deaths resulting from motor vehicle usage it is important to examine the blood/alcohol level of drivers involved. How many had a reading between 50mg and 80mg in 100ml of blood? If the numbers are low then justification for lowering the limit to 50mg is questionable.

4. One major consequence of lowering the limit relates to enforcement. During the last decade there has been a serious decline in the number of traffic patrol officers and, therefore, a reduction in enforcement of the drink/drive legislation by officers dedicated to reducing accidents and enforcing the traffic laws. The proposed reduction in police numbers throughout the country, in line with government cost cutting measures, will reduce enforcement even further and, laws not enforced, are soon brought into disrepute.

5. Lowering the limit will result in those few officers, actually enforcing the drink/drive laws, being in custody suites with motorists who have consumed less than a pint of beer or a small glass of wine (and who are almost certainly not impaired) whilst those seriously above the limit and, a real danger to other road users, are not detected and arrested.

6. Legislation is important but, for the vast majority of people, the fear of getting caught is what stops them from breaking the law.A high profile police presence is a far better deterent than simply lowering the drink/drive limit.

August 2010

Memorandum from The Royal Society for the Prevention of Accidents (RoSPA) (DDD 07)

1. Introduction

1.1 RoSPA gave both oral and written evidence to the North Review of Drink and Drug Driving Law. A copy of our written evidence is available on RoSPA's website at www.rospa.com/roadsafety/consultations/2010/north_review_written_submission.pdf. This submission reflects our original evidence to the North review and our views on the subsequent North Report[1] and its associated research papers.[2, 3]

1.2 We strongly support the recommendations made by Sir Peter North and have urged the Government to implement them as soon as possible.

2. *Should the permitted blood alcohol limit be reduced as proposed?*

2.1 RoSPA believes that the Blood Alcohol (BAC) limit should be lowered to 50 mg of alcohol per 100 ml of blood (50 mg/100 ml) as recommended by the North Report. In fact, the evidence in support of this change is stronger now than before the North Review.

2.2 Before the North Review, RoSPA's support for a lower limit was based on evidence that:

- between 50mg and 80 mg drivers are 2–2.5 times more likely to be involved in an accident than drivers with no alcohol, and up to 6 times more likely to be involved in a fatal crash.[4]
- In 2000, the Government's Road Safety Strategy[5] estimated that reducing the limit to 50mg could save 50 lives, and prevent 250 serious injuries and 1,200 slight injuries each year.
- A more recent examination of the figures suggests that reducing the legal limit could save 65 lives each year and prevent 230 serious injuries.[6]
- An International review[7] of the impact of introducing or lowering limits found that they resulted in fewer drink drive accidents, deaths and injuries.

2.3 However, research by the Centre for Public Health Excellence NICE[2] for the North Review indicates that the number of lives saved by a lower limit would be much greater than previous estimates. The North Review concludes:

> A reduction to 50 mg/100 ml would undoubtedly save a significant number of lives. In the first year post-implementation, estimates range from at least 43 to around 168 lives saved—as well as avoiding a larger number of serious injuries—a conservative estimate is 280 although as many as almost 16,000 has been modelled. It is estimated that the impact of any lowering in the blood alcohol limit will actually increase over the first few years of implementation with an estimate of up to 303 lives annually saved by the 6th year.

2.4 These estimates do not include casualty savings in Scotland, which the North Report notes account for about 7% of drink drive-related casualties in Great Britain, so the overall number of lives saved would be even greater. Northern Ireland are separately considering whether to lower their drink drive limit.

2.5 The main argument against lowering the limit appears to be that the focus should be on drivers who are significantly above the current limit of 80mg/100 ml, and lowering the limit to 50 mg/100 ml would not affect their behaviour. However, the NICE research[2] and the North Report[1] state that there is strong evidence to indicate that lowering the limit changes the drink-driving behaviour of drivers at all BAC levels.

2.6 RoSPA believes that a lower drink drive limit should be introduced as part of a wider a package of drink drive measures, including:

- Evidential roadside breath testing.
- Wider powers to breath test drivers, including random breath testing.
- Wider use of drink drive rehabilitation courses.
- Encouragement for employers to set zero limits for staff who drive for work.
- Improved public education.
- Further development of alco-locks.

3. *If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?*

3.1 RoSPA believes that the penalties for exceeding the current drink drive limit should apply to the lower limit of 50mg. Less stringent penalties would suggest that it is a less serious offence. However, the lower limit should be accompanied by sustained and high profile publicity and education to raise awareness that people who previously had one or two drinks and then drove are likely to find themselves exceeding the new limit.

3.2 Particular attention should be focused on the "Morning After" effect. It is very difficult to know exactly how much alcohol has been consumed, and how long it will take the liver to remove it from the bloodstream (which varies from person to person). Some drivers who do not drive when drinking at night, find themselves unknowingly still over the limit the following morning. This happens now with a limit of 80mg, and will happen more often with a lower limit. Care should be taken to avoid a perception that such people are being unfairly criminalised, especially when the penalties are so severe.

3.3 A more sustained educational effort will be required to raise awareness of this issue and enhance drivers' understanding of the length of time necessary following drinking to allow alcohol levels to decline to safe levels. Many agencies and organisations need to be involved, including employers of staff who drive both to commute and for work purposes. There needs to be a recognition that for those who drive on a daily basis regular heavy drinking is no longer a practicable option if they are to comply with the law. Given the very large proportion of the population in this category this will mean a major change in the Nation's drinking habits with related health benefits which in turn should be taken account of in any overall cost benefit analysis.

3.4 The UK's penalties for drink driving are considerably more stringent than most other countries. However, the effectiveness of laws and penalties depends to a large extent on the perceived and actual level of enforcement. In the case of drink driving, we believe much depends on the level of breath testing conducted by the police and the "visibility" of that testing.

3.5 The penalties are stringent enough to act as a significant deterrent, provided that people think there is a strong chance they will be caught if they drink and drive. If people do not think they will get caught, the level of penalties is largely irrelevant. An increase in breath testing and more consistency across the country would improve the effectiveness of drink drive laws.

3.6 RoSPA supports the courts having the power to impose a driving ban as part of bail conditions, where a defendant might commit a further drink-drive offence whilst on bail. The immediate confiscation of the driving licence of drivers who have failed an evidential breath test and who are high risk offenders would be another way of reducing the likelihood that such people would drive while waiting for their case to come to court. A further measure would be to ensure that where an offender is imprisoned as well as disqualified from driving, the disqualification period does not begin until they have been released from prison.

4. *How severe is the problem of drug driving and what should be done to address it?*

4.1 Drug driving is a much more complex issue than drink driving, and the level of knowledge and research we have about drugs and driving is far less comprehensive. Although we know that the effects of many drugs impair driving and that a proportion of drivers take drugs and then drive, we still do not have clear data about the numbers and types of road accidents and casualties caused by drug driving. Even where drugs have been detected in a driver following a crash, this does not necessarily mean that the drugs caused or contributed to the crash. The presence of drugs in a driver may also be masked by the presence of alcohol.

4.2 The review[3] of drug driving evidence commissioned for the North Review identified a lack of recent UK data on the impact that drug driving has on casualty rates as it is over 10 years since the last survey exploring the incidence of drugs in road accident fatalities. It found that analysis of the various data sources that are available shows:

- Cannabis remains the most prevalent illicit drug, but, there has been a significant increase in cocaine use.
- Regional variations are apparent: in Scotland, benzodiazepines are the most prevalent drug group, with over 80% of drivers suspected of being impaired by drugs testing positive for a benzodiazepine.
- There appears to have been a considerable increase in polydrug use by drivers since the 1990s.
- Recent surveys and anecdotal evidence suggest there has been a surge in the use of legal highs, but there is limited evidence of the extent to which those using these drugs are also driving, or what effect the substances have on road safety.

4.3 The contributory factor database shows that in 2008, impairment by illicit or medicinal drugs was judged by the police to be involved in just 56 fatal and 207 serious accidents. In comparison, drink drive figures show 380 fatal accidents (resulting in 430 deaths) and over 1,200 serious accidents (resulting in over 1,600 seriously injured people) involved alcohol in excess of the legal limit.

4.4 Very few drivers are convicted of driving while unfit through drugs. The complex procedure for detecting, charging and convicting a drug driver makes it difficult for the police to enforce the law adequately. During the Christmas 2009 drink/drug drive campaign fewer than 500 Field Impairment Tests for drugs were conducted, compared with over 223,000 alcohol breath tests.[8]

4.5 Compulsory drug testing of drivers in fatal or serious accidents should be introduced. This would provide better data as well as act as a deterrent. As with drink driving, RoSPA believes that the police should have the power to conduct random and targeted drug drive tests.

4.6 A new offence of driving with an illegal drug in the body would make it easier to catch and convict drug drivers, which in turn would be a greater deterrent. RoSPA believes that the only way to emulate the success we have had against drink driving is to implement a practical and effective system for detecting, charging and convicting drivers who are driving while impaired through drugs.

4.7 In RoSPA's view, an absolute ban would be best, so the law does not set a legal level of use for drugs that are illegal in the first place. However, many illegal drugs can be used legally if they are prescribed, so an exemption will be needed for drivers who have been prescribed the drugs. If their driving is impaired, the existing offence of driving under the influence of drugs can be used. The Review of Drug Driving Evidence[3] states that:

> "The complex nature of drugs makes it difficult to establish values that would represent impairment in the general population. Tolerance issues and interactions with other drugs suggest that identifying suitable cut-off values for other drugs may also be inappropriate."

4.8 RoSPA believes that any new offence should not apply to prescribed or over-the-counter medicines, because some people may be deterred from taking the medicines that they need. Including prescribed and over-the-counter medicines would make the new offence little different from the existing one, and the benefit of making it easier to catch and convict drivers with illegal drugs in their bodies would be lost. Individuals need to be responsible for deciding whether they are fit to drive, and where they get this substantially wrong, the existing offence of driving under the influence of drugs could be used.

4.9 Another key tool is the development of a roadside drug test device (a "drugalyser"). There have been attempts to develop such devices for at least 20 years, and it has still not been possible yet to produce a device that can be used as evidence in court. However, recent announcements suggest that a roadside drug tester may become available in the next two years. The Review of Drug Driving[3] refers to the experience of introducing roadside screening devices with impairment testing and a zero tolerance approach in relation to a new Drug Impaired Driving law in Western Australia, where the police almost exclusively favoured the use of the drug testing device because the process was simple, straightforward, quick to administer and unambiguous.

5. *What wider costs and benefits are likely to result from changes to drink and drug driving law?*

5.1 Given an average cost of over £1.6 million per fatality, the economic benefits would be very significant.

5.2 Changes to drink driving laws, and the public attention that is likely to accompany such changes, may contribute to the wider public health debate about sensible drinking.

6. *What would be the implications of such changes for enforcement?*

6.1 The North Report identified a "decreasing priority given to drink drive policing", attributed, in part, to the fact that drink driving offences (other than causing death by careless driving when under the influence of drink or drugs) are not prioritised in England and Wales by inclusion within the "Offences Brought to Justice" regime. It concluded that "Drink driving needs to be afforded a much higher policing priority."

6.2 RoSPA believes that this lack of priority can be seen in Home Office Statistics. Enforcement levels (ie, the number of breath tests conducted) have been inconsistent, fluctuating substantially from year to year. In 2007, just under 600,000 breath tests were conducted—200,000 fewer than 10 years previously.[9] But, in 2008, the number increased to over 700,000, although this may in part be due to better recording with new digital recording equipment rather than necessarily a large increase in tests. The number of tests varied from 650 per 100,000 of the population in the West Midlands region to 2,961 in Wales.[10] An increase in breath testing and more consistency across the country would improve the effectiveness of drink drive laws.

6.3 The NICE research[2] suggests that:

> "UK citizens stand out from the rest of Europe in their lack of knowledge of their country's legal BAC limit; and UK drivers are among the least likely to have experienced a check for alcohol levels, and, in common with drivers in other countries without systematic random breath testing, are more likely to think they will never be checked."

6.4 The police should have wider powers to breath test drivers, including the power to conduct random breath tests. This would increase drivers' perception of the risk of being caught. The North Report[1] notes:

> "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."

6.5 The NICE research[2] identified evidence from other countries that sobriety checkpoints (random and selective breath testing) can help reduce road traffic injuries and deaths, and that random breath testing had an immediate, substantial and permanent impact on accidents in three out of the four states studied in an

Australian study. High quality review evidence also shows that mass-media campaigns can reduce alcohol-impaired driving and alcohol-related crashes. The effects of the 0.05 BAC law in Austria and Netherlands were attributed in part to publicity and enforcement measures.

