

# Report of the Review of Drink and Drug Driving Law

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Sir Peter North CBE QC

June 2010

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Department for Transport  
Great Minster House  
76 Marsham Street  
London SW1P 4DR  
Telephone 0300 330 3000  
Website [www.dft.gov.uk](http://www.dft.gov.uk)

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## Executive summary

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The Review of Drink and Drug Driving law was requested by the Secretary of State for Transport to carry out a study into the legal framework in Great Britain governing drink and drug driving. It was asked to consider, in particular:

- the legal framework applying to drink and drug driving in Great Britain;
- the evidence on the nature of the drink and drug driving problems which the nation faces;
- the evidence on the impact of potential measures to reduce drink and drug driving casualties;
- discussions with, and representations received from, interested groups and individuals.

In carrying out the Review, fundamental principles were considered:

- drink and drug driving are clearly activities which endanger public safety and more should be done to detect and deter those driving while impaired by drink and drugs;
- there should be a focus on practical steps which can deal with a significant part of the problem of drink and drug driving – the best must not be the enemy of the good;
- the law should command respect among the general public and the public should understand both the law and the effects of drugs and alcohol upon driving;
- the law and penalties imposed should be focussed on road safety (not on enforcement of wider law or policy on drugs and drink) and should reflect the degree of risk caused by impairment;
- the procedures involved in enforcing the law should be fair to both the citizen suspected of the offence and to the wider public who are at risk from drink and drug driving;
- the evidence of both the level of drink or drugs in a suspect's body and the level of impairment should provide the best practicable indication of the levels at the time of driving;
- the penalties for the offences should be a deterrent, adequate punishment for the offence and should safeguard the public;
- any changes to the law or legal procedure need to be accompanied by appropriate and complementary campaigns of public information and enforcement.

### Drink driving

Over recent decades there has been a welcome reduction in deaths and serious injuries on the roads, including those associated with drink driving. However, there are still some 430 deaths and 1600 serious injuries every year which are attributable to drink driving. Reduction in that number requires further road safety initiatives to be adopted.

## Improving the evidence

Whilst the annual figures of road deaths due to drink driving are a reliable estimate, they are not an exact actual figure. Steps should be taken to improve the completeness of the actual figures which are available by requiring coroners (and procurators fiscal) to report all results of blood alcohol levels of drink driver fatalities.

## The alcohol limit

There is very considerable public support for a reduction in the current drink drive limit, commonly expressed as 80 milligrammes (mg) of alcohol per 100 millilitres (ml) of blood (shortened to 80 mg/100 ml and equivalent to 35 microgrammes of alcohol in 100 ml of breath). That support is clear from the evidence to the Review, both written and oral. Furthermore, a reduction would be consistent with the approach adopted by a large majority of countries in the EU. Research evidence consistently demonstrates that the risk of having an accident increases exponentially as more alcohol is consumed. Drivers with a blood alcohol concentration (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.

There is a case for a reduction to 20 mg/100 ml which would be wholly consistent with a policy of "Do not drink and drive". However, only a small minority of other countries have such a "zero tolerance" approach. It would seem to be a step too far in this country, at this time, risking the loss of public support for strengthening our drink drive legislation.

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. These figures do not fully reflect the additional lives that might be saved in Scotland who make up 7% of the drink drive-related casualties in Great Britain. While there are many uncertainties related to the data and the assumptions used in the modelling, nevertheless, they provide a helpful indication of what might be achieved by a reduction in the current limit. In the light of that, the current 80 mg/100 ml should be reduced to 50 mg/100 ml.

The issue of whether to have a lower alcohol limit for young or novice drivers is the most difficult addressed in the Review. Most novice drivers are young, and there is currently a separate penalty point regime for such drivers. It is clear from the drink drive statistics that younger drink drivers create a considerably greater risk than average, both to themselves and to others. It appears that that elevated risk extends to drivers up to the age of 30 but it does not appear proportionate to apply a stricter regime to all drivers for a

dozen years from gaining a licence. Given the high risk, there is, nevertheless, a strong case for a lower limit for the first five years of driving.

There are, however, real policing difficulties with an age related provision, since licences are not required to be carried by drivers. Singling out novice drivers fails to address the issue that the most problematic group of young drivers are those in their mid twenties. Furthermore, it does not seem wise to have an age or experience related provision which, in effect, says that you are allowed to drink more and drive once you have passed the appropriate age limit or period since passing your driving test. The evidence from around the world also suggests that the young, and young men in particular, are likely to be the demographic group which benefits most from any reduction in the general blood alcohol limit.

It therefore appears sensible to see what impact a general change in the limit to 50 mg/100 ml has on drink driving casualties associated with this group before deciding whether to move to set a limit specifically for them. The case for a 20 mg/100 ml limit for the first 5 years of driving should therefore be reviewed 5 years after implementation of the new 50 mg/100 ml limit, on the basis of the trend in the relative risk posed by young drivers.

### The impact on industry

Concern was expressed by some representatives of the drink and hospitality industry, in evidence to the Review, that lowering the limit to 50 mg/100 ml would have adverse consequences on their industry, not least in relation to rural pubs and restaurants. Also recent press coverage has suggested that lowering the limit would mean that drinking and driving would equate to a limit of less than one pint of beer or one glass of wine. These two matters are connected. The press coverage was exaggerated. It would appear that, even at a 50 mg/100 ml level, the responsible driver who wishes to enjoy a drink to accompany their pub meal or have a glass of wine or a pint of beer could do so without being in danger of breaking the law. Whether that would be wise, given the evidence of impairment at even low levels of blood alcohol, is another matter. The hospitality industry could do more to protect itself, evidence to the Review made clear, by for example more generally adopting and promoting the “designated driver” schemes and by giving attention to the high cost of non-alcoholic drinks.

### Appropriate penalties

Reduction in the limit to 50 mg/100 ml requires consideration of the appropriate penalties to be imposed at and above that level, particularly the penalty of a mandatory minimum period of disqualification. Various approaches can be canvassed, and have been in the evidence to the Review: keep the present 12 months mandatory disqualification at 50 mg/100 ml; impose 6 months minimum mandatory disqualification at 50 mg/100 ml, rising to 12 months at 80 mg/100 ml; have a mandatory 6 penalty points and discretionary disqualification at 50 mg/100 ml, with 12 months mandatory disqualification at 80 mg/100 ml or upon conviction for a second offence above 50 mg/100 ml. The weight of evidence favours the first approach; but that would mean that Great Britain had the toughest penalty regime of any



EU country with a 50 mg/100 ml limit. It must be recognised, however, that the threat of a substantial period of mandatory disqualification has proved to be a potent weapon in combating drink driving. It would be a retrograde step to diminish the force of that weapon, with the conclusion that, in addition to the current band C fine, 12 months mandatory disqualification should continue to be imposed if the limit is reduced to 50 mg/100 ml.

There are particular concerns over high risk offenders (HROs), a category which includes those who have a blood alcohol level more than 2 ½ times the legal limit (i.e. over 200 mg/100 ml), those who refuse a breath test and repeat drink drive offenders. Those drivers whose BAC is greater than 200 mg/100 ml have over 500 times the risk of dying in a road accident than if they had not drunk any alcohol. There are some 40,000 such offenders each year. A number of issues need to be addressed. First, HROs are subject to lengthy periods of disqualification and are required to satisfy a DVLA doctor of their fitness to have their licence restored. At the moment they can resume driving before they have been cleared by a doctor. This loophole needs to be closed without delay. Secondly, if the BAC limit is reduced to 50 mg/100 ml, there is a case for the threshold for the very high blood alcohol level which determines one section of HROs to be reduced proportionately to 125 mg/100 ml (where the risk of dying in a road accident is still almost 50 times the risk of a driver without alcohol), and the Sentencing Council should give this, and other issues associated with the escalation of penalties for HROs, close consideration. (Similar provision should be made in Scotland by any new equivalent Scottish body.) Thirdly, there are powers in England, Wales and Scotland for courts to order the forfeiture of vehicles involved in drink driving cases. There is recent experience in Scotland of effective use of these powers; and courts should, as a matter of routine, consider the exercise of such powers in the case of serious repeat offenders. Fourthly, in such serious cases, consideration should also be given by the courts to ordering permanent disqualification.

## Procedures

Turning to the procedure in drink drive cases, the current system involves a screening breathalyser test, normally at the roadside, followed by an evidential breath test on a fixed machine in the police station. It appears that type approval of a mobile evidential machine is close to being achieved. It is important that that process be concluded without delay. Mobile evidential testing machines should then be made available for use both at the roadside and at any convenient place in a police station or elsewhere. That should speed up the process of dealing with drink driving very considerably.

In a case where the evidential breath recording in the police station is between 40 and 50 microgrammes (mcg) per 100 ml of breath, there is then available to the arrested driver the “statutory option” of requiring a blood or urine test to see whether the driver is under the limit for the chosen test. This option was introduced some thirty years ago, at a time when there were doubts as to the accuracy of breath testing machines and because of concerns then expressed over the conversion of breath readings into blood or urine test levels which resulted in the use of a blood breath ratio of 2300:1. In evidence to the Review, there was very widespread support for the

abandonment of the statutory option because testing equipment is now far more efficient and precise; and, though the legal breath limit is 35 mcg/100 ml, there is already a degree of tolerance given in that no one is prosecuted at a reading under 40 mcg/100 ml. There is also scientific doubt as to the primacy given to the blood or urine alcohol level, as opposed to breath, and to the impact on the alcohol level of the elapsed time taken to get the blood or urine sample; in reality the public are concerned to know the breath reading on modern digital breathalysers rather than some conversion to blood or urine, and no other country has been identified as providing such an option. The clear conclusion is that the “statutory option” should be abandoned.

The more generous blood breath ratio of 2000:1 would allow for the natural variation in the blood breath ratio and for the small normal variability of the evidential breathalyser equipment. Calculated from this, the recommended new breath limit, based on a blood alcohol level of 50 mg/100 ml of blood, would be 25 mcg/100 ml of breath. It will then be necessary for the police to enforce the law from this threshold level.

The evidence to the Review identified the decreasing priority given to drink drive policing as a significant source of concern. This was 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. This is so even though there are nearly twice as many drink drive deaths as deaths as a result of knife crime. Drink driving needs to be afforded a much higher policing priority. The Scottish Executive will need to ensure that appropriate priority is given to the offence in Scotland.

The police have unlimited powers to stop vehicles, but they can only conduct a breath test if they suspect that the driver has been drinking, has been involved in an accident or has committed a moving traffic offence (however minor). These powers do, in fact, enable the police to test for drink driving in most cases where they would wish to do so. However, it is not possible to convey the simple message to the public that whenever you drive you may be subject to a breath test. The evidence to the Review revealed very wide support for the introduction of so-called “random breath tests”. In fact, in a large recent poll of AA members, 79% were in favour of the police being able to breathalyse a driver at any time. It is very desirable that an unambiguous message can be given to the public about the risks of being breath tested and the law should be broadened to achieve this. That said, it is only sensible and appropriate for the police to use this extended power in a targeted and intelligence led way.

## Drug driving

The recommended action on drug driving involves improving the evidence, streamlining the current procedures and longer term legislative steps to strengthen legal regulation of drug driving.

### Improving the evidence

The level of evidence on drug driving is poor. In part, this is because of the inherent illegality of many of the drugs which cause driving problems and the ethical and practical problems of getting accurate information on their use among drivers. But greater efforts should be made to improve the evidence in two ways:

- through ensuring that coroners and procurators fiscal routinely require testing for, and provide data on, the presence of drugs in road fatalities;
- and through studies of drug use patterns among drivers – including surveys and voluntary roadside saliva drug tests.

Nevertheless, on the basis of the evidence to the Review, it appears that there is a significant drug driving problem, which is out of all proportion to the 56 fatal and 207 serious injury accidents reported by police in 2008 as involving impairment by drugs. It would assist in monitoring the problem if the Government were to make clear distinctions in its collected statistics between offences for driving whilst impaired by drugs, by alcohol and by both alcohol and drugs in combination. However, even that change would not reveal the true picture, since the police will, understandably, routinely charge a suspect solely with drink driving when there is a positive breath test, without going on to consider whether drugs are involved too. For example, in England and Wales in 2008, there were approximately 73,000 drink driving offence proceedings in contrast to fewer than 3,000 proceedings which could be drink or drug driving offences. Less than 10% of these cases were recorded as drug driving.

### Improving procedure

Detection of drug impairment among drivers, and the quality of evidence put before the courts, can be improved by greater use of Field Impairment Tests (FIT) through which police officers in some forces assess physical co-ordination and cognitive abilities in order to establish whether impairment might be present. Each police force should invest in training officers to conduct the FIT test and make it a matter of policy to carry out the test in all cases of suspected driving impairment where excess alcohol has been ruled out with a breath test.

Under a Code of Practice, Chief Constables are supposed to maintain details of officers trained to carry out FIT tests, yet no central record is held; nor is there data on the number of FIT tests carried out by police officers. These figures should be collected and published annually, acknowledging the value that the FIT skills offer.

In order to try to ensure that the police give appropriate priority to the offence of driving whilst impaired by drugs, the police should be clearly incentivised to tackle the problem with greater energy, by making it one of

the 'Offences Brought to Justice' reported by police forces in England and Wales. The Scottish Executive should also endeavour to ensure that it is given appropriately high priority by the police in Scotland.

## The 'Road Map'

The Review has identified five stages of development in improving the process of detecting and deterring drug driving and improving the legal framework. The first two stages rely on developments which are close at hand, but which need a show of will on the part of Government and police.

### *Stage one: improving the current process*

The efficiency and effectiveness of the process can be improved, through reducing the time between suspicion of impaired driving and the taking of blood for testing

The current requirement for a forensic physician (FP) to determine whether the suspect has a "condition which might be due to a drug" introduces delay to the blood-testing of the suspect in two respects: the delay in getting the doctor to the station and the time spent by the doctor in carrying out the examination to determine the answer to the question. The first of these delays appears unacceptable; the second justified.

Nurses, in addition to doctors, should be able to fulfil the role, given the responsibility they take in other aspects of custody, as well as their role in protocol-led decision making in such areas as minor treatment centres, NHS Direct and in triage at A&E. The extension of this role to nurses is particularly appealing in light of the fact that many police forces now routinely employ nurses to provide round-the-clock cover for their custody suites.

Whatever the healthcare discipline of the person making the assessment, they need to be trained for the specific task: understanding the drugs which might be involved and their effects; and being able to assess suspects appropriately to exclude significant medical conditions which might also be present. The training should also be clear in describing the limits of the role and should discourage their becoming involved in consideration of the evidence of impairment, particularly in court, as this should be provided by police officers who have witnessed the impaired driving.