6.6 The power to use evidential breathalysers at the roadside was introduced in the Serious Organised Crime and Police Act 2005. This would mean that the roadside test could be used as evidence in court and eliminate the need for the second test, which in turn would free much police time. However, this equipment is still not in use.

6.7 In Scotland, the Christmas/New Year Drink Drive campaign included, for the first time, seizing the vehicle of repeat drink driver offenders.[11] During the campaign, four drivers had their cars forfeited, and a further 24 had their cars seized pending consideration by the Court. During a two-week summer campaign in July 2010,[12] six repeat offenders were caught and now risk having their cars seized. In addition, drug driving was added to the forfeiture scheme, so drug driving recidivists are at risk of losing their vehicle. The forfeiture scheme for drink and drug drive recidivism in Scotland is now general practice and not just for specific campaigns. RoSPA believes that this is a significant additional deterrent and should be adopted throughout the UK.

7. Conclusion

7.1 RoSPA supports the broad conclusions of the North Report[1], that:

- The drink drive limit should be lowered as this is likely to reduce the number of alcohol-related deaths and injuries.
- A lower limit 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.
- A lower limit should be supported by increasing the public's awareness and understanding of the limit and the likelihood of being tested.
- Much more research and data about drug driving is needed to inform future policy.
- Police forces should training more officers to conduct the Field Impairment Tests (FITs) and increase significantly the number of FIT tests conducted.
- Drug screening devices (in Police stations and at the roadside) should be developed and introduced.
- Drug drive rehabilitation courses should be considered.

7.2 We are not convinced about the recommendation to research and set legal limits for driving with illegal drugs in the body, but support the recommendation that if it proves not to be possible to set such limits, a zero limit should be considered.

7.3 Since the North Review the need to reduce the public deficit has become clear, and while RoSPA recognises that it is public spending cuts will affect road safety because they will affect every area of our lives, it is crucial that that spending decisions are informed and based on clear evidence and data, and crude, blanket spending cuts are not imposed. The casualty and financial savings that a lower drink drive limit, the other recommended drink drive measures and the drug driving recommendations would produce must be very carefully considered and balanced against the need to reduce spending. Getting these hard decisions wrong will cost lives.

August 2010

References

[1] Report of the Review of Drink and Drug Driving Law, Sir Peter North CBE QC, June 2010.

[2] Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths, Centre for Public Health Excellence NICE, 2010.

[3] A Review of Evidence Related to Drug Driving in the UK: A Report Submitted to the North Review Team, P G Jackson and C J Hilditch, Clockwork Research Ltd June 2010.

[4] Combating Drink Driving: Next Steps: A Consultation Paper, DETR, 1998.

[5] Tomorrow's Roads: Safer for Everyone, DETR, 2000.

[6] Reducing the BAC level to 50 mg—What Can We Expect to Gain, R Allsopp, PACTS Research Briefing, 2005.

[7] The Effects of Introducing or Lowering Legal per se Blood Alcohol Limits for Driving: An International Review, Mann et al, Accident Analysis & Prevention, 2001; 33(5).

[8] ACPO Press Release 006/10, 21 January 2010.

[9] Road Safety Compliance Consultation, DfT 2009.

[10] Police Powers and Procedures, England and Wales 08/09, Home Office, April 2010.

[11] Vehicle Forfeiture to Continue Beyond Festive Drink Drive Campaign, ACPOS press release, 2 January 2010.

[12] Drink Driving Campaign—No Journey Is Worth The Risk, ACPOS News Release, 20 July 2010.

Memorandum from the Gin and Vodka Association (GVA) (DDD 08)

The GVA welcomes the opportunity to respond to the House of Commons Select Committee for Transport inquiry into drink and drug driving. Being an organisation which represents producers of gin and vodka our comments relate to drink driving alone.

THE GIN & VODKA ASSOCIATION (GVA)

The GVA's 34 members represent 90% of the UK trade. Gin and vodka are exported to some 200 countries. Over 70% of UK produced gin and more than 20% of our vodka is exported. Exports of UK-produced gin and vodka are up 50% compared to 1990 and were worth over £250 million in 2007. It is the largest sector by volume in the UK spirits market.

We recognise and share the Government's desire to tackle and reduce harmful consumption of alcohol. GVA members support Drinkaware and the Campaign for Smarter Drinking which are working with the Department for Transport to investigate potential for collaboration on anti drink driving activities.

The GVA responded to Sir Peter North's enquiry. Our views on his recommendations are as follows:

1. *Should the permitted blood alcohol limit be reduced as proposed?*

   The current limit combined with robust enforcement, and effective anti-drink driving campaigns has been effective in reducing drink driving. A continued focus on all three elements is necessary rather than focusing on the blood alcohol level alone.

2. *If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?*

   Yes. If you reduce the limit and reduce the penalties you risk compromising support for the law. If a case if made for reducing the blood alcohol level the current penalties should remain.

3. *How severe is the problem of drug driving and what should be done to address it?*

   No comment.

4. *What wider costs and benefits are likely to result from changes to drink and drug driving law?*

   No comment.

5. *What would be the implications of such changes for enforcement?*

   We would support strict enforcement of current penalties and continued education campaigns. Consistent anti drink drive campaigns supported by strong enforcement of the law are key to addressing alcohol misuse. They have achieved a significant cultural shift in attitudes to drink driving. They need to be maintained.

   We would support strengthening the measures available to the police.

   We would support random breath testing as another tool for enforcement. It is this combination of measures rather than adjustment of the blood alcohol level which can be shown to have made a positive difference.

August 2010

Memorandum from Claire and Denise McCutcheon (DDD 10)

We would wish to place on record our total opposition to any change to the drink-drive laws on the grounds it would probably ruin us.

This is an old "drovers'" pub, situated 1.5 miles from the nearest town and between two small villages, so that no more than a dozen houses are within a mile of us. We are the third generation to run the Harrow, our grandparents becoming brewery tenants there in 1932. There is no bus service and in the early nineties the direct road to our nearest town, Petersfield–the old Saxon droving road–was cut off by the A3M by-pass, making the journey here even more difficult for the road user. Four years ago the smoking ban further added to our commercial problems.

Despite this however the Harrow has been able to maintain its appeal to families, walking groups and traditional "regulars", being mentioned in every edition of *The Good Pub Guide* (including a "long service" award) and being recognised for its "authenticity" by Alastair Sawday. Only this year it won an entry into *The Good Food Guide*. Over the last 10 years it has raised £27,000 for cancer charities.

Our concern is chiefly for our "regulars", people who have always enjoyed a nightly gossip, drink a pint or two and then go home. We now cater for them by only selling 3.8abv beers. In all the years our family has been here there has never been an accident.

This pub is known throughout the world as unchanging. There are still two bars, toilets are across the lane, brass tapped barrels sit in the servery and the same Victorian clock ticks on the mantelpiece the way it did right through World War 11.

Can we suggest that, before you make any recommendations about reducing alcohol levels, you should visit us and perhaps advise us how we can continue to be commercially viable if a virtual nil alcohol level is introduced and our customers risk acquiring criminal records just because they like a pint or two.

August 2010

Memorandum from the Police Federation of England and Wales (DDD 13)

The Police Federation of England and Wales welcomes this opportunity to contribute to this short inquiry.

As the staff association that represents the interests of over 140,000 police officers, from the rank of Constable to Chief Inspector, we bring together views on the welfare and efficiency of the service, and take responsibility for their presentation to both Government and other opinion formers. For more information about the Police Federation please visit www.polfed.org.

The Police Federation is fully supportive of most of the recommendations contained in the body of the recent report by Sir Peter North in relation to drink and drug driving. We have in fact been instrumental in calling for some of the recommendations for some time, so welcome the opportunity to further enhance our credibility in pushing for appropriate changes to the legislative framework surrounding drink and drug driving.

The Roads Policing Group of the Police Federation of England and Wales has previously suggested that there could be an opportunity to consider a change in the drink driving limits which provide for a lower limit for professional drivers whilst carrying out that specific role, eg, taxi drivers, LGV and PCV drivers. We understand Sir Peter North's assessment of the situation within the body of his paper which rejects this proposal, but we feel this is an opportunity missed.

In relation to the issues which you have suggested we focus on, we would respond as follows:

1. *Should the permitted blood alcohol limit be reduced as proposed?*

1.1 As identified in the North report comments, the current drink drive limit was set over 40 years ago, and public opinion has significantly changed since those early days in relation to tolerating drinking and driving. Likewise, enforcement equipment has developed over years into being exceptionally accurate.

1.2 There are understandably higher risks associated with drivers who consume alcohol sufficient to put them on the high side of the current limit or in ill judged cases beyond that. This we feel can be addressed through a change to the current limits. This is readily resolvable by changing the law to the limit recommended by Sir Peter North, which we feel would receive global public support.

1.3 For the avoidance of doubt and absolute clarity, we of course see that pro rata to the blood alcohol limit being reduced, the breath, urine equivalent amounts should be accordingly lowered within the law to the proposed standard.

1.4 The review has very carefully and robustly considered the wider ramifications associated with lowering the drink drive limit, following which, there has never been a more appropriate time to address these issues and align our standards with those of we believe every other European Country. It seems perverse that our tolerance and legal limits have not changed to reflect the seriousness of drinking and driving.

2. *If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?*

2.1 If drinking and driving is to be continually treated as a serious issue, and carry with it penalties that have been successful in deterring people from abusing the law and supporting compliance, then we believe there will be a public support for keeping the penalties as they currently are for the higher 80mg limit. To have a raft of penalty options will create a series of problems that disrupt the key message which is to refrain from alcohol whilst drinking and driving. It could also encourage people to take a gamble with drink whilst driving knowing the penalties to be less severe if caught. The risks and safety issues remain relative to the consumption of alcohol whilst in charge of a motor vehicle. Hence the Police Federation of England and Wales roads policing group believe that the current mandatory disqualification should be retained.

2.2 We would however be open to consideration to reduce such a sentence if there were suitable alternative educational options to offer convicted drivers, after having served a portion of their disqualification, subject to certain criteria being met. This would not be dissimilar to that of the driver and speed awareness schemes, which have showed remarkable success in recent years. We would propose that convicted drivers would be expected to attend such a course at their own cost as part of the rehabilitation and educational programme, whilst still retaining the disqualification period as a significant deterrent.

3. *How severe is the problem of drug driving and what should be done to address it?*

3.1 This is a difficult question to answer with any degree of accuracy, and the problem varies in degree from policing area to policing area. The real fact is that we simply do not know the scale of the problem for a number of reasons. The only really measurable statistic which has any level of credibility are from those samples taken at post mortem and in evidence to HM Coroners following a road death.

3.2 The principle reason being that it is difficult to enforce the current legislation relating to drug driving. Officers need to have confidence in applying the law, which means they need to rely on a series of road side tests, which only a small handful in England and Wales have the skills and knowledge to test. It is important having those skills they use them frequently to retain competency for evidential purposes.

3.3 Officers complain that the road side testing takes too long and in busy areas late at night, can become a bit of a "circus" with onlookers goading or distracting officers from the drug assessment process.

3.4 There are consistently reported issues with police station procedures in relation to establishing medical conditions due to the influence of drugs sufficient to impair driving. Furthermore, officers seem unsure of what evidential issues CPS and the Courts are looking for in relation to proving an offence. Some will say that CPS lawyers do not always know the issues in sufficient detail to successfully prosecute a case, and that it is often a challenge to provide evidence to satisfactorily press a conviction home, often destabilised because opinions can vary so much. This focuses on the need to prove an impairment, which links to a drug, which may not always be the fundamental ingredient as to why the driver was stopped or dealt with by the Police in the first place.

3.5 The Police Federation of England and Wales roads policing group has been asking for some time now for a much simpler and practical scientific process of testing at the road side for the presence of drugs (screening device). We are aware that work is ongoing in this respect, but we feel that a much closer relationship between government legislators, Home Office Scientific Development Branch (HOSDB) and manufacturers needs developing in order to progress the issue, so that a type approval can be provided by HM Government.

3.6 It would be a requirement that such screening devices are manufactured at a price that is not cost prohibitive to forces in purchasing sufficient quantities of the kit to apportion to each Police vehicle used on operational policing work, or as deemed required on a case by case basis.

3.7 There has been much debate in recent times about the need to remove the legal imperative of proving driver impairment to that of simply driving whilst under the influence of a drug. We are fully supportive of engaging in further discussion over these issues, whilst simultaneously appreciating that there are a number of factors that make this quite difficult to easily resolve.

4. *What wider costs and benefits are likely to result from changes to drink and drug driving law?*

4.1 It has been suggested by key academics who understand the science and adverse physiological ramifications of drinking and driving that up to 50 or 60 deaths per year could be prevented if the alcohol level were to be reduced to the recommended levels suggested by Sir Peter North. We would expect an equally significant reduction in injury cases.

4.2 It is difficult to assess the relative impact on a reduction of drug driving deaths for reasons stated above, but we believe there could be derived benefits if drug driving could be tackled more engagingly by the Police with the advantage of a far more simplified process, which is better understood in terms of evidential necessity.

4.3 The economic cost to such death trauma and related injuries is difficult to quantify, but benefits through reduced costs, reduced risks, public safety and better behaviour must be worthy of significant favourable considerations.

4.4 We have campaigned for some years in relation to removing the drink drive statutory option, and we welcome this as part of Sir Peter's recommendations. If this were to be removed we would see this as representing but a small measurable benefit in reducing the time spent by officers waiting for a registered medical practitioner attending police stations.

4.5 We can see no real reason to retain the current "get out of jail" option where a driver has already been allowed a reasonable tolerance above the current legal limit. Unless there has been some specific reason to switch the breath test to one of blood or urine as a consequence of technical issues with evidential testing devices.

4.6 Policing and enforcement alone cannot get the message across. There will have to be a commensurate package of public awareness and media activity which promotes and discourages drinking and drug driving. This will inevitably come at a cost, as will local initiatives aimed at pressing the message home though whatever programme of educational and information facilities are delivered through community action to the more vulnerable groups.

5. *What would be the implications of such changes for enforcement?*

5.1 Obvious benefits should translate into safer roads and drivers, such that the number of incidents involving drinking and driving should decline over time. However we offer a warning, that in the short to medium term we would expect a natural rise in casualty and fatality figures due to drink driving (especially) because a change in law to the lower limits would produce an expected rise in such recorded incidents, until the public change their pattern of behaviour and reduce alcohol consumption prior to driving.

5.2 We express our concerns that the pressure on policing is increasing at a time when operational resources to deal effectively with roads policing considerations are decreasing and likely to suffer further cuts through ongoing budgetary challenges. For this reason the ability of forces and operational officers to provide more attention to these important criminal and road safety related areas could be seriously challenging, through a lack of capacity and resilience. The operational resource implications varies from force to force, but the overall outlook for a high profile 365 presence is indeed an issue that has to be addressed to ensure drink and drug driving enforcement retains a high level priority.

5.3 It is a fact that there is such a high degree of compliance with drink driving regulations, because the public are justifiably concerned or afraid of the consequences of their actions or being caught, even though the chances of being stopped by the Police, remain minimal unless or until an adverse attention is brought about their behaviour. So it is important that making an impact and keeping the momentum going should be a policing priority. We are therefore concerned that in the event there is any further reduction in capacity to enforce the rules, then any positive impact on changes to legislation in furtherance of driving down deaths and injuries on our roads could well be lost.

5.4 We reserve our position with regard to the recommendation (27) made by Sir Peter in respect of the deployment of portable evidential machines, sufficiently reliable and evidentially proven to replace the current substantive machine. Laudable though the recommendation is for the right reasons, there are a number of matters for our concern, namely in that we have not yet evaluated the devices, or the process sufficiently to be satisfied.

I hope you find our response of help in your deliberations.

August 2010

Memorandum from the British Institute of Innkeeping (BII) (DDD 14)

BII is the professional body for licensed retail with 13,000 members, most of whom are individuals running licensed premises. The following responses to the questions around drink driving, posed by the Transport Committee, have been gathered from a representative sample of our membership. We have not commented on the issues around drug driving.

Statistics relating to the industry have already been outlined by the British Beer and Pub Association in their independent response.

Should the permitted blood alcohol limit be reduced as proposed?

BII members feel that any reduction in the BAC limit will make no impact on those who habitually drink and drive. Whilst they have sympathy with the aims of the proposal, members do not support a reduction. The current limit is bedded-in and respected. Lowering it could cause that respect to be diminished and cause confusion.

Another issue is the additional risk to the economic viability of some pubs, particularly those in rural areas. The question is not that these pubs rely on "drinking and driving" customers, but the reality that most people have one drink with a meal and pose little risk. Drivers have, in the main, changed their drinking habits over the five years following the introduction of drink-drive legislation any changes could confuse customers and make them unwilling to make a journey.

On a positive note, BII members do run a variety of schemes to support their customers such as soft drinks promotions and taxi services.

If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?

The majority of BII members agree that the one year ban is appropriate. Some, however, feel that a six month ban might be better to differentiate between what is currently felt to be safe and the new lower limit and perhaps the current tariff needs revision overall if the limit is reduced.

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

Costs:

BII members feel that wet-led pubs particularly, that do not rely on local trade, will see a significant impact in reduced sales (see above). The consequences of this will mean more closures and higher job losses. Currently, individual puts contribute around £17,000 to the local economy so such closures will impact on communities and society generally. The BBPA's response outlines the economic impact that these changes could have with around 18,000 pubs potentially being affected.

The changes will increase the cost of policing.

Benefits:

BII members feel that the changes may result in fewer alcohol-related accidents.

An opportunity could be made to maximise sales attracting a higher GP, such as coffee and soft drinks.

What would be the implications of such changes for enforcement?

BII members felt that the changes would put an extra burden on the police and judicial system generally. It was also felt that the introduction of a lower limit might divert the police focus from other tasks if spending cuts were significant.

What other measures (other than stricter limits) do you consider could be effective in addressing drink-driving?

BII members were overwhelmingly in favour of more education to promote personal responsibility; TV advertising campaigns; the promotion of the "I'll be Des campaign" and the adoption of local driver schemes as well as better public transport systems within larger conurbations.

August 2010

Memorandum from the Road Haulage Association (RHA) (DDD 18)

The Road Haulage Association (RHA) is the trade and employers association for the hire-or-reward sector of the road haulage industry. The RHA represents some 8,000 companies throughout the UK, with around 100,000 HGVs and with fleet size and driver numbers varying from one through to thousands.

The RHA provides advice and guidance to member companies on management and employment issues. We recommend a zero tolerance approach to alcohol and drug abuse at work by workers in safety-critical roles, including driving, which should be viewed as gross misconduct most likely leading to dismissal. Clauses to that effect are contained in the RHA Contracts of Employment service which is available to all members.

We are grateful for the opportunity to contribute to the debate on the possible reform of the drink and drug driving laws, which follows the publication of the report by Sir Peter North in June 2010.

We have set out our views below, relating points to the questions specifically raised by the Transport Select Committee. Our views have been formulated following consultation with RHA members.

Should the permitted blood alcohol limit be reduced as proposed?

Yes. As a keen supporter of proportionate road safety measures and noting that only the UK and Malta within the EU now maintain an 80mg per 100 ml of blood alcohol limit, the RHA agrees with the proposal in the North report to reduce the limit to 50mg.

When surveyed a majority of RHA members supported the proposal to reduce the current limit from 80mg of alcohol to 50mg per 100 ml of blood.

We have considered the suggestion that the new limit would be applied to all drivers with no lower limit for HGV or other professional drivers. We support this approach.

Of those members who responded to our survey most were against a separate, lower limit for professional drivers.

If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?

The RHA does not support an automatic one year driving ban at the new lower limit.

Of those RHA members agreeing with the introduction of the lower limit of 50mg, most did not want to see an automatic driving ban come in for those caught over the lower limit.

In circumstances where a driver had been convicted at the new lower limit but had not been banned by the courts from driving, our members would prefer to deal with such an employee through disciplinary procedures up to and including dismissal.

We note that North suggests that under a new regime HGV or other professional drivers found breaking any new 50mg limit would face stiffer penalties at court than other drivers. While we agree that any breach of the reduced limit, however minor, should be viewed very seriously in the case of a professional driver we are of the view that it should be up to the courts to decide on the imposition of a driving ban, after considering all the circumstances.

How severe is the problem of drug driving and what should be done to address it?

We have no comments about the prevalence of drug driving in the general population; however we have tried to assist the Committee by auditing RHA members for their experience. We have asked our members about the extent of the drug driving problem in their fleets and found that the vast majority do not test for drugs currently.

We found that the majority *do not test* drivers and at the same time do not think there is a drug use problem.

Of members responding a small proportion *do test* for drugs currently and having tested think there is no significant problem.

A substantial minority of RHA members *do not test* drivers currently but suspect there is a significant problem.

A tiny proportion *do test* and as a result think there is a problem.

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

We note that North estimates that a reduction in the drink drive limit could save up to 168 deaths in the first year of implementation and 303 lives by the sixth year. The RHA would welcome such a reduction in road deaths and does not anticipate any serious long term dis-benefits in the context of the haulage industry since responsible hauliers do not support a drink-drive culture amongst their employees.

With regard to drug driving it is more difficult to come to a firm conclusion given that there is limited evidence about the extent problem, however again the RHA and its members would welcome measures that lead to improved road safety.

The specific benefits for RHA members and to wider society of the proposals in addition to increased road safety and a reduction in road deaths could be as set out below:

- A reduction in costs to the NHS.
- A reduction in costs to the emergency services.
- Reduced congestion costs/delay resulting from a reduction in the number of road accidents.
- Increased public awareness of the hazards of alcohol and drug consumption.
- Possible increase in business for taxi firms.
- Possible reductions in insurance premiums for fleets that test drivers for drink and drugs.
- A reduction in sickness absence from work.
- Encouragement of more professionalism amongst truck drivers.

The possible costs of any change might be as set out below:

- Increased police costs in relation to testing and enforcement.
- Increased court costs in relation to prosecutions and appeals (these may reduce as the new rules and culture become embedded).
- Damage to the pub trade in rural areas.
- Increased recruitments costs to businesses which have to hire replacement drivers when the changes are first introduced.
- Increased cost to hauliers for training replacement drivers when new rules are first introduced.

What would be the implications of such changes for enforcement?

At the initial stage after implementation of a new regime there is a chance that confusion over the amount of alcohol that can be consumed to keep within the new lower limit blood alcohol might result in enforcement problems for the police as well as more appeals in the courts. Similar problems might arise, particularly in relation to consumption of prescription drugs, if there was greater enforcement in relation to drug driving. Such problems may well diminish over time as the public becomes accustomed to the new regime.

August 2010

Memorandum from Mr Philip Hayton (DDD 20)

I write as a concerned individual, worried that the proposed lowering of the alcohol threshold for prosecution will have detrimental consequences that far outweigh the few as yet un-quantified benefits.

I live in a pleasant rural community typical of middle England where we all rely on the car to function. There are no buses that go where we want to go when we want to go. To lose the licence even for a year would mean no mortgage payments, a doubling of the car insurance premium for the next five years, in short, penury and homelessness. The only way I could be sure of not falling foul of the reduced alcohol level is to avoid my colleagues who live in the village and have the "swift half" after work where we exchange village gossip, what's to look forward to, dates, times, social interaction, a very important part of village life, especially for those of us who live a few miles from the pub.

There are no drunken drivers leaving our pub, anybody who the landlord thinks has had "One over the eight" gets a taxi whether they want it or not and the car can be collected next day. If the taxi fare is a problem the rest of us pay as it is not in our interest to have a friend hurt driving into a ditch. The embarrassment caused when the locals claim back the fare has a salutary effect and is seldom used more than once.

The pub along with the post office and school are an essential part of village life and when one closes the loss is felt by all, even those who don't use them, require the reassurance of them being there "just in case".

It is difficult to see who benefits from a lower alcohol limit as the ones who crash when over the limit do more damage to themselves and their property than to others on the whole. There are some very unfortunate examples of innocent people being killed of injured by drivers over the limit but the existing limit is stringent enough to catch and punish the impaired driver.

At the lower limit, drivers who will be over the 50mg limit will appear normal and without any obvious outward signs of inebriation, so the police will have to rely on "gut instinct" or worse, breathalyse all motorists they stop for the most minor offence.

The police are not liked in rural England for a variety of reasons and this law, if it is ever enacted will only make matters worse.

Before one considers lowering the alcohol limit one must be sure the consequences don't outweigh the dubious advantages.

There is no technology presently or in the near future that can reliably detect the wide range of substances both natural and synthetic available to ingest or inhale. What about the thousands of prescription medicines that, on their own or taken in combination, can impair ones judgment on and off the road. How could you possible set a safe level?

The police have sufficient powers available now to stop anyone they consider incapable of driving safely, adding a severely complicated piece of temperamental equipment won't make it easier for them.

As we all know from past experience one can't trust the figures for the supposed benefits of this alcohol reduction or drug test. If it isn't bust don't fix it.

Please don't consign the village pub to oblivion, we all love and cherish them.

August 2010

Memorandum from RoadPeace (DDD 22)

Introduction

RoadPeace, the national charity for road crash victims, welcomes this inquiry and the opportunity to reduce the threat posed by drink and drug impaired drivers.