### *Stage two: preliminary drug screening tests*

The second stage involves removing the role of the forensic physician or nurse in relation to the investigation of driving whilst impaired by certain controlled drugs and replacing that screening role with preliminary drug testing of saliva. This is allowed for by the current legislation, but progress has been hampered by the lack of type-approval of suitable screening devices. The Government should shift its short-term focus from type approval of roadside testing devices, which has so far been confounded by issues of accuracy, interference and harsh environmental conditions, to approval of more reliable devices for drugs screening in the more controlled environment of the police station.

Type approval ought in the first instance to focus on devices which are together capable of detection, at the least, of:

- opiates;
- amphetamines;
- methamphetamine;
- cocaine;
- benzodiazepines;
- cannabinoids;
- methadone;
- ecstasy (MDMA).

The evidence shows that these are more widely misused by drivers. Where a preliminary drug test for a listed drug proved negative but there was continuing concern over the driver's impairment, the police officer would be able to revert to the existing procedure and call for a doctor or nurse to confirm that the suspect had a condition which might be due to a drug, prior to any blood test.

In addition to the benefits of shortening the time involved in the process, the introduction of such screening devices should have benefits in terms of conveying to the wider community that the police have technology which can readily detect common drug use among drivers.

### *Stage three: a specific offence*

The third stage involves the introduction of a new specific offence of driving with certain controlled drugs in the blood at, or above, levels at which those are deemed to be impairing. This would need:

- research into, and agreement upon, levels at which controlled drugs which are prevalent among drivers could be deemed to be impairing, with a focus on the active and impairing metabolites of those drugs;
- the creation of a new offence in primary legislation;
- the establishment of a list of controlled drugs, the presence of which was banned in drivers at or above the specified levels.

The process would then involve the use of the preliminary drug screening of saliva in the station, screening for drugs, the presence of which was banned in drivers at or above specified levels. That 'panel' of drugs would be selected, based on intelligence relating to local drug use patterns, from a longer list of controlled drugs, which should include all the substances listed above. If one or more of the drugs are detected by the screening device to be present, then a blood sample would be required. A positive test in the laboratory at or above the specified level for a given drug would be an offence, regardless of any evidence of impairment.

The establishment of levels of deemed impairment for controlled drugs is a considerable task and, should it prove impossible, Government might instead wish to create a "zero tolerance" offence of driving with the active and impairing metabolites of the controlled drugs listed above in the body.

Some of these drugs of concern might also be used legitimately, according to medical advice. There ought also therefore to be a statutory defence, against the offence of driving with a listed drug in the blood above the specified level, that the defendant was driving having taken the drug in accordance with medical advice.

This stage three regime would provide a means of tackling the major part of our drug driving problem, but it would not deal with the vast majority of prescribed and over-the-counter medicines, nor would it deal with all controlled drugs or new social drugs and legal substances taken for their impairing effects, including so-called 'legal highs'. It would therefore be necessary to maintain the existing offence of driving while impaired by drugs, as a 'catch-all' to cover these other substances and instances. There should be no statutory defence of having taken a drug in accordance with medical advice in relation to that existing offence, just as there is not at present.

#### *Stage four: roadside screening*

Ultimately it would provide a great help to the efforts to detect and deter drug driving to introduce a system as similar as possible to drink driving, where positive roadside screening for alcohol routinely leads onto evidential testing in the police station. Therefore, once drug screening devices are type approved for use in police stations, Government should continue its work on roadside screening devices, since experience in other parts of the world shows promise in this area. If the roadside screening test proved positive, the suspect would be arrested and taken to the police station for a healthcare professional to take blood.

#### *Stage five: evidential drug testing*

The last stage of development would be the introduction of evidential drug testing of oral fluids, removing the need for a blood test. Initially this would be in the police station. Following this development, the roadside preliminary drug test of saliva would, if positive, be followed by an evidential drug saliva test back at the station which would substitute for the blood test. Whilst the development of evidential testing equipment is some way off, it is notable that some jurisdictions use, or are moving to use, oral fluid/saliva drug tests as evidence of an offence.

Eventually, it is to be hoped that problems of environmental interference can be overcome and evidential testing could ultimately be done at the road side.

Even under this scenario, the general offence of impairment due to drugs would need to be maintained to deal with non-listed substances, prescribed drugs and over-the-counter medicines.

## Legal drugs/medicines

A driver impaired by legal drugs – whether prescribed or over-the-counter – is as much a danger to the public as one impaired by controlled drugs. Research suggests that, amongst health care professionals, current knowledge of the impact of medical conditions on driving standards is poor; it may not be unreasonable to infer that advice to patients on medicines may also be inadequate. As such, there is the potential to give better advice on the possible impairing effects of these medicines, both on the part of healthcare professionals and through the leaflets provided to purchasers of over-the-counter medicines.

The NHS, the Department of Health and the DVLA should ensure that doctors are consistently reminded, in their training, their practice and their assessment, routinely to provide clear advice to patients on the effects of prescribed drugs on driving. Government, in conjunction with the pharmaceutical industry, should closely consider the patient information provided with both prescribed and over-the-counter medicines and the merits of a simple and easily communicated system of advice related to driving. The French, for example, have instituted a simple colour-coded system of labelling of drugs, indicating those which are incompatible with the driving task, those where caution should be exercised and the degree to which advice should be sought.

## Drugs and drink in combination

Lastly, it is clear, in the evidence considered, that the problem of driving having taken drugs and alcohol in combination is a serious one. The international evidence shows how relatively low levels of drugs combined with relatively low levels of alcohol can be very impairing and are not uncommon among drivers. For example, alcohol at a level below the legal limit combined with cannabis is found by the research to be very impairing.

There is no case for a specific new offence to deal with this problem, given that the current offence of driving while impaired by drink or drugs is a perfectly adequate legislative response, if it is pursued more regularly.

Certain of the Review's conclusions will also assist in tackling this offence. More and better FIT testing will help police officers to assess and bring to justice cases where a driver is impaired by both drink and drugs. The proposal that police should, as a matter of routine conduct a FIT test (or in time a preliminary drug screening test of saliva) of an impaired driving suspect, who gives a breath reading below the drink drive limit, should assist with this. The improvement in data from coroners and procurators fiscal will provide annual evidence of the prevalence of driving with drugs and alcohol combined among driver fatalities.

In addition, however, in England and Wales the Magistrates' Court Sentencing Guidelines should be revised by the Sentencing Council to make the combination of alcohol and drugs an aggravating factor in all drug driving and drink driving cases. Similar provision should be made in Scotland by any new equivalent Scottish body.

# List of recommendations

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## Drink driving

**Recommendation (1):** The Ministry of Justice and the new Chief Coroner should ensure that coroners routinely test for, and provide data on, the presence of alcohol in road fatalities. The Scottish Executive Government should ensure that similar action is taken by procurators fiscal in Scotland.

**Recommendation (2):** The current prescribed blood alcohol limit in section 11(2) of the Road Traffic Act 1988 of 80 mg of alcohol per 100 ml of blood should not be reduced to 20 mg of alcohol per 100 ml of blood.

**Recommendation (3):** The current prescribed blood alcohol limit in section 11(2) of the Road Traffic Act 1988 of 80 mg of alcohol in 100 ml of blood should be reduced to 50 mg of alcohol in 100 ml of blood and the equivalent amounts in breath and urine.

**Recommendation (4):** The drinks, hospitality and night-time entertainment industry should promote and operate measures and best practice across Great Britain that encourage and facilitate situations where the person who is driving abstains from drinking.

**Recommendation (5):** There should not be a lower prescribed blood alcohol limit of 20 mg of alcohol per 100 ml of blood for drivers of HGVs, PSVs or taxis and private hire vehicles.