Dedication

This response is dedicated to 18 year old Eluned Cleverley who was killed on 5 August 2006 by a 24 year old van driver who was over the limit and speeding on his way to buy more alcohol in the Wirral. Eluned was walking home with friends after her father had said that he was unable to pick them up as he had had a glass of wine. Eluned's family remain devastated at the death of their daughter by an act of criminal disregard for the safety of others.

Summary

- The drink drive limit should be reduced without further delay, given the new NICE estimates of the much larger casualty savings that could be achieved with a lower limit.
- One year ban would ensure the new limit was taken seriously. But if this is thought to be a step too far for a government that was not keen to even reduce the limit, then shorter bans would be acceptable. But it is important that drink drivers involved in fatal or injury crashes receive immediate bans. We would also like to see higher mandatory bans stated for commercial drivers.
- Extent of impaired drug driving is unknown and statistics from contributory factors do not help.

— We strongly approve of Sir Peter North's staged approach to tackling drug driving.

— Drink and drug driving is a serious crime and capable of much damage to people, not just property. They deserve to be included under the Offences Brought to Justice with local borough units expected to do their share of roadside testing.

— Care should be taken not to encourage any misbelief that impaired driving is dangerous whilst speeding is acceptable. A review of traffic laws to ensure that there is consistent treatment with relative burdens of harm is needed.

KEY QUESTIONS

1. *Should the permitted blood alcohol limit be reduced as proposed?*

1.1 RoadPeace supported the reduction of the BAC drink drive limit even before NICE review concluded many more lives than previously thought would be saved by this measure. But it was a welcome move by the government to get an independent estimate of the casualty savings from a lower limit, an encourage the government to adopt this same approach with speed enforcement and speed limits.

1.2 But we still maintain that a zero tolerance (0.2) should apply to all commercial drivers, and ask that this be revisited, as Sir Peter North has suggested be done with the limit for young drivers.

2. *If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?*

2.1 We agree with the North Report's conclusion that having the mandatory minimum one year driving band was key to reducing drink driving in Britain. We believe that without this tough approach, attitude to drink driving would have changed much more slowly.

2.2 We were surprised that it was proposed for the lower limit as, given how long the government has dragged its feet about reducing just the drink driving limit. Such boldness would again create a media storm and thus a self funded publicity campaign. However, we do not think the one year long driving ban is a requirement to reducing the drink drive limit and would prefer to see a shorter driving ban imposed than not have the limit reduced at all.

2.3 We also call for immediate suspension of a driving license after a fatal or injury collision involving a driver over the limit. At present they are allowed to continue driving until they are found guilty, unless there is evidence that they are likely to re-offend. We believe that they have already done enough damage to justify the temporary loss of their license.

2.4 We would also like to see longer mandatory minimum bans be set for commercial drivers.

3. *How severe is the problem of drug driving and what should be done to address it?*

3.1 We agree with the North Report's conclusion that it is not possible to know the extent of the problem of drug driving. In 1996, ACPO adopted the policy of breathalysing every driver after a fatal crash. For years we have called for them to adopt the policy of drug testing every driver in a fatal crash, or at least in a night-time fatal crash, which is when we know drink drive crashes are concentrated. We could have had much better data on the extent of drug driving (and drink driving) if we had introduced a consistent policy with drivers in a fatal crash, or a programme of random testing every year. This should have been a priority.

3.2 We do not think the findings from the analysis of Contributory Factors are accurate. We have consistently argued that these are misleading and collected at the wrong time. There is no need for them to be immediate guestimates. They should be collected at the end of the investigation and include the option of unknown, so that it is not simply yes or no, and the basis for any conclusive finding.

3.3 We believe that Sir Peter North has proposed a sensible staged approach to tackling drug driving. Until the extent of drug driving is known, a practical programme cannot be developed.

4. *What wider costs and benefits are likely to result from changes to drink and drug driving law?*

4.1 Any costs to the pub business could be offset with increased food and non-alcoholic sales. It was recently reported that food sales in pubs had already overtaken that of alcohol.

4.2 Enforcement costs could be offset with offenders having to pay for the costs of the tests and proceeds from confiscation of vehicles of drink drivers.

4.3 The British struggle with alcohol will be helped by having this nudge not to have a second drink when someone is driving.

4.4 Care should be taken that any tightening of drink and drug law is not interpreted as acceptance of speeding. Given a choice of being hit at 30 mph by a driver over the limit or at 35 by a sober driver is an easy decision. We are very concerned about the disparity between penalties for impaired driving with that of speeding, including the proposed graduated speeding penalties. As noted by research published in Australia some 13 years ago where the drink drive limit is already 50mg/100ml, on roads with a speed limit of 60 km/h, "the risk of involvement in a casualty crash associated with that free travelling speed is almost the same as the risk associated with the blood alcohol concentration. Hence, the risk is similar for 0.05 and 65; for 0.08 and 68; for.12 and 72, and so on." (Kloeden *et al*, 1997). A review of traffic law enforcement

penalties is needed to ensure the punishment matches the relative burden of risk, particularly with speeding, the only offence conducted by the majority of drivers (at least on higher speed roads), while also receiving the lowest fixed penalty possible.

5. *What would be the implications of such changes for enforcement?*

5.1 Enforcement is critical into making this reduction effective. We support Sir Peter North's recommendation to include drink and drug driving in the Offences Brought to Justice so that the efforts of individual police forces are monitored and compared. On the basis of the greater toll of death caused by drink driving than knife crime, this is also an argument for including speeding in the Offences Brought to Justice as speeding kills more than drink driving.

5.2 Enforcement must not be the responsibility of the traffic police alone. For years, ACPO has said that roads policing could be devolved and it is important that motoring offences are shared with borough police, including safer neighbourhood teams. Through our North West group, we are aware that Merseyside Police required individual borough commanders to undertake a minimum number of drink drive tests.

5.3 We encourage the extension of confiscating the vehicles of serial or severely impaired first time drink drive offenders. The statistics show that few drink or drug drivers are ever imprisoned and we believe that vehicle confiscation should be much greater used, along with long term of life long driving bans.

5.4 We do ask that at the time the drink and/or drug drive laws are changed, that there are specific offences that mention when someone has been seriously or slightly injured. At present we are not able to know how many innocent victims of drink/drug drivers there are and this is not acceptable. These victims deserve to be counted and included in Violent Crime statistics.

August 2010

Memorandum from the Medicines and Healthcare products Regulatory Agency (MHRA) (DDD 23)

1. Introduction

1.1 The pharmacological properties of some classes of medicines are such that there is the potential for driving ability to be impaired. The MHRA recognises the seriousness of the impact which some medicines can have on a patient's ability to drive, and medicines takers and their carers must be made aware of the potential risks.

1.2 Communication of potential effect on driving ability currently depends on the product information, label warnings added in the pharmacy and wider education initiatives. While there is overall a lack of evidence of significant harm from driving impairment by medicines, the MHRA is exploring a strategy for the further review and development of effective risk minimisation measures centred on improving patient and health professional awareness. This strategy will be risk-based, targeting classes of medicines that have a significant potential to impair driving ability according to known pharmacology, published evidence, and reporting of suspected adverse drug reactions.

1.3 The issue of impairment of driving ability by medicines is also being debated at a European level and the MHRA is playing a leading role in developing a European consensus on the optimal approach for medicines via risk categorisation and labelling.

1.4 The Commission on Human Medicines (CHM), the Government's independent scientific advisory committee on medicines safety, has highlighted the need for improved safety information for the public, communicated through various routes, and an expert Working Group of the CHM is being convened this autumn to consider this further.

2. Background

2.1 The Medicines and Healthcare products Regulatory Agency (MHRA) continuously monitors the safety of all medicines in the UK, and where necessary, takes suitable action to safeguard public health. The Agency uses a variety of methods of collecting information on medicines safety, both prescription and over the counter (OTC). Healthcare professionals, as well as patients, are encouraged to report suspected adverse drug reactions to the MHRA via the Yellow Card Scheme and there is a legal requirement for pharmaceutical companies to report reactions to their products. A database of these suspected adverse reactions is maintained which helps provide early warnings of potential drug hazards.

2.2 Before taking regulatory action, the MHRA seeks advice on medicines safety issues from the CHM. The MHRA/CHM take action based on the available evidence of the risk and benefit of a medicine and different courses of action are necessary in different situations proportionate to risk.

2.3 As new information becomes available, regulatory action undertaken by the MHRA to minimise the risk of driving impairment by licensed medicines has included issuing warnings to healthcare professionals about particular medicines through our drug safety publication Drug Safety Update.

3. Medicines and Driving

3.1 There is a dearth of evidence that medicinal drugs, as opposed to those taken for recreational purposes, contribute significantly to road accidents. The Department for Transport (DfT) collects extensive information about road casualties, including information provided by the police on contributory factors. There are significant limitations with this data—for example, an officer is likely to identify drugs as a contributory factor only where the related offence has been formally investigated. The figures published for drugs—illicit or medicinal—as a contributory factor are low, but are not considered to be a correct representation of the incidence of accidents in which impairing drugs may have been involved. The current offence of driving whilst impaired by drugs does not distinguish between illicit drugs or legitimate medicines. Therefore it is not possible to distinguish from the data available from the Ministry of Justice whether the main contributor in "drug driving" is the recreational consumption of illicit drugs or the use of legitimate medicines.

3.2 Medicinal drugs are used to treat medical conditions, and are authorised on the basis that benefits outweigh risks. Some medicines, such as benzodiazepines, can affect the ability to carry out skilled tasks such as driving and operating machinery, often by affecting cognitive function. Inexperience, speed, alcohol, tiredness and illicit drugs are factors that contribute to road traffic accidents and there is a high level of awareness of these factors by both health professionals and the general public. The contribution that some medicines may make is not, however, well established, and this has been acknowledged in the North review.

3.3 Medicines are widely used to prevent and treat disease and although it is difficult to quantify their impact, some have potential to impair driving skills. If a patient has a particular medical condition treated by medicines which may affect their ability to drive eg Parkinson's disease and dopamine agonists, this is monitored by their doctors and the Driving Vehicle and Licensing Agency (DVLA). In addition it is recognised that some licensed medicines prescribed for therapeutic purposes, which may affect ability to drive, may also be abused for recreational purposes, eg benzodiazepines. Interactions between medicinal drugs also need to be borne in mind. Non-impairing drugs may in combination become "impairing" by exacerbating cognitive effects.

3.4 While it is recognised that some medicines may affect the ability to drive It is recognised that some medicines may affect ability to drive It is recognised that some medicines may affect ability to drive It is recognised that some medicines may affect ability to driveiiii It is recognised that some medicines may affect ability to driveit is important to remember that some diseases themselves such as Parkinson's disease, epilepsy, depression and schizophrenia may impair driving performance. The use of medicines in these conditions may alleviate the driving impairment associated with the condition itself enabling patients to continue to drive.

4. The North Report

4.1 The MHRA has worked closely with the Department of Health (DH) and the Department for Transport (DfT) on the review undertaken by Sir Peter North. The North report makes two recommendations about the management of patients taking medicine which might impair driving, on patient information with medicines, and on education and awareness:

Patient information

— The Government, in conjunction with the pharmaceutical industry, should address the issue of the quality and clarity of the patient information provided with over-the-counter medicines and the merits of a simple and easily communicated system of advice related to driving, along the lines of that used in France.

4.2 Patients are more informed about their medicines today than they once were. All medicines are required to be accompanied with a Patient Information Leaflet (PIL). Research undertaken by the University of Leeds indicates that a large proportion of patients read the PIL which accompany medicines.[1] Since amendments to the European legislation in 2005, PILs are subject to "user testing" to ensure that patients are able to read and understand the written information to ensure that it meets their needs. PILs are therefore key risk minimisation tools in communicating messages about the impact of medicines on driving.

4.3 The provision for warnings in PILs is catered for in current National and European medicines regulation. Where any medicine is known to affect cognitive function a warning is included in the information for prescribers and patients. Updates to particular PILs have regularly been undertaken when new safety information has become available. The safe use of all medicines depends on users reading the label carefully and being able to act appropriately on the information presented, supported by healthcare professional advice.

[1] Raynor D K, Silcock, J, Knapp, P, Edmondson, H. How do patients use medicine information leaflets in the UK? *International Journal of Pharmacy Practice*, Volume 15, Number 3, September 2007, pp 209–218(10).

4.4 The use of pictograms on the product packing to communicate a message about a medicine has not so far been generally supported in the UK. There is a lack of robust evidence about the effectiveness of pictograms in communicating information, and resulting in appropriate action being taken. An Expert Working Group of the Committee on Safety of Medicines (now the CHM) advised that warning symbols were open to misinterpretation. If warning symbols were introduced, the meaning of any such symbol would need to be clear and patients, the public, and healthcare professionals would need to be able to take appropriate action. This would require a process of user testing.