**Recommendation (6):** Drink driving offences in breach of the proposed lower blood alcohol limit of 50 mg of alcohol per 100 ml of blood committed when driving any HGV, PSV or private hire vehicle should continue to be an aggravating factor in the Magistrates' Court Sentencing Guidelines and in any future Scottish sentencing guidelines.

**Recommendation (7):** Best practice on drink and drug driving interventions, including interlocks, and employer guidelines should be rolled out throughout the transport industry.

**Recommendation (8):** There should not be a lower prescribed blood alcohol limit of 20 mg of alcohol per 100 ml of blood for either young or novice drivers.

**Recommendation (9):** The Government should, after 5 years, review the impact of the new prescribed limit of 50 mg of alcohol per 100 ml of blood on young and novice drivers and, if the anticipated casualty reductions in that population do not materialise, consideration should then be given to introducing a limit of 20 mg of alcohol per 100 ml of blood for those drivers.

**Recommendation (10):** The reformed driver training and testing regime, including the new pre-driver qualification, should give greater emphasis to the dangers of drink and drug driving.

**Recommendation (11):** The statutory option contained in section 8(2) of the Road Traffic Act 1988 should be removed.



**Recommendation (12):** In establishing a new equivalent in breath to the blood alcohol limit of 50 mg of alcohol per 100 ml of blood, a ratio of 2000:1 should be used, giving an alcohol concentration limit of 25 mcg of alcohol per 100 ml of breath.

**Recommendation (13):** The laboratories should apply a lower allowance to the analysis of blood and urine specimens of 3 mg/100 ml (or 3%).

**Recommendation (14):** There should be no charging threshold applied to the new lower limit of 25 mcg of alcohol per 100 ml of breath. A person who drives or attempts to drive or is in charge of a motor vehicle on a road or other public place after consuming so much alcohol that the proportion of it is that person's breath exceeds the prescribed limit in breath of 25 mcg of alcohol per 100 ml of breath commits an offence and should be charged, at that level.

**Recommendation (15):** The excess alcohol offence under section 5(1)(a) of the Road Traffic Act 1988 of driving or attempting to drive a motor vehicle on a road or other public place after consuming so much alcohol that the proportion of it in a person's blood exceeds the prescribed limit of 50 mg of alcohol per 100 ml of blood should carry a period of disqualification of not less than 12 months and a band C fine.

**Recommendation (16):** The Sentencing Council (and any future Scottish Sentencing Council) should determine the applicable bands of penalties in the Magistrates' Court Sentencing Guidelines for drink driving offences involving alcohol concentrations in excess of a new limit of 50 mg of alcohol per 100 ml of blood.

**Recommendation (17):** The High Risk Offenders scheme should continue to operate in respect of offenders who fail to provide a specimen.

**Recommendation (18):** The provisions of the Magistrates' Court Sentencing Guidelines in respect of those who fail to provide a specimen should be maintained and followed to guard against offenders benefiting from failure to provide. Any future Scottish sentencing guidelines should include equivalent provisions.

**Recommendation (19):** The High Risk Offenders scheme should continue to operate in respect of offenders with high levels of alcohol concentration.

**Recommendation (20):** The application of the High Risk Offender threshold of two-and-a-half times the prescribed limit should be applied to a lower prescribed blood alcohol limit of 50 mg of alcohol per 100 ml of blood.

**Recommendation (21):** The High Risk Offenders scheme should continue to operate in respect of repeat offenders.

**Recommendation (22):** The Government should move swiftly to bring into force those provisions of the Road Safety Act 2006 which will ensure that High Risk Offenders do not regain their licence without first being assessed by a Department for Transport-approved doctor.

**Recommendation (23):** Provision should be made in England and Wales, as in section 33A of the Road Traffic Offenders Act 1988 in relation to Scotland, for seizure and forfeiture of vehicles used by repeat offenders in drink (and drug) driving offences involving mandatory disqualification.

**Recommendation (24):** The Magistrates' Court Sentencing Guidelines should be amended so that, in cases of repeat drink-drive convictions for offences involving mandatory disqualification and particularly of those convicted of such offences whilst disqualified, permanent disqualification from driving is routinely considered by the magistrates. Similarly, sheriff courts should also routinely consider permanent disqualification in such circumstances.

**Recommendation (25):** The offences involving mandatory disqualification in sections 4(1), 5(1)(a), 7(6) and 7A(6) of the Road Traffic Act 1988 should be added to the list of 'Offences Brought to Justice' determined by the Ministry of Justice, on which the police in England and Wales are required to report.

**Recommendation (26):** Section 6 of the Road Traffic Act 1988 should be amended to provide a general and unrestricted power to require anyone who is driving a motor vehicle to cooperate with a preliminary breath test. This power should not be extended to a person who had been driving, was or had been attempting to drive or who is or has been simply in charge of a motor vehicle.

**Recommendation (27):** Type approval and deployment of portable evidential breath testing equipment should be completed no later than the end of 2011.

**Recommendation (28):** Section 7(1)(c) of the Road Traffic Act 1988 should be amended to dispense with the requirement for the police to administer a preliminary breath test before an evidential breath test.

## Drug driving

**Recommendation (1):** The Ministry of Justice and the new Chief Coroner should ensure that coroners test for, and provide data on, the presence of drugs in road fatalities. The Scottish Executive should ensure that similar action is taken by procurators fiscal in Scotland.

**Recommendation (2):** The Government should commission more research in the driving community to understand better the prevalence of drug driving in Great Britain and should monitor the impact of changes in law or policy.

**Recommendation (3):** The Government should improve the clarity of its information on drug driving by:

- collecting data from Chief Constables on the numbers of constables trained to carry out the Field Impairment Test;
- collecting data on the number of FIT tests carried out by police constables; and
- making clear distinctions in its collected statistics between offences for driving whilst impaired (a) by alcohol, (b) by drugs and (c) by both alcohol and drugs.

**Recommendation (4):** Each police force should invest in training constables to conduct the Field Impairment Test. The number of FIT tests conducted should increase significantly, with forces making it a matter of policy to carry out the test in all cases where impaired driving is suspected, notwithstanding a negative breathalyser test.

**Recommendation (5):** The Crown Prosecution Service and Crown Office, in deciding whether to proceed with cases, and Magistrates and Sheriffs, in determining cases, should take greater account of evidence of general impairment of a driver other than while actually driving.

**Recommendation (6):** The principal drug driving offence in section 4(1) of the Road Traffic Act 1988 should be included in the 'Offences Brought to Justice' determined by the Home Office and monitored by police forces in England and Wales. The Scottish Executive should also endeavour to ensure that this offence is given appropriately high priority by the police in Scotland.

**Recommendation (7):** Within a year, section 7(3)(c) of the Road Traffic Act 1988 should be amended to allow nurses also to take on the role currently fulfilled by the Forensic Physician in determining whether the drug driving suspect has 'a condition which might be due to a drug'.

**Recommendation (8):** Appropriate training should be provided to all health care professionals who undertake the role of assessing whether suspects have 'a condition which might be due to a drug' in accordance with section 7(3)(c) of the Road Traffic Act 1988, to ensure an understanding of their specific role and of the potential medical complications which may arise in relation to persons in custody.

**Recommendation (9):** The training of Forensic Physicians and custody nurses to carry out the role under section 7(3)(c) of the Road Traffic Act 1988 of determining whether a suspect has a 'condition that might be due to a drug' should be clear in describing the limits of that role. The training should encourage discussion between the healthcare professionals and the police officers involved in the case, as the observations of the officers might well assist healthcare professionals in answering the question. However, training should discourage their becoming involved in consideration of the evidence of impairment in court, since this is not required under the legislation.

**Recommendation (10):** Chief Constables should ensure that no samples are submitted by their force to laboratories for analysis without the MD DD/E form or other details of the circumstances of the case which can aid laboratory analysis.

**Recommendation (11):** Steps should be taken for the earliest practicable type approval and supply to police stations of preliminary drug screening devices to be used in accordance with section 6C of the Road Traffic Act 1988. This should be achieved within two years. Type approval ought in the first instance to focus on devices capable, in aggregate, of detection of those drugs or categories of drugs which are the most prevalent, including amongst drivers, namely:

- opiates;
- amphetamines;
- methamphetamine;
- cocaine;
- benzodiazepines;
- cannabinoids;
- methadone;
- ecstasy (MDMA).

**Recommendation (12):** The Government should actively pursue research to determine the levels of the active and impairing metabolites of the following controlled drugs or categories of controlled drugs which can be deemed to be impairing (as the prescribed limit currently does in relation to alcohol):

- opiates;
- amphetamines;
- methamphetamine;
- cocaine;
- benzodiazepines;
- cannabinoids;
- methadone;
- ecstasy (MDMA).

**Recommendation (13):** As and when research has established the impairing levels of the active and impairing metabolites of particular controlled drugs or categories of controlled drugs, prescribed levels for such drugs or categories of drugs should be set in legislation and a new offence introduced which makes it unlawful to drive with any of the listed drugs in the body in excess of the prescribed level.

**Recommendation (14):** A statutory defence should be available in respect of any new offence of driving with a listed drug or category of drug in the body above the statutory prescribed level if the defendant had taken the drug in accordance with medical advice. This defence should not be available in respect of the impairment offence under section 4 of the Road Traffic Act 1988 of driving while unfit due to drugs.

**Recommendation (15):** If, despite the above recommendations, it should prove beyond scientific reach to set specific levels of deemed impairment, the Government should consider whether a 'zero tolerance' offence should be introduced in relation to the following drugs and categories of drugs:

- opiates;
- amphetamines;
- methamphetamine;
- cocaine;
- benzodiazepines;
- cannabinoids;
- methadone;
- ecstasy (MDMA).

rather than continuing to rely solely on the offence of impaired driving under section 4 of the Road Traffic Act 1988.

**Recommendation (16):** The current offence under section 4 of the Road Traffic Act 1988 of driving while unfit due to a drug should be retained in order to deal with impairment from prescribed and over-the-counter medicines, new drugs or other drugs for which it is not possible to determine an impairing level.

**Recommendation (17):** Once preliminary drug screening devices have been type approved for use in police stations, the Government should continue to work on type approval of preliminary drug screening devices which are capable of being used at the roadside, drawing from overseas experience.

**Recommendation (18):** Following type approval of roadside preliminary drug screening devices, research should continue in the quest for reliable evidential saliva testing devices for an appropriate range of drugs at prescribed levels. This should focus first on the type approval of indoor testing devices. Subsequently, research and development should focus on roadside evidential drug testing devices. However, such research and development should not be at the expense of reaching the achievable goal of developing and type approving a preliminary drug screening device for use at the police station in accordance with section 6C of the Road Traffic Act 1988 as soon as possible.

**Recommendation (19):** Regulation 74 of the Motor Vehicle (Driving Licences) Regulations 1999 should be amended to also include offenders who are disqualified for driving whilst unfit due to drugs under section 4 of the Road Traffic Act 1988, thereby resulting in the inclusion of drug driving offences in the High Risk Offender scheme. This would mean that those who are disqualified twice, within a ten-year period, for any drink or drug driving offences involving mandatory disqualification are subject to assessment by a Department for Transport-approved doctor prior to regaining their licence to ascertain whether they have a drink or drug dependency or misuse problem.

**Recommendation (20):** Following reform of the drug driving law and process, the Government should consider the case for the introduction of drug driver rehabilitation courses.

**Recommendation (21):** 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.

**Recommendation (22):** 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.

**Recommendation (23):** The Magistrates' Court Sentencing Guidelines should be revised by the Sentencing Council to ensure that in England and Wales the combination of alcohol and drugs is made an aggravating factor in all drink and drug driving cases where there is evidence of a combination of drugs and alcohol present. Similar provision should be made in Scotland by any new equivalent Scottish sentencing body.

# Part I – Introduction

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# Chapter 1: Drink driving – Law and procedure

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## Introduction

1.1. On 3 December 2009, I was appointed by Lord Adonis, the then Secretary of State for Transport, to conduct an independent Review of the law on drink driving and drug driving. It was agreed that the Review would provide initial advice to the Secretary of State by 31 March 2010. That advice was provided on 29 March.

1.2. I have been supported by three Department for Transport (DfT) officials, who were seconded to me and who gave up their Departmental responsibilities for the duration of the Review:

Chris Watts, Secretary to the Review

Dr Liz Brutus, Medical Adviser

Hannah Carpenter, Legal Adviser.

I am most grateful to them for the energy, imagination, commitment and enthusiasm which they have devoted to the work of the Review.

1.3. I also took advice from three independent experts in the field of impaired driving:

Dr Doug Beirness, Senior Research and Policy Analyst and Advisor, Canadian Centre on Substance Abuse

Dr Paul Jackson, Clockwork Research, London

Professor Alain Verstraete, Laboratory of Clinical Biology, Ghent University Hospital

1.4. The Review's terms of reference were published by the former Secretary of State on 3rd December:

"To carry out a study into the legal framework in Great Britain governing drink and drug driving and to provide Ministers with initial advice by 31 March 2010. To consider in particular:

On drugs

- (a) the evidence that a new offence is needed, taking into account the evidence base on the involvement of drugs in road fatalities/accidents, data on cases brought to justice etc;
- (b) how any new offence should be framed – for example, whether it should be based on an absolute ban, or as with alcohol and driving, a certain level of drugs within the driver's system;
- (c) which drugs should be covered by any new offence (including the status of prescribed medications);
- (d) the consistency of any new offence with wider government strategies for tackling the adverse health and social impacts of drugs;
- (e) the practicability of identifying impairing substances in a legally robust way (including the availability of testing equipment);

- (f) whether, and if so how, administrative procedures (including the role of the Forensic Medical Examiner) could be improved;
- (g) evidence of any such offences in other countries, the associated penalty regimes and the success of policies in those nations.

On alcohol

- (a) the evidence that a new limit or framework of limits is needed, taking into account the evidence base on the involvement of alcohol in road fatalities/accidents;
- (b) the impacts of any change in the blood alcohol limit on health outcomes, businesses and on the economy more widely;
- (c) how any reduction in the drink drive limit should be framed, and the associated penalty regime.”