4.5 The MHRA is keen to work together with European regulators to strengthen information for prescription and over-the-counter medicines. We are playing a key role in European discussions and have been consulting with researchers in the European Commission funded DRUID (Driving Under the Influence of Drugs, alcohol and medicines) project to examine how other Member States are addressing this issue.

4.6 The DRUID project has also examined risk categorisation systems currently being used in some EU countries for medicines which may impair ability to drive. There is no consistent approach in Europe on the use of pictograms on medicines packaging, and several different systems have been put in place over time.[2] The effectiveness of these systems has been reviewed by the countries concerned, leading to various adjustments. For example, the French categorisation system has been amended with the introduction of four levels of warnings and three different pictograms added to those medicines considered to have an effect on driving ability. In contrast, Spain had a four tier system and recently moved to a two tier system with a single pictogram (launched 2009). Sweden abandoned the pictogram as their categorisation system was considered to be obsolete. It was also recognised that the pictogram was not interpreted correctly, or even associated with driving ability. Sweden now has a generic warning added to patient information leaflets for medicines under a section entitled "driving and using machinery."

4.7 The research findings of the DRUID project concerning categorisation systems are to be presented and discussed later this year with our European partners and the MHRA will be contributing to the discussions and outcome.

Education and awareness

— The NHS, Department of Health and Driver Vehicle Licensing Agency should ensure that doctors are consistently reminded, in their training, their practice and their assessment, of the importance of routinely providing clear advice to patients on the effects of prescribed drugs on driving.

4.8 The MHRA are examining ways to focus educational activities to different target audiences including medicines takers and healthcare professionals. This is one of the issues that the forthcoming CHM Expert Working Group will consider.

5. Conclusion

5.1 The MHRA is exploring a strategy for the further review and development of risk minimisation measures in respect of taking medicines and driving, centred on improving patient and health professional awareness.

5.2 The issues are being debated at a European level and the MHRA is playing a leading role in developing a European consensus on the optimal approach for medicines via risk categorisation or labelling.

5.3 The CHM has highlighted the need for safety information for the public, communicated through various routes and an expert Working Group of the CHM is being convened to consider the issues further.

August 2010

Memorandum from Living Streets (DDD 24)

Summary

— As set out in a letter sent to the Secretary of State by the Parliamentary Advisory Council for Transport Safety on the 14th of July, to which Living Streets was a signatory, we strongly support the recommendation made in the North Review Report to reduce the permitted blood alcohol concentration (BAC) when driving from 80mg/100ml to 50 mg/100ml on the grounds of the estimated reduction in road casualties which would ensue.

[2] Review of existing classification efforts. Available from DRUID website http://www.druid-project.eu/cln_007/nn_107534/Druid/EN/deliverales-list/deliverables-list-node.html?__nnn=true

— Living Streets would emphasise the importance of public awareness campaigns calling for no alcohol consumption before driving.

— Living Streets would further support a reduction of the permitted blood alcohol concentration to an "effective zero" of 20 mg/100ml on the grounds of consistency and because drivers with a BAC of between 20 and 50 mg/100ml are at a higher risk of causing, or suffering, road death than those who have consumed no alcohol.

— In line with this emphasis on a consistent approach, Living Streets considers that the mandatory one year driving ban for drink-driving is appropriate even if the permitted blood alcohol concentration is reduced to either level.

— Living Streets supports the recommended approach to drug driving outlined in the North Review Report of improving the evidence, streamlining the current procedures and strengthening legal regulation of drug driving.

— Placing these reforms in their wider context, the civil liability framework in the UK must be reformed such that the burden of proof falls upon the driver to prove that s/he was not at fault in the event of a collision with a vulnerable road user, as is the case in most other European countries.

1. About Living Streets

1.1 Living Streets is the national charity that stands up for pedestrians. With our supporters we work to create safe, attractive and enjoyable streets, where people want to walk. We work with professionals and politicians to make sure every community can enjoy vibrant streets and public spaces.

1.2 The history of Living Streets demonstrates the strength of our agenda. We were formed in 1929, as the Pedestrians Association, and have grown to include a network of 100 branches and affiliated groups, 28 local authority members and a growing number of corporate supporters. As well as working to influence policy on a national and local level, we also carry out a range of practical work to train professionals in good street design, and enable local communities to improve their own neighbourhoods. We run high profile campaigns such as Walk to School and Walking Works, to encourage people to increase their walking levels and realise a vision of vibrant, living streets across the UK.

1.3 Living Streets' response focuses on the need to ensure that the safeguarding of pedestrians, as the most vulnerable highway users, is paramount when establishing policy on drink and drug driving. The response draws on our 80 year experience of standing up for pedestrians. Our arguments and evidence led to such road safety milestones as the introduction of speed limits and the driving test in the 1930s, the green cross code in the 1970s, and 20 mph zones in the 1990s.

2. Responding to the Consultation

Blood alcohol concentration

2.1 Living Streets warmly welcomes the North Review's recommendation to lower the permitted BAC for drivers to 50 mg/100 ml on the grounds that this "would undoubtedly save a significant number of lives" (p 6) with the associated costs that such a reduction in serious road traffic incidents would entail. This would also represent a worthwhile alignment with other EU countries, the vast majority of which have a BAC limit of 50 mg/100 ml or less.

2.2 Living Streets also notes the evidence quoted by the Report that "drivers with a BAC of between 20 mg/100 ml and 50 mg/100 ml have at least a three times greater risk of dying in a vehicle crash than those drivers who have no alcohol in their blood. This risk increases to at least six times with a BAC between 50 mg/100 ml and 80 mg/100 ml, and to 11 times with a BAC between 80 mg/100 ml and 100 mg/100 ml" (p 6). This clearly suggests, as mentioned in the Frequently Asked Questions for the North Review, that "Alcohol at any level impairs driving. So don't-drink-and-drive is the right message."[1]

2.3 We note that this "right message", which has been put across with a large degree of success by campaigns over the years, is set against widespread public ignorance, consistently set out in research over several years by the RAC, Brake and others, over the relationship between units of alcohol, typical measures served and drink-drive limits. A reduction to 50 mg/100ml will be beneficial, but to cement these benefits, it should be accompanied by substantial efforts to ensure improved comprehension of how alcohol is measured and the amount of alcohol that can legally be consumed before driving.

2.4 Further to this emphasis on public understanding, Living Streets would put forward the argument that setting a limit at an "effective zero" of 20 mg/100 ml would cement the "don't drink and drive" message set out by government and local authority campaigns, which largely form the public face of the relevant legislation. We do not feel that a 20 mg/100 ml BAC limit would, as the Report argues, entail "risking the loss of public support for strengthening our drink drive legislation" (p 6) and believe that public support and understanding of the aims of drink drive legislation would in fact be well-served by addressing the discrepancy between public awareness campaigns and legislation in this area.

2.5 Similarly, Living Streets does not support a graduated approach for drivers of different ages or levels of experience, as the potential benefits are in our view outweighed by the additional complexity this would introduce to the public dissemination of the simple, effective "don't drink and drive" message.

Drug driving

2.6 Living Streets supports the idea that drug driving should be taken as seriously as drink driving and that this should be reflected both in legislation and in accompanying awareness campaigns.

2.7 We agree with the inclusion of prescription drugs within the scope of drug driving legislation and would suggest that this review process is an opportunity to ensure that awareness campaigns send a clear message that people should not drive while under the influence of any drug—whether illegal, prescription or a legal recreational drug such as alcohol—rather than risking a complacent response by implying that alcohol is not a drug and therefore somehow "safe".

Enforcement

2.8 Living Streets supports the emphasis placed on awareness and enforcement by a 2010 National Institute for Clinical Excellence report, which notes that "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 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".[2]

2.9 In line with the approach of setting a clear, consistent and well-enforced norm of not consuming alcohol before driving, Living Streets considers that the mandatory one year driving ban for drink-driving is appropriate even if the permitted blood alcohol concentration were to be reduced from the current 80 mg/100ml to 50 or 20 mg/100 ml.

2.10 Living Streets notes the evidence presented in the North Report on the positive safety impact of random and selective breath testing, and would broadly support the availability of random testing for drink and drug driving as an enforcement and monitoring measure, provided that this was conducted with sufficient and transparent regard to civil liberties, due process and the viability of businesses.

2.11 Given the nature of the legislative and political processes, the current process is likely to be the only chance to make these reforms for several years. Living Streets advocates taking this opportunity to establish an effective, consistent stance which goes furthest towards reducing road casualties and ensures that drivers are clear on their best course of action.

Broader context

2.12 Living Streets recognises the notable success that the UK has had in containing and reducing drink driving and advocates a broader shift towards more responsible road behaviour; for example, moving towards a new social norm whereby travelling above the speed limit is considered as anti-social as drink driving.

2.13 A major practical issue in achieving a positive behavioural shift is the UK's civil liability framework, which is currently such that it discriminates against vulnerable road users and must be reformed. As it stands, motor vehicle drivers are presumed not liable for damages in the event of a collision with a pedestrian or cyclist. This is in contrast to most of the countries in the rest of the EU, where the burden of proof falls upon the driver to demonstrate that they were not at fault in such collisions. In this way, by establishing an element of fairness in civil liability, we can move towards a culture wherein motor vehicle drivers take their responsibilities as "kings of the road" more seriously than at present.

2.14 Living Streets would be delighted to provide further evidence and information to the Select Committee or to discuss these issues more informally.

August 2010

References

[1] North Review (2010). *Frequently Asked Questions.* http://northreview.independent.gov.uk/faq, accessed on 17 August 2010.

[2] National Institute for Clinical Excellence (2010). *Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths.* Available at http://www.nice.org.uk/media/3FE/1A/BloodAlcoholContentEffectivenessReview.pdf, accessed on 17 August 2010.

Memorandum from the Royal College of Physicians (RCP) (DDD 25)

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 25.000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

1. *Should the permitted blood alcohol limit be reduced as proposed?*

The RCP has consistently called for the blood alcohol limit to be reduced to 50mg/dl. The data confirming BAC of 50mg/dl as a suitable level for legislation has been accepted by all EU countries with the exception of the UK. Ireland has recently passed a Bill reducing the level to 50mg/dl. There is clear evidence that a reduction in the drink drive limit will reduce the number of deaths and serious injury caused by drink driving. Reaction times and motoring skills of drivers begin to deteriorate after even a small amount of alcohol, with the effects becoming more marked with increasing alcohol consumption.

With blood alcohol levels (BAC) between 50mg/dl and 80mg/dl the risk of accident increases by 400%, this data is quoted by the Dept of Transport in a previous consultation document.[i] When blood alcohol levels were reduced from 80 to 50mg/dl in New South Wales, fatal accidents reduced by 8% and single vehicle night time crashes by 11%.[ii] When Denmark reduced BAC from 80mg% to 50mg% in 1998, overall accidents were reduced although there was no significant change in fatal accidents.[iii] Furthermore introduction of BAC of 20mg/dl for inexperienced drivers led to reduction in fatal crashes of between 9% and 24% in California.[iv]

If there is to be a BAC prescribed limit, we believe that 50mg limit is the simplest message for drinkers to understand. The current level is complex and difficult for people to calculate what they are likely to be able to drink. This is dependent on body size, gender, age and whether food is consumed. One pub measure of alcohol (a 175ml glass of standard-strength wine or half a pint of strong beer) is all that would be allowed; compliance would increase as it would be easier to understand.

A survey by the Automobile Association in conjunction with Populus in 2008 found that two thirds of the Association's members were in support of a reduction in the drink driving limit. Almost a third of respondents felt that a "zero tolerance" approach would be preferable.[v] Clearly there is strong public support for action on drink driving. Responses to the Government's consultation, "*Combating Drink Driving*", published in 2000, revealed a clear majority in favour of a lower limit, including 79% of the local authorities which responded.[vi]

2. *How severe is the problem of drug driving and what should be done to address it?*

The RCP believes that there are good grounds for believing that driving under the influence of drugs, both recreational and prescription may be a factor in traffic fatalities and injuries, and we regret the paucity of good data that would enable policy in this area to be evidence based. In view of the lack of good data we strongly support the proposal that the routine assessment of alcohol levels in fatal accidents is extended to the presence of both prescription and recreational drugs. All fatal or near fatal traffic accidents should be fully investigated with samples taken for the assay of alcohol and levels of recreational and prescription drugs.

3. *What are the wider costs and benefits that are likely to result from changes to the drink and drug driving law?*

Between 50mg and 80mg drivers are 2–2.5 times more likely to be involved in an accident than drivers with no alcohol, and up to 6 times more likely to be involved in a fatal crash.[vii] In 2000, the Government's Road Safety Strategy estimated that reducing the limit to 50mg could save 50 lives, and prevents 250 serious injuries and 1,200 slight injuries each year. A more recent examination of the figures suggests that reducing the legal limit could save 65 lives each year and prevents 230 serious injuries.[viii] Given an average cost of over £1.6 million per fatality; the economic benefits would be very significant. Changes to drink driving laws, and the public attention that is likely to accompany such changes, may contribute to the wider public health debate about sensible drinking.

August 2010

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[i] Dept of Transport, Relative probablity of causing an accident in relation to blood alcohol; Road Safety Compliance Consultation. 2008
http://www.dft.gov.uk/consultations/open/compliance/

[ii] Hendsridge J, Homel R, Mackay P. The long-term effects of random breath testing in four Australian states; a time series analysis. Canberra: Federal Office of Road Safety; 1997.

[iii] Bernhoft I M, Behrensdorff I. Effect of lowering the alcohol limit in Denmark. *Accid Anal Prev* 2003, Jul; 35:515–25.

[iv] Voas R B, Hause J M. Deterring the drinking driver: the Stockton experience. *Accid Anal Prev* 1987 Apr; 19:81–90.

[v] Automobile Assocation. Call for Cut to Drink Drive Limit,2008.

[vi] Department for Transport. Next Steps: Combating drink driving, 2000.

[vii] Tomorrow's Roads: Safer for Everyone, DETR, 2000.

[viii] R Allsopp. Reducing the BAC level to 50 mg—What Can We Expect to Gain?, PACTS Research Briefing, 2005.

Memorandum from Jack Brownhill (DDD 26)

DRINK AND DRUG DRIVING LAW—NORTH REPORT

1. I have read with much interest Sir Peter North's report in this connection.

2. I have a few observations regarding the report and Sir Peter's recommendations—many of which I totally agree with.

3. It is clear that enforcement has a pivotal role to play in the fight against drink or drug driving. The actions of many impaired drivers are likely to be heavily influenced by the driver's perception of how likely it is that they will be able to complete their journey without detection and, indeed, how frequently they can undertake identical or similar journeys without detection.

4. Although I have no evidence common sense would suggest that many of these impaired journeys are relatively short and most often are undertaken on roads known to the driver. This may give added confidence to many drivers that the likelihood of detection is relatively low, confidence that may grow with each occasion they successfully drive undetected. This added confidence may also lead to drivers increasing their alcohol intake.

5. The breath test data in Annex L to the report clearly suggest that where checks are undertaken the detection rate is exceptionally high. This appears to suggest that current targeting of drivers is highly effective.

6. However, the "checks per driver" (in Annex L) is exceptionally low when compared with all the other countries in the table which may suggest that we are not committing enough resources to the detection of impaired drivers and that an increase in resources (suitably targeted, of course) would not only increase the detection rate but would also act as an increased deterrent to drivers tempted to drive whilst impaired.

7. I agree 100% with **Drink Driving Recommendation (4)** although I think that society's perception of how committed the drinks trade is to helping here is tinged with a high degree of scepticism. When one sees how intoxicated many people are when leaving licensed premises it is hard to grasp how firmly over the bar requests for drinks by people who have clearly already had too much to drink are resisted. However, it may also point to difficulties that licensed premises have in "policing" this when people are drinking in groups and this is, I believe, something the drinks trade needs to revisit.

8. In a similar vein I believe that car parks adjacent to licensed premises should be required to display highly visible signs carrying drink/drugs messages which could also remind drivers of the (drink drive) limit and what this limit represents from an alcohol intake perspective.

9. In relation to **Drink Driving Recommendation (5)** the professional drivers' organisations make a strong and possibly valid case for not introducing a lower limit for "at work" vocational drivers. However, this appears to be partly based on the "aggravating factor" in the current Magistrates' Court Sentencing Guidelines referred to in **Drink Driving Recommendation (6)**.

10. However, there appears to be no available evidence to identify the extent to which this "aggravating factor" should be taken in to account and the impact it has had on sentencing in relevant cases. As the intention of the drink/drug driving laws is surely to deter drivers there must be reason to believe that a lower limit for vocational drivers would act as an important deterrent and send out a clear message to the relevant sectors of society. A lower limit may also give a clearer message as to how much these drivers can and cannot drink whilst at work (or prior to starting work).

11. I wholeheartedly agree with **Drink Driving Recommendation (7)** although I am a little unclear as to exactly which sectors are being targeted in the reference to "the transport industry". One would naturally expect this to embrace haulage, delivery, public transport and taxi (public and private hire) bodies but I hope it also embraces the wider fleet operator community and, perhaps, even the car rental companies recognising that both fleet operators and rental companies have the ability to impose additional penalties on drivers who are caught driving one of their vehicles whilst impaired particularly where this has resulted in an at-fault accident (for example, an employer or car rental company could apply an increased insurance excess, and an employer could also apply this increased excess or a financial contribution to the insurance cost for a certain future period).

12. **Drink Driving Recommendation (8)** calls for the new proposed lower limit to be applied to all drivers regardless of their age and/or experience. The driving performance of youngsters (particularly males) is, of course, well documented and it is my understanding that the driving test (and the pre-test learning process) is currently under review. That review should also be looking at the post-test scenario given the adverse impact that younger (particularly new) drivers have on the annual road casualty figures.

13. The younger driver "problem" is not, of course, unique to the UK and many countries have looked at ways of trying to improve the position. Tuition and testing can only achieve so much and we clearly need a way of helping these younger drivers stay safer whilst improving their on the road experience and general roadcraft. Graduated licences have been introduced in many countries although I accept that this introduction is often on the back of a legal requirement to carry one's driving licence whilst driving.

14. If it was felt that introducing a graduated licence scheme in to the UK to help tackle the young driver situation would be a significant step forward it would be deeply disappointing if such a scheme was discounted because there is no current requirement to carry a licence.

15. I believe it is true to say that the vast majority of "on the road" police officers have ready access to DVLA driver information via the Police National Computer (PNC) and although this may present some difficulties when dealing with drivers who may attempt to hide their true identity or holders of non-UK licences (neither of which should be insurmountable) the inability to produce a hard copy driving licence at the roadside should not pose any major stumbling block to determining the age of a driver at the time of an incident.

16. I strongly believe that the introduction of a lower limit for young drivers and provisional drivers should be considered as part of this review and, if possible, drivers of all ages who have held a full licence for less than a certain period of time should also be considered as part of this exercise although I recognise this may be more difficult when one takes in to account holders of non-UK licences.

17. I hope you find my observations helpful and constructive.

18. Although these observations are given in a personal capacity it may be helpful if you are aware that I have been employed in the European motor insurance arena for in excess of 45 years and have been actively involved with the both the UK Association of British Insurers and the parallel Brussels based CEA—the European Insurance and Reinsurance on a wide range of insurance and road safety issues.

August 2010

Memorandum from Addapt (Association of Approved Providers of Drink Drive Rehabilitation Courses) (DDD 27)

(A) *Should the permitted blood alcohol limit be reduced as proposed*

Yes for the following reasons:

1. It would help harmonise GB with the rest of Europe (Northern Ireland have also signalled their intention to reduce their limit to 50 mcg—so would also keep UK the same).
2. The argument that the UK is better at enforcement is not borne out by statistics—other countries breathalyse much higher numbers than GB.
3. Despite calls from the alcohol industry that the public do not want a reduction considerable public support exists for a ban. Claims that such a reduction would "kill off the country pub" are exactly the same as the claims made in 1967 prior to the introduction of the current law and proved groundless.
4. It is irresponsible to persist with the notion that it is okay to drink up to 80 when significant evidence of impairment occurs well below that limit.
5. Overwhelming evidence from people convicted that the current laws are ambiguous ie don't drink and drive but a "legal" level which permits males to drink up to two and a half pints of beer and women to drink 175 ml glass of wine. As an organisation we have educated hundreds of thousands of convicted drink drivers who are in favour of the reduced limit.
6. The existing limit does leave an estimated extra 50 people liable to die on our roads each year and many more seriously injured. Apart from not wishing to put a value on a human life the cost is estimated at in excess of £1.6 million per fatality and obviously the combined costs of the many seriously injured would be much more.
7. It is erroneous to claim that there is no public appetite for a reduction in the limit—and one perpetuated by the drinks industry. In reality the message should be irrespective of the limit "do not drink and drive" so that the actual limit is irrelevant. Visitors to country pubs should not be making a choice of having one drink at the new limit or two at the old.

8. Any decision to change the limit must be accompanied by an effective public education campaign—this is not just about drink driving but about the general problems we have with health and alcohol in this country. The joining up of health and transport issues is to be welcomed. The move to increased opening hours has undoubtedly marred the lives of many people in towns and villages across Great Britain and the general acceptance of alcohol misuse is already creating massive costs to the health service.

(B) *If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level*

— Yes, but if the limit were to be lowered, then it may have more credibility with the public if a reading of between 50 and 80 had a disqualification of say 6 months providing a drink drive education course was undertaken.

(C) *How severe is the problem of drug driving and what should be done to address it*

— The objective of this legislation is to make the roads safer. If a driver's ability is impaired by drugs, it matters not whether the drugs are illegal, prescribed or over the counter, (evidence suggests there is for example significant problems with tranquilisers). In the same way we do not differentiate between spirits, wines or beer etc if a driver is impaired by alcohol. The important factor is the impairment and drug driving is no different.

— The aim is to remove impaired drivers from the roads, and we strongly feel the new offence should include all drugs, illegal, prescribed and over the counter.

— It should be unnecessary to identify drugs by name. They are illegal, prescribed or over the counter. Any other definition will create unnecessary complications when cases come to court and potentially provide openings for unnecessary arguments and appeals. The matter to be brought before the court is an allegation of driving whilst impaired through drugs and/or alcohol. The question of whether the drug was old, new, illegal, prescribed or over the counter is mostly irrelevant, except the deliberate act of driving having taken an illegal substance, may carry a heavier penalty than if the drug was prescribed.

— We believe this is long overdue. There are many examples of Police forces around the world conducting successful drug driving campaigns. We do not have to reinvent the wheel, only endeavour to improve what already exists and works elsewhere.

— Implementation procedures for identifying illegal drug driving should replicate those used for addressing drink driving. This should include use of evidential road side testing.

(D) *What wider costs and benefits are likely to result from changes to drink and drug driving law?*

— Firstly much greater clarity than the current very mixed message- which drivers say is very confusing reducing the limit would give the proper message that any alcohol is likely to result in a prosecution. Any efforts which reduce this countries problems with alcohol, including issues of health and safety—e.g on our roads, within families at work etc is to be welcomed.

(E) *What would be the implications for enforcement*

— ACPO had already we understand their support for a reduction in the limit. A public information campaign should accompany any change in legislation.

August 2010

Memorandum from TTC 2000 (DDD 28)

1. *Do you think that the current prescribed blood alcohol limit of 80mg/100ml should be reduced to 50mg*

— It should certainly be reduced to 50mg. This would bring us in line with most of the rest of Europe. This could also be 20mg for professional and new drivers. This response is based on asking in excess of 100,000 convicted drink drivers who (a) find the current messages confused—ie you must not drink and drive but by the way you can drink up to 80mg! Northern Ireland intend to reduce their limit to harmonise with the South/ rest of Europe.

2. *If so, is the mandatory one year ban appropriate for less severe offenders, at the new lower level?*

— Yes, it should be noted that it is widely believed that, it is this length of ban that is the greatest deterrent; but if the limit were to be lowered, then it may have more credibility with the public if a reading of between 50mg and 80mg had a disqualification of say six months, providing a drink drive rehabilitation course was undertaken.

3. *How severe is the problem of drug driving and what should be done to address it*

— Most research considers drug driving to be a severe issue and the use of a new offence would make the regulation of drug driving more effective particularly with regard to a specific drug. However we appreciate that "level of drugs" is a very difficult concept. In particular drugs such as cannabis which are likely to impair for one to six hours following use, but may remain in the system for up to 28 days or longer for regular cannabis users. We believe these difficulties lie at the heart of government in action.

(a) *an absolute ban on driving with drugs in the system?*

— Ideally yes, but please note response to 3 above.

(b) *driving with a certain, specified level of a drug within the driver's system, as is the case with alcohol? If yes, what drugs do you think should be included or specified and why?*

— Certainly all illegal drugs and if tied with a certain amount, this would address the problems identified in 3 above ie the trace elements in the body some days after consumption, which would not be impairing, would not result in prosecution. Also if you had a level then over the counter and prescribed medicines could also be covered We believe that a new offence should apply to (a) all controlled drugs (eg heroin, cannabis, cocaine) and (b) prescribed or over the counter drugs which are used inappropriately or may otherwise have impairing effects.