- 1.5.** The Review has considered these issues as they apply to Great Britain, since that is the jurisdiction to which the relevant law on drink driving and drug driving currently applies. Road safety in Northern Ireland is a devolved matter.
- 1.6.** In relation to drink driving, it is important to note recent developments in relation to devolution and Scotland. The Report of the Calman Commission on Scottish devolution<sup>1</sup> recommended that the regulation-making powers over drink-drive limits in Scotland should be devolved to Scottish Ministers. The previous Government’s response<sup>2</sup> to the Commission’s Report accepted this recommendation, and the Conservative Liberal Democrat coalition negotiations statement of Agreements reached, dated 11 May 2010, also expresses agreement to implement the Calman Commission proposals. Any such change will require primary legislation.
- 1.7.** From time to time over the duration of the Review, I provided the former Secretary of State for Transport with updates on the progress of the Review and I have provided a small group of Government officials with a draft of the final report, to provide the opportunity to highlight any factual inaccuracies and missed evidence. However, I have not invited comment or observations from Ministers or Departmental officials on the findings of the Review or on its recommendations. The findings, conclusions and recommendations in this Report are mine alone.
- 1.8.** In reaching the conclusions included in this report, I have borne in mind certain fundamental principles that:
- drink and drug driving are clearly activities which endanger public safety and that more should be done to detect and deter those driving while impaired by drink and drugs;
  - there should be a focus on practical steps which can deal with a significant part of the problem of drink and drug driving – the best must not be the enemy of the good;

<sup>1</sup> Commission on Scottish Devolution. *Serving Scotland Better: Scotland and the United Kingdom in the 21st Century: Final Report*, June 2009.

<sup>2</sup> *Scotland’s Future in the UK*. Scotland Office. November 2009.



- the law should command respect among the general public and the public should understand both the law and the effects of drugs and alcohol upon driving;
- the law and penalties imposed should be focussed on road safety (not on enforcement of wider law or policy on drugs and drink) and should reflect the degree of risk caused by impairment;
- the procedures involved in enforcing the law should be fair to both the citizen suspected of the offence and to the wider public who are at risk from drink and drug driving;
- the evidence of both the level of drink or drugs in a suspect's body and the level of impairment should provide the best practicable indication of the levels at the time of driving;
- the penalties for the offences should be a deterrent, adequate punishment for the offence and safeguard the public;
- any changes to the law or legal procedure need to be accompanied by appropriate and complementary campaigns of public information and enforcement.

## Trends in road safety

- 1.9.** In 1966, the year before the introduction of both the blood alcohol limit for drink driving and the preliminary breath test (commonly known as and referred to in this Report as the 'breathalyser'), there were 7,985 road deaths in Great Britain – a peacetime peak. Since then, initiatives by central and local government, the police and the vehicle industry have seen British road safety transformed. In 2008 there were 2,538 road deaths in Great Britain. In that year, 430 deaths – and 1630 serious injuries – were estimated to have involved drivers in excess of the blood alcohol limit. Given the context of motor vehicle traffic having trebled between 1967 and 2008, both road safety and the drink drive regime are areas of conspicuous public policy success. Strategies combining effective enforcement of heavy penalties for drink driving backed by high profile advertising have contributed to these successes. Significantly, there has also been a cultural shift where, for the majority of the public, drink driving is no longer considered acceptable.
- 1.10.** Yet the total of both road deaths and of drink driving deaths remains high. The number of drink-drive deaths compares unfavourably with other issues of popular concern. For example, the 380 drink-drive deaths in England and Wales in 2007<sup>3</sup> compare with 270 knife murders<sup>4</sup> and 227 deaths due to fire.<sup>5</sup> Furthermore, the total of road deaths in England & Wales<sup>6</sup> – 2,266 – compares with 784 homicides.<sup>7</sup> The Department for Transport has estimated that the prevention of those drink drive accidents which resulted in all reported injuries (including killed, serious and slight injuries) in 2008 would have

<sup>3</sup> Reported Road Casualties Great Britain 2008 (supplementary tables). Department for Transport 2009.

<sup>4</sup> Home Office. Crime in England and Wales 2007/08: Findings from the British Crime Survey and police recorded crime. Home Office Statistical Bulletin. Jul 08.

<sup>5</sup> Office of National Statistics. Mortality Statistics. Deaths Registered in 2007.

<sup>6</sup> Reported Road Casualties Great Britain 2008. Department for Transport.

<sup>7</sup> Home Office. Crime in England and Wales 2007/08: Findings from the British Crime Survey and police recorded crime. Home Office Statistical Bulletin. Jul 08.

saved around £1.2 billion, taking no account of those accidents that resulted in damage only.

- 1.11. A minority of drivers persist in drink driving. The last ten years in particular have seen a tailing off in the reduction of drink drive casualties and, as such, the subject needs to be revisited to determine whether more can be done to reduce drink driving incidents further. Of those at risk, people under 30 are a particularly vulnerable group.
- 1.12. All those successful initiatives on road safety – behaviour, enforcement and engineering – can offer a continuing benefit in terms of reducing casualties only once. Therefore it is important to consider what more can be done to produce a further reduction.
- 1.13. A considerable amount is known about drink driving, following many years of research and analysis of casualty and collision statistics. Considerably less is known about drug driving, partly because of the illegality of possessing and supplying controlled drugs, in clear contrast to alcohol, and partly because of a lack of domestic research on the issue.
- 1.14. The available casualty data suggests that there were 56 fatal accidents in which impairment by legal or illegal drugs was judged by the police to be a contributory factor.<sup>8</sup> Yet more than one in ten of adults admitted to using illegal drugs in 2008/09<sup>9</sup> and, among the limited evidence that there is, a Scottish Executive study has suggested that drug driving might be prevalent among as much as 11% of the driving population.<sup>10</sup> We also know that the evidence from coroners and procurators fiscal showed a massive increase in drugs in the blood of deceased drivers in the decade to 2000.<sup>11</sup> There is therefore reason to suspect that the official data on drug driving tell only a small part of the story.

## Evolution of the drug driving and drink driving offences

- 1.15. Driving whilst impaired by drink or drugs has been an offence since 1930. Until the 1960s, impairment had specifically to be proved in the case of both drink and drugs.
- 1.16. On the basis of international research about the relationship between blood alcohol levels and involvement in road traffic accidents, legislation in 1967 introduced a blood alcohol limit above which it was illegal to drive. Effectively, drivers with a blood alcohol concentration above that limit were deemed to be impaired, regardless of any argument that they might mount to the contrary. A driver would first be subject to a breathalyser test and, if that was positive, would be required to provide a specimen of blood or urine to confirm the level of alcohol present. The penalty for driving whilst over the blood alcohol limit was a minimum of one year's disqualification. Fines and prison sentences were at the courts' disposal.

8 Reported Road Casualties Great Britain 2008. Department for Transport. 2009.

9 Hoare J. British Crime Survey, 2008-2009: Special Licence Access, Drug Use Module (BCS). Home Office. 2010.

10 Scottish Executive Social Research, Myant *et al.* 2006.

11 Tunbridge RJ, Keigan M, James F. (2001) The Incidence of Drugs and Alcohol in Road Accident Fatalities. TRL Report 495. Crowthorne: TRL

- 1.17. The offence of driving while impaired by alcohol was also retained and continues to apply to impaired driving and to some additional classes of vehicles.
- 1.18. The early 1980s saw the introduction of evidential breath tests in police stations. This meant that, in most cases, the suspect would have a screening, breathalyser test at the roadside and then, if the breathalyser indicated a positive result, a further, evidential, breath test at the police station which would form the basis for any charge and which would be used in evidence.
- 1.19. This is the regime which prevails in Great Britain today. The current law in respect of drink driving is more fully explained in Chapter 2.
- 1.20. It is useful to consider this history not only because it casts some light on the issues of how to improve our drink driving record, but also because it helps in considering how an offence of drug driving might be developed. The current offence of driving while impaired by a drug still relies on proof of impairment, as drink driving cases did prior to the introduction of the blood alcohol limit. Consideration of a new drug driving offence has often, in the light of the development of the drink driving offence, focused on the possibility of the establishment of a specific offence of driving with particular drugs in the blood at specified levels. Fuller details of the drug driving offence are set out in Chapter 5.