4. *What wider costs and benefits are likely to result from changes to the drug driving law?*

Both road safety and health would be improved.

5. *What would be the implications of such changes for enforcement*

An effective machine for road side testing would be needed in respect of drugs. The current silly situation where motorists failing preliminary impairment tests at the roadside are "let off" by police surgeons without even considering blood tests even though PIT are well recognised as meeting a national standard.

August 2010

Memorandum from the Magistrates' Association (DDD 30)

The Magistrates' Association welcomes the opportunity to submit written evidence for a short inquiry into drink and drug driving law, setting out their views on Sir Peter North's recommendations.

Our views on the particular issues noted are as follows:

1. *Should the permitted blood alcohol limit be reduced as proposed?*

It has long been the policy of the MA that the limit should be lowered from 80mg to 50mg, based on a resolution passed at a previous AGM of the Association. We can offer no evidence to support this, as clearly we do not see in court any drivers below the current limit. We have been waiting to see data collected by the new generation of enhanced, memory equipped, electronic road side screening devices to see what light it sheds on the question.

2. *If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?*

No, this matter was recently considered at the National Council of the Magistrates' Association, which concluded that there should be mandatory disqualification for the new lower range embraced, but it should be for a shorter period, say six months. It is a general principle that punishment should be proportionate to the severity of the offence. We also note that other European countries that have adopted the lower level have much less severe penalties.

3. *How severe is the problem of drug driving and what should be done to address it?*

We are aware of the widespread use of illegal drugs through our court experience but since we see only a small number of prosecutions for drug driving, we therefore suspect that the current legal regime is not very effective, and there is a considerable problem which is not being addressed. In those cases where both drugs and alcohol have been taken, the police are likely to proceed only on the alcohol issue, as that is readily measurable.

We support the recommendations made by Sir Peter North, in particular the introduction of screening devices and the introduction of an offence of driving with a level of certain drugs in the body over a prescribed limit.

4. *What wider costs and benefits are likely to result from changes to drink and drug driving law?*

The benefits of a lower number of road accidents are self-evident, and a stricter regime in relation to drug-driving would hopefully lead to something of a reduction in the use of drugs. There would be costs implication in introducing screening and measuring devices to test the level of drugs in a driver's body. There may be a cost to the alcohol industry and to rural pubs in lowering the drink-drive limit.

5. *What would be the implications of such changes for enforcement?*

In our view the effectiveness of the law depends very largely on the number of tests carried out. We would welcome legalising random breath tests and the abolition of the statutory option of a blood test at a low level of breath. Evidential roadside breath testing when introduced should mean less time is spent in the police station, and therefore the possibility of more time at the roadside looking for further offenders. Random drug testing could be carried out alongside breath testing.

6. *Disqualification*

We should like to mention one other matter. The most effective sanction against drink-driving is disqualification, but this is effective only if it can be enforced. We are concerned at the number of people we see who drive while disqualified, and the prevalence of driving while disqualified as a repeat offence. We see people with convictions numbering in the 20s, 30s and 40s. Clearly, the period of custody which can be imposed for what is currently a summary-only offence is not a sufficient deterrent for such offenders. We have been pressing the government to make driving while disqualified an either way offence once again, at least when it is a serial offence, so that a longer period of custody could be imposed. The previous administration was not persuaded that this is necessary, but we urge that this position should be revisited, or alternatively that the provision already enacted that increased the maximum sentence available to a magistrates' court to 12 months should be implemented.

August 2010

Memorandum from VMCL Ltd (DDD 31)

The following are the views and comments of VMCL Ltd submitted in response to an email received Saturday 27 August 2010, requesting views from interested parties on Sir Peter North's recommendations.

VMCL Ltd

VMCL Ltd is a training and consultancy company, established in 1993, specialising in alcohol and drug awareness, with particular emphasis on road safety and the working environment. Our services include both re-active and pro-active training. We welcome the publication of Sir Peter North's Review and the opportunity to comment on his recommendations.

VMCL have participated in the Drink Drive Rehabilitation Scheme since its introduction as an experiment via the Road Traffic Act 1991 and we currently provide training for 125 Magistrates' Courts in the South of England, plus 46 Sheriff Courts in Scotland. In excess of 150,000 drink drive offenders have been referred to our Company for training. The aim of our course is to make roads safer by reducing the drink drive reoffending rate.

Our client base includes the Courts mentioned above, HM Prison Service, County Councils and large private organisations.

In addition to providing Drink Drive Rehabilitation Courses, VMCL Ltd has been awarded a contract by the Home Office to deliver training courses across the South of England to support Drink Banning Orders and helps run an Alcohol and Drug Agency dealing with all levels of dependency. This includes providing drug and alcohol assessments in custody suites and assessing patients in hospital.

Comments

Reduction in the permitted blood alcohol limit

A very fundamental and recurring message throughout our educational courses is "Don't Drink and Drive" and we strongly believe that this simple, yet non-negotiable message makes a major contribution to the successful outcome of our courses.

We strongly agree the prescribed blood alcohol limit should be reduced to 50mg of alcohol in 100ml of blood. In excess of 150,000 drink drivers have been referred to our Company for training and the same comments are made time and again by the offenders, namely "I didn't realise I would reach the drink drive limit so quickly" and "the limit should be reduced so that everyone knows where they stand. At the moment, I am unsure about how much alcohol is a safe amount, if the limit was reduced it would be easier to understand".

This comment has been made by literally hundreds of offenders referred to VMCL Ltd for training.

Even before the publication of Sir Peter's report there was overwhelming evidence that reducing the current level from 80mg/100ml to 50mg/100ml would significantly reduce the KSI figures and the subsequent and associated costs in human suffering and financial cost.

Sir Peter's report consolidates and highlights the latest information available relating to drink driving and as such presents, in our opinion, an overwhelming case for reducing the legal limit from 80mg/100ml to 50mg/100ml; VMCL Ltd supports this conclusion.

Mandatory one year ban

Our view is that the mandatory one-year ban should be retained for the new lower level. A reduced ban would send out mixed messages and convey the wrong signals to those that drink and drive. It has been proved in several tests involving vehicle simulators, the Manchester Bus Driver Experiment etc that any amount of alcohol will cause impairment as it affects those faculties essential for safe driving, judgement, reaction time and vision. The message we must reinforce is "You must not drink and drive" not one of "OK if you drink a bit less we won't penalise you so much". This would send out the completely wrong message and potentially undermine the encouraging results achieved so far in reducing the KSI statistics.

To reinforce the message that drinking and driving is not acceptable, we would achieve a better result by leaving the minimum ban at one year, but offering a greater reduction of say 50% for those who are between 50mg and 80mg in 100ml of blood and who complete a drink drive course, instead of the current maximum reduction of 25% for those who exceed 80mg per 100ml in the blood. This would continue to emphasise the perils of drink driving and support the theme of "Don't drink and drive", but would also highlight the benefits of education in attending a drink drive course. This would also recognise there may be a perception of undue severity of penalty for the lower limit, without the opportunity to voluntarily reduce the mandatory one year ban further.

Pre driver/novice driver qualifications

It is of some concern to our Company that having been involved with the drink drive scheme since its inception and sitting on the original steering group etc, we have seen no reduction in the number of drink drive offenders referred to our Company for training. The profile of the offender may change over the years, the average age may get lower or higher etc, but the numbers are fairly static.

It would seem that although the training provided by the drink drive scheme achieves excellent results, a lot more could be done to provide alcohol and drug awareness training to drivers before they are arrested.

The logical time to conduct alcohol and drug awareness training is at the time the individual is receiving driver training, but not by the driving instructor. The Department for Transport and the Driving Standards Agency have spent considerable time and money in developing a recruitment and training procedure for the continual development of drink drive course tutors, which all drink drive training providers have taken on board. This has been a lengthy process and we are seeing measurable improvements as a result.

Driving instructors are excellent at one to one training, but when we interviewed two driving instructors for a drink drive tutor vacancy, we found them far from adequate and they really struggled when questioned about group dynamics etc. An important part of alcohol or drug awareness training is group interaction. We find this is essential for the long term learning process.

To help address the issue of learner/novice driver training, we produced a short four hour module consisting of two x two hour sessions, which we wanted to trial free of charge with learner drivers. However, when we approached our local driving schools with the concept and to obtain referrals, they only wanted to know what was in it for them. When told we would not be charging as it was a trial, no one wished to participate.

Drug Driving

Sir Peter's report comprehensively documents the lack of reliable information necessary to accurately determine the severity of the problem relating to drug driving, and many of the reasons and the history behind this.

This lack of evidence based information is clearly a serious obstacle in making informed decisions and consequently those parts of Sir Peter's report which address this issue assume greater importance.

With the absence of reliable statistics about drug driving from the other agencies, we can only comment on the information we receive from the offenders who attend our drink drive courses.

Our average course attendance for drink driving courses is fourteen offenders. When we ask if anyone in the room is prepared to admit if they have taken illegal substances and then driven a motor vehicle, at least one person will raise their hand and sometimes as many as three, and these are just the ones who are prepared to admit what they have done. When we ask if anyone knows someone else who has taken illegal substances and driven, at least half the class will raise their hands.

When those who admit they have committed drug driving are questioned about it, they state they felt safe as they know the Police have difficulty in proving the case, unlike drink driving. One man stated he regularly takes ecstasy and drives. The effect depends on where the drug is purchased. If from club "A", it is probably only made of flour as it has no effect. If, however, it is purchased from club "B" the effect is immediate. On one occasion, after buying the drug in club "B" he started to drive along a dual carriageway, but the road appeared to become narrower and then widen again on a regular basis. Eventually, he stopped because he thought the road was too narrow to travel along, even though he was the only vehicle on a dual carriageway.

From our experience in helping to run an alcohol and drug agency, it is very clear that the rehabilitation of drug driving offenders cannot follow the exact same path as that for drink drivers.

The breathalyser measures the consumption of all types of alcohol and the drink drive courses are suitable for all drink drivers no matter what alcohol they have consumed.

Drug drivers, however, are very different and should be treated according to the drugs they have taken. In the past, VMCL Ltd has produced a course for drivers who have taken recreational drugs such as cannabis and ecstasy and this course was submitted to the DfT for information. This course would be totally unsuitable for someone who was convicted of driving having used cocaine.

Those who are hooked on hard drugs sometimes have to change their friends, change their job and sometimes move home to help them break their habit and this cannot be achieved with a classroom based course attended by offenders who have taken various drugs.

The alcohol and drug agency we help run deals with all levels of dependency and unfortunately we have several deaths each year among our patients.

The first step in helping and educating any drug user is an accurate and detailed assessment by a qualified assessor. They then need a period of one to one counselling, this time by a qualified counsellor. This may only require one session depending on the level of help required. The person is then allocated to a supervised group consisting of other drug users, who either have a similar level of dependency or may use similar drugs. These meet on a regular basis, following a set programme. The process from beginning to end takes approximately 13 weeks and after this period all but the hard drug users show positive results. Our procedures are such, that the agency was the first in the UK to receive the new Kite Mark for alcohol and drug services and we now offer 20 placements each year for students taking degree courses in related subjects.

It is important that any training or counselling of drug users, even if they are only recreational users or convicted of impairment whilst using prescribed drugs, meets the standards laid down by DANOS to guarantee a measurable level of quality.

August 2010

Memorandum from The Wine and Spirit Trade Association (DDD 33)

Introduction

The Wine and Spirit Trade Association is pleased to submit written evidence to the Transport Select Committee's inquiry into drink and drug driving.

The Wine and Spirit Trade Association is the UK organisation for the wine and spirit industry representing over 300 companies producing, importing, transporting and selling wines and spirits.

While the WSTA does have pubs in membership, we do not speak on behalf of the on-trade and would leave this to other trade associations who are better placed.

As such we have responded to the Committee's questions that are within our expertise and that of our members.

Consultation Questions

Should the permitted blood alcohol limit be reduced as proposed?

While we do not have the expertise needed to asses the full impact of the lowering the blood alcohol limit, it is notable that the UK is experiencing a long term decline in drink drive fatalities and injury. In the shorter term, fatalities resulting from drink and drive accidents fell by 5% from 400 in 2008 to 380 in 2009,while total casualties fell by 8% from 12,990 to 11,990.[3]

[3] Reported Road Casualties in Great Britain: 2009 estimates for accidents involving illegal alcohol levels, 5 August 2010.

The UK has a favourable road safety record compared with many European countries. It seems that there is a good level of awareness of drink driving in the UK and levels of compliance with current limits are high and rising. Drink driving is an area of public health where the success of behavior change campaigns is proven[4] and as increased enforcement of the law has been shown to be effective,[5] an assessment of the outcome of these strategies could be undertaken before lowering the blood alcohol limit.