## Measuring alcohol in the body

- 1.21. Alcohol concentrations can be measured in 3 main body samples – in breath (in terms of microgrammes of alcohol per 100 millilitres of breath, expressed as mcg/100 ml), in urine and in blood (in terms of milligrammes of alcohol per 100 millilitres of urine or blood, expressed as mg/100 ml). Internationally, alcohol concentration is most commonly expressed in terms of blood, the blood alcohol concentration (BAC). BAC can be expressed in a variety of ways; however, in this report it will be expressed in mg/100 ml. Therefore, as an example, the legal BAC limit in Great Britain is 80 mg/100 ml.
- 1.22. In Great Britain, the ratio that describes the relationship between the alcohol in breath and blood has been defined (because it is known to vary) as being 2300:1. For example, this means that a blood alcohol concentration of 80 mg/100 ml is equivalent to a breath alcohol concentration of 35 mcg/100 ml.
- 1.23. Reference is often made to a “zero” BAC limit. However, the Review has considered the practical minimum BAC limit to be 20 mg/100 ml and not 0 mg/100 ml. This is because certain common substances such as cough syrups and mouthwashes may contain alcohol and there is also a theoretical possibility of natural alcohol production from bacteria in the gut. (This 20 mg/100 ml limit will also permit the consumption of a small amount of alcohol as part of a religious function.)

## Consultation

- 1.24. Reforming the current legal framework covering drink and drug driving raises complex legal and practical issues which may affect a great many individuals and organisations. It has therefore been essential that ways in

which the current legislative regime, including enforcement and penalties, might be changed should be discussed with as many interested persons and bodies as possible within the time available.

- 1.25.** With this in mind, an invitation to submit views was published on the Review website and circulated to more than 150 organisations with a particular interest in the issues involving drink and drug driving. Written views were invited in response to questions arising from the Terms of Reference. These questions can be found in Annex A, and a list of those organisations and individuals who responded is in Annex B.
- 1.26.** In addition 31 meetings have been held with key interested organisations to discuss the issues of drink- and drug driving. A list of those organisations and individuals who gave oral evidence is at Annex C. The comments which have been received both in writing and through meetings have greatly assisted the work of the Review.

## Visits

- 1.27.** In the course of the Review, visits have been made to the police in order to observe efforts to detect drivers impaired by drink and/or drugs. These visits have also provided the opportunity to observe the process of testing and charging suspects at the police station. A visit was also made to one of the main laboratories used by the police to test blood and urine samples for drug and alcohol content. Members of the Review team also saw for themselves proceedings on drink driving cases at Horseferry Road Magistrates' Court, Westminster, London. I am grateful to all those who have assisted the Review in this way. The visits are listed at Annex D.

## Statistics and analysis

- 1.28.** The Department for Transport and the Ministry of Justice collate data regarding drink and drug driving offences and casualties each year due to drink or drug driving. The Home Office also publishes data on the number of breathalyser tests conducted and the outcome of such tests. Both published data and data kindly provided by Government statisticians have been used in the course of the Review and these are cited throughout this Report.

## Other information

- 1.29.** A list of statutory provisions, text books, policy documents, articles, websites and television programmes considered in the course of the Review is at Annex E.

## Evidence review

- 1.30.** A list of research referred to is attached at Annex F. Supplementary research into drug driving was commissioned from Dr Paul Jackson. This has been published in parallel with this Report.

## **Department for Transport impact assessment**

- 1.31.** The Review has not included any detailed economic analysis of proposals to reduce drink or drug driving. However, the Department for Transport has, in parallel, been making an analysis of potential measures to reduce drink and drug driving as preparation for an Impact Assessment to be published with any subsequent consultation. The economic impact data, as well as data on the impact of possible measures on the criminal justice system, will therefore be exposed and open to consideration with the Review's recommendations.

## **The Report**

- 1.32.** In considering the structure of the Report, the Review was keen to choose a structure which allowed those readers who have specific interest in either drink driving or drug driving, as well as readers who have a general interest, to be able to navigate their way around the Report and to find easily those parts of the Report in which they had a particular interest.
- 1.33.** Following this first, introductory Part, the remainder of this Report is divided into two Parts. Part II considers drink driving and Part III drug driving. Whilst these two Parts are intended to be capable of being read independently, the subjects of drink and drug driving do interlink with each other and there is, therefore, some cross referencing.
- 1.34.** Part II is divided into three chapters:  
Chapter 2: Drink driving – Law and procedure  
Chapter 3: Drink driving – Evidence, issues and opinion  
Chapter 4: Drink driving – Conclusions and recommendations
- 1.35.** Part Three is divided into 3 chapters:  
Chapter 5: Drug driving – Law and procedure  
Chapter 6: Drug driving – Evidence, issues and opinion  
Chapter 7: Drug driving – Conclusions and recommendations
- 1.36.** There are also 14 annexes which provide more detailed reference material.

## Part II – Drink driving

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# Chapter 2: Drink driving – Law and procedure

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## Introduction

- 2.1. This chapter deals with the current law and procedure in relation to drink driving. It sets out the current legislation, including the drink drive offences, alcohol testing procedure and the associated penalty regime. It also contains definitions and descriptions of processes or terms that are referred to in the remainder of Part II as well as other legislation which is of relevance to this subject and the Review's recommendations.
- 2.2. This chapter is divided into the following seven headings:
- Introduction;
  - Legislative history;
  - The current law;
  - Other procedural issues;
  - The current penalty regime for drink driving offences;
  - Coroners and procurators fiscal;
  - The current law in relation to drink and drugs and operating other modes of transport.

## Legislative history

- 2.3. In order to put the specific offence of driving over the prescribed limit into context, it is useful to begin with a general overview of the legislative history of drink driving offences.
- 2.4. The offence of driving, attempting to drive or being in charge of a motor vehicle while under the influence of drink (or drugs) first appeared on the statute book in the Road Traffic Act 1930.<sup>12</sup> Under the Road Traffic Act 1930, a conviction required proof that the driver was under the influence of alcohol to such an extent that the driver was not in proper control of the vehicle.
- 2.5. The modern wording of driving while unfit to drive through drink (or drugs) was introduced by section 6 of the Road Traffic Act 1960, although it was not until the Road Traffic Act 1962 that the definition of unfit to drive was amended from meaning under the influence of drink or a drug to such an extent as to be incapable of having proper control of a motor vehicle, as in the Road Traffic Act 1930, to meaning that the person's ability to drive properly is for the time being impaired, which remains the wording today.
- 2.6. The Road Traffic Act 1962 also introduced for the first time the power to obtain and use evidence of the proportion or quantity of alcohol or of any drug which was contained in the blood or present in the body of the accused. The legislation provided that a specimen of breath, blood or urine could be obtained by a medical practitioner for such purposes, with the consent of the accused. It also made provision for a refusal to give consent

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12 Prior to the Road Traffic Act 1930, it was an offence under the Criminal Justice Act 1925 to be found drunk in charge of any mechanically propelled vehicle on any highway or other public place.

without reasonable cause to be used against the accused. The current legal blood alcohol concentration (BAC) limit of 80 mg of alcohol in 100 ml of blood was first introduced by the Road Safety Act 1967 (the 1967 Act) which made it an offence to drive in excess of that limit and obliged drivers to submit to a screening, breathalyser test at the roadside. Prior to the 1967 Act, drivers could only be convicted of driving while under the influence of alcohol to such an extent that the driver was not in proper control of the vehicle. The 1967 Act was replaced by the Road Traffic Act 1972 (the 1972 Act) without any significant amendments to the legislation.