If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?

We believe that consistency in blood alcohol limits and penalties is preferable, to avoid confusion among drivers. However, if a lower limit was instituted, a transitional lower penalty would seem fairer to many drivers.

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

While we do not speak on behalf of the on-trade and would leave this to other trade associations who are better placed, we would expect that reducing the blood alcohol limit would reduce the number of consumers prepared to drive to on-trade premises in rural locations.

What would be the implications of such changes for enforcement?

Instituting a lower blood alcohol limit would require a significant public awareness campaign to inform drivers of the change to the law. Making the change meaningful would necessitate an increase in enforcement,[6] however it is worth nothing that increased enforcement in itself has been successful in reducing level of drink driving.[7]

Levels of breath testing have already increased 19% between 2007 and 2008,[8] as the Government rolls out new digital recording equipment. The impact of this could be assessed before changes are made to the blood alcohol limit.

August 2010

Further memorandum from The Wine and Spirit Trade Association (DDD 33a)

Regarding the Transport Select Committee evidence session of 14 September 2010 on drink and drug driving, when the issue of smaller glass sizes for wine and spirits was raised.

I wanted to make you aware that as part of the Mandatory Licensing Conditions brought in by the Policing and Crime Act 2009, it will be mandatory for on-trade premises to make 125ml measures of wine (as well as the smallest measures of other drinks) available and apparent to their customers. This will come into force on 1 October 2010. We believe in full consumer choice and support this measure to ensure that consumers are always able to purchase the smallest drinks measures.

September 2010

Memorandum from Draeger Safety UK Ltd (DDD 35)

What follows is the response of Draeger Safety UK to the inquiry into changes in the UK's drink and drug driving laws.

Before commenting on the areas highlighted in the Inquiry, I would like to inform you of Draeger Safety's experience in the field of detection of drink and drug drivers, and a brief overview of the company.

Draeger has its head quarters in Lubeck Germany and employ over 8,000 people worldwide, with daughter companies in most major countries. Our portfolio includes medical ventilators, respiratory protection, gas detection, as well as alcohol and drug detection. We first produced the "blow in the bag" breathalyser tubes in 1953 in Germany and a derivative of this the Alcotest-80 was the first UK Home Office Approved breathalyser in 1967. In the 1980's we introduced to the UK the first electronic breathalyser the Draeger Alert and currently have breath alcohol equipment in service with 20 Police Forces within the UK. Worldwide we currently have over 100,000 breath alcohol devices in service and saliva based drug testing equipment in service with a number of national and regional police forces.

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4 Elder R W, Shults R A, Sleet D A *et al* (2004) Effectiveness of mass media campaigns for reducing drinking and driving and alcohol-involved crashes: a systematic review (brief record). *American Journal of Preventive Medicine* 27 (1).
5 North, P, Report of the Review of Drink and Drug Driving Law, June 2010, Para 3.20.
6 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.
7 North, P, Report of the Review of Drink and Drug Driving Law, June 2010, Para 3.20.
8 Police Powers and Procedures England and Wales 2008–09, 15 April 2010, p 65.

Should the permitted blood alcohol limit be reduced as proposed?

NO.

Comment

The current law is well understood and should be more rigorously enforced by random stops and road blocks before we look at the limit, however, the data enabled screeners now in use by Police Forces in England and Wales may give insight to the of drivers involved in accidents in the 50 to 80 mg/100mL range. The average drink driver is almost twice the current legal limit and is unlikely to be deterred by a low limit without more rigorous enforcement.

If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level

NO.

Comment

In most European countries where a lower limit is in place the penalty is less severe than a one year ban.

How severe is the problem of drug driving and what should be done to address it?

In many studies, carried out in different countries, the numbers of individuals found with substance of abuse other than alcohol is generally the same order of magnitude as the number of drivers with alcohol above the local drink drive limit. In Queensland official figure have shown that the number of people convicted for drug driving was one in fifty, the number convicted for drink driving is 1 in 80.

We would suggest the issuing of drug testing devices to Police Officers should be expedited, and consideration given to roadblocks, like they have in many countries worldwide to increase the chances of being tested and caught and increase the deterrence factor.

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

No comment.

What would be the implications of such changes for enforcement?

No comment.

August 2010

Memorandum from the Chronic Pain Policy Coalition (CPPC) (DDD 38)

The Chronic Pain Policy Coalition (CPPC) welcomes the opportunity to contribute to the Transport Select Committee consultation on drink and drug driving law.

The CPPC executive committee members have studied Sir Peter North's report and welcome proposed legislative changes expected to improve safety for drivers and members of the public. The principal interest of the CPPC in relation to this consultation relates to drivers who may be using prescribed or over the counter (OTC) medications for pain relief and the impact on them and on healthcare professionals.

SUMMARY

— Patients with persistent pain may have mobility problems and driving may be important for them to enhance vocational and social function.

— Persistent pain and associated morbidities (including fatigue) may impair ability to drive.

— Medications for pain relief (including controlled drugs) may have side effects which impair ability to drive. Patients may be taking more than one class of drug. Medications are not always taken as prescribed.

— Current research suggests that stable doses of opioid drugs do not impair driving ability.

— Drivers using opioids illegally may not be comparable to those using prescribed controlled drugs or OTC medications.

— Collaboration between service users and healthcare providers underpins successful long-term condition management and this includes decisions about medications.

— Advice about fitness to drive should be given when prescribing medications for pain.

— The balance of benefits and harms of treatments must be considered. Patients may only achieve useful pain relief at medication doses which make them unfit to drive.

— Healthcare providers must ensure that patients understand the rationale behind drug driving laws and that concerns regarding fitness to drive relate to their safety and that of others.

— A patient has a responsibility to consider their fitness to drive.

— Current best practice guidance in relation to opioid prescribing includes advice to patients regarding driving.

— The effect of a given dose of medication on patient function will vary between individuals and in a given individual at different times. Driving ability cannot be inferred from drug dose.

— Assessment of impairment should acknowledge limitations relating to underlying physical disability.

1. *Pain and driving*

Management of long term pain is focused toward improving patients' quality of life and supporting independence. Many patients with persistent pain have activity related symptoms and mobility is often, in consequence, impaired. The ability to drive can help a patient with pain to improve not only their self-sufficiency but also function in social and vocational domains. Patients who are unable to drive may become socially isolated and dependent on others.

Pain impairs the ability to drive. There is robust experimental research to demonstrate that pain can interrupt the performance of attentionally demanding tasks including driving. Intense pain interrupts more than mild pain. Vigilance/attention, psychomotor speed, and working memory may be significantly impaired in patients with persistent pain with impairment being correlated with pain severity. Pain associated with cancer may impair neuropsychological performance to a greater degree than pain medication. In addition, patients with pain may have associated physical difficulties which make driving difficult. Pain frequently interrupts sleep so patients may be tired when driving but also here is a strong association between persistent pain and the symptom of fatigue (this may be related to common aetiology) which might be expected to further impair the ability to drive safely.

2. *Pain medication and driving*

Medications used to treat pain are usually centrally acting and may have central nervous system effects such as somnolence which impair ability to drive. Patients with persistent pain may be taking other classes of drugs for symptom relief including tricyclic antidepressants and anti-epileptic drugs. Sedative side effects are more likely to occur when such medications are taken in combination.

The discussion document rightly highlights the need for research into the effect of drugs on driving but there exists a significant body of literature in relation to driving ability and medicinal use of drugs. This includes:

Role of medications in motor vehicle accidents

An epidemiological review of the role of opioids in motor vehicle accidents found that opioid use in subjects found intoxicated whilst driving was 10% that in the general population and. The same review found that experimental studies showed that opioids did not seem to play a role in motor vehicle accidents or motor vehicle related fatalities.

Studies of relevant psychomotor skills

Short term ingestion of opioid drugs can cause central side effects such as dizziness and somnolence but when taken regularly patients become tolerant to these side effects. Several studies show that stable doses of opioids do not impair performance skills related to driving. Furthermore, relevant skills (including attention) may improve if effective pain relief is achieved by opioid therapy. Side effects may appear after upwards dose titration but these usually disappear within a few days of dose change.

In respect of inferences drawn from studies of patients being prescribed opioids for pain relief, these data are unlikely to be generalizable to individuals using opioids illicitly. Opioids used as medication are of defined dose and are under the supervision of the prescriber in relation to effectiveness and adverse effects and the two subject populations are likely to be different in regard to other physical and mental health morbidities.

3. *Advice on medication and driving*

Collaboration between service users and healthcare providers underpins successful long-term condition management and this includes decisions about medications. The balance of benefits and harms of treatments must be considered. If pa patient wishes to continue driving they must understand that the end point of medication treatment may be partial pain relief only. Similarly, patients should understand that they may only achieve useful pain relief at medication doses which make them unfit to drive. Many patients do not take medication as prescribed and the risks of this in relation to driving need to be highlighted.

Healthcare providers must ensure that patients understand the rationale behind drug driving laws and that concerns regarding fitness to drive relate to their safety and that of others. Advice about fitness to drive should be given when prescribing medications for pain but the patient has responsibility to consider their fitness to drive and they should make this on every occasion that they wish to drive a car.

Recent guidance on prescription of opioids for persistent pain has been issued to healthcare professionals and service users. The current advice regarding driving states:

(for prescribers)

"Patients being treated with opioids should be advised to avoid driving when:

- the condition for which they are being treated has physical consequences that might impair their driving ability;
- they feel unfit to drive;
- they have just started opioid treatment;
- their dose of opioids has been recently adjusted upwards or downwards (as withdrawal may have an impact on capability); and
- they have consumed alcohol or other drugs that can produce an additive sedative effect.

The only body that can advise a patient about their legal right to hold a driving licence is the Driving and Vehicle Licensing Authority (DVLA).

Patients starting opioids should be advised to inform the DVLA that they are taking opioids. Prescribers should document that this advice has been given."

(for patients)

"Can I drive if I am on opioids?

The law in the UK allows you to drive if you are taking opioid medicines. You should not drive if you have changed your dose or if you feel unsafe. You are responsible for making sure you are fit to drive. The only organisation that can advise you about your legal right to hold a driving licence is the Driving and Vehicle Licensing Authority (DVLA). You should let DVLA know that you are taking opioid medicines."

This guidance will need to be expanded to support new drug driving legislation. Technology in relation to electronic prescribing is available that would allow the prescriber to be prompted to discuss specific driving related issues with the patient and this could be accompanied by a patient information sheet with each opioid prescription.

4. *Assessing fitness to drive*

The effect of a given dose of medication on patient function will vary between individuals and in a given individual at different times. Although for a given individual being treated with opioid medication, any impairment is generally dose related, the degree to which a patient is impaired may depend, amongst other factors, on the intensity of their pain, other medications they have been taking and the length of time that they have been taking the drug. It is not possible to define a dose of medication at and above which a patient is likely to be impaired. Assessment of impairment would be necessary to objectively assess and individual's fitness to drive. Such assessment should acknowledge that patients with pain may have physical difficulties which might affect their ability to perform some components of testing as currently described.

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The British Pain Society 2010 *Opioids for Persistent Pain: Good Practice*
http://www.britishpainsociety.org/book_opioid_main.pdf

The British Pain Society 2010 *Opioids for persistent Pain: Information for Patients*
http://www.britishpainsociety.org/book_opioid_patient.pdf

The Chronic Pain Policy Coalition is a forum established in 2006 to unite patients, professionals and parliamentarians in a mission to develop an improved strategy for the prevention, treatment and management of chronic pain and its associated conditions.www.policyconnect.org.uk/cppc

September 2010

Memorandum from Professor Nutt, Chair, Independent Scientific Committee on Drugs (ISCD) (DDD 40)

Should the permitted blood alcohol limit be reduced as proposed?

Yes.

If so, is the mandatory one year driving ban appropriate for less severe offenders, at the new (lower) level?

No—we suggest a graded response of three to six months ban for alcohol levels from new lower level to the current level then one year as currently. This will incentivise reduced drinking.

How severe is the problem of drug driving and what should be done to address it?

This is hard to ascertain as detection of drug in blood of other body fluids bears little relation to impairment. Indeed some drugs may improve driving under certain situations. There are no meaningful studies on drug levels and driving performance that can be translated into a threshold test as currently exists for alcohol. This means that injustice is likely if a positive test brings prosecution.

The only fair and just response is to monitor driving or related performances.

It therefore follows that detection of drugs in a person in control of a vehicle should NOT be an offence in the absence of impairment, just as it is not a criminal offence in other situations.

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

Reducing the drink driving limit will save lives and reduce accidental injury to drivers, passengers and the public. Costs will be negligibly changed from the current situation.

September 2010