- 2.7.** The procedure under the 1967 Act and subsequently the 1972 Act was, however, flawed. Persons charged with the offence had the right to trial on indictment before a jury<sup>13</sup> and this, together with the strict rules regarding the use of the breathalyser devices, meant that drivers were often acquitted despite evidence that such defendants' BAC was far in excess of the limit, on grounds of technicalities by arguing that some procedural step had not been carried out precisely as set out in the statute.
- 2.8.** In order to address this, the provisions in the 1972 Act were replaced by section 25 of and Schedule 8 to the Transport Act 1981 (the 1981 Act) which increased the number of circumstances in which a driver was obliged to provide a breath or other specimen and, significantly, introduced the use of evidential breath testing equipment. This removed the need to routinely test blood or urine. The result of the evidential breath test is admissible as evidence in court.
- 2.9.** The evidential breath testing devices were novel and their introduction raised concerns regarding the reliability of the new machines, the blood to breath ratio that the machines were calibrated to and the issue of self-incrimination by the driver who was obliged to submit to the test. Consequently, Parliament considered it necessary to allow a defendant the opportunity to offer a blood or urine sample in place of breath where the breath result was marginally over the prescribed limit. A provision to this effect was inserted into section 8(6) of the 1972 Act by Schedule 8 to the 1981 Act.
- 2.10.** The rationale behind this provision was to provide a safeguard for individuals whose blood/breath correlation was different to the 2300:1 ratio that the machines are calibrated to and to allow for any slight variations in the machines' accuracy. Whilst it was acknowledged that the optional blood or urine test would more often than not validate the evidential breath test and that the option could also give rise to defendants using it as an opportunity for their BAC level to decrease whilst waiting for a blood or urine test, it was felt that the option would help to ensure public acceptance of the machines by providing an accused person with the chance to have their sample independently analysed. This option is known as the 'statutory option' and is currently enacted in section 8(2) of the Road Traffic Act 1988 (the Traffic Act).
- 2.11.** The Traffic Act and the Road Traffic Offenders Act 1988 (RTOA) repealed the whole of the 1972 Act and Part IV of, and Schedules 7 and 8 to, the 1981 Act.

<sup>13</sup> The Criminal Law Act 1977 abolished trial by jury for offences carrying no more than 6 months' imprisonment.



This was mostly an exercise in consolidation and no major changes were made to the statutory provisions concerning road traffic offences.

- 2.12.** The Police Reform Act 2002 inserted a new section 7A into the Traffic Act to provide for specimens of blood to be taken from persons without their consent provided certain conditions are met.
- 2.13.** The Railways and Transport Safety Act 2003 amended the Traffic Act by amending section 6 of the Traffic Act (breath tests) and adding five new sections, section 6A to 6E. The amended section 6 provided new powers for the police to administer three preliminary tests – a preliminary breath (breathalyser) test (section 6A), an impairment test to indicate whether a person is unfit to drive due to drink or drugs (section 6B) and a test for the presence of drugs in a person’s body (section 6C). The amended section 6 enabled a constable to require a person to co-operate with any one or more of the three preliminary tests in certain circumstances and made it an offence if, without reasonable excuse, that person failed to co-operate with such a request. As explained in further detail in paragraph 5.31, there is currently no drug screening device authorised for use by the police in Great Britain. Sections 6D and 6E made provision for power of arrest and powers of entry respectively in connection with the administration of the preliminary tests.
- 2.14.** The Serious and Organised Crime and Police Act 2005 made further amendments to the Traffic Act by amending sections 6D (arrest), 7 (provision of specimens for analysis), 8 (choice of specimens of breath), 9 (protection for hospital patients) and 10 (detention of persons affected by alcohol or a drug) to permit the police to carry out evidential breath testing not only at the police station, but also at a hospital or at a place near where the preliminary breathalyser test has been administered (such as at the roadside).
- 2.15.** Although these amendments allowed the police to conduct evidential breath testing at the roadside, it was recognised that there may be circumstances where it may be necessary to arrest and detain the person until they are fit to drive. Accordingly, section 10 of the Traffic Act was also amended so as to provide that a person can be detained at a police station if a constable has reasonable grounds for believing that, were that person driving a mechanically propelled vehicle, they would be unfit to drive and therefore committing an offence under section 4(1) of the Traffic Act.

## **The current law**

- 2.16.** The current statutory provisions concerning drink (and drug) driving are contained in sections 4–11 of the Traffic Act. The principal provisions can be summarised as:
- driving, attempting to drive or being in charge of a mechanically propelled vehicle whilst unfit to drive through drink or drugs (section 4(1) and (2));
  - driving, attempting to drive, or being in charge of a motor vehicle with excess alcohol levels (section 5(1)); and

- failing to provide a specimen for a breath test or specimens for analysis and failing to permit a specimen of blood to be tested in a laboratory (sections 7(6) and 7A(6)).

2.17. The full text of the relevant sections of the Traffic Act is reproduced in Annex G.

### A note about drugs

2.18. The offence under section 4 involves the consumption of drink or drugs. Accordingly, some of the provisions concerning the testing regime, related offences (for example, refusing to provide a sample) and penalties apply equally in cases involving either type of substance. This Chapter considers the relevant provisions of the Traffic Act in the context of alcohol and Chapter 5 does so in relation to drugs. There is, however, some unavoidable overlap in the discussion of the legislative framework concerning drink- and drug -driving and there is consequently some cross-referencing between Chapters to avoid unnecessary duplication.

### Motor vehicles

2.19. The Traffic Act legislation distinguishes between motor vehicles and mechanically propelled vehicles. Section 4 of the Traffic Act applies to driving, attempting to drive or being in charge of a *mechanically propelled vehicle* whilst the excess alcohol offence under section 5 applies only to *motor vehicles*.

2.20. A motor vehicle is defined in section 185 of the Traffic Act as a mechanically propelled vehicle intended or adapted for use on a road. Vehicles such as golf buggies are not intended or adapted for use on the road and are therefore considered to be mechanically propelled vehicles, not motor vehicles, within the meaning of the Traffic Act. Consequently, the offence under section 5 does not apply in relation to such types of mechanically propelled vehicle.

### Unfit to drive

2.21. It is an offence under section 4(1) of the Traffic Act to drive or attempt to drive a mechanically propelled vehicle on a road or other public place while unfit to drive through drink (or drugs). This is referred to in this Report as 'the impairment offence'. It is an offence under section 4(2) to be in charge of a mechanically propelled vehicle while unfit to drive through drink (or drugs).

2.22. These are behaviour based provisions which require evidence of unfitness to drive. Under section 4(5), a person is considered unfit to drive if that person's ability to drive is for the time being impaired. A successful prosecution under the impairment offence (section 4(1)) will require evidence of impairment at the time of driving (or attempting to drive) and that that impairment was caused by drink and not by something else (e.g. fatigue or illness).

2.23. The impairment offence is covered in more detail in Chapter 5 in relation to drugs. However, it is of relevance in relation to alcohol, where scientific or expert evidence will be required to show that alcohol was found to be present following a breath, blood or urine test and evidence of a more subjective nature, such as that the defendant appeared to be under

the influence of alcohol, from the way that person was behaving, their appearance or demeanour, the manner of their driving and any other relevant other indicators. Such evidence may also be obtained from observations made during the administration of a preliminary impairment test. This procedure is considered in more detail in Chapters 5 and 6 in relation to defendants who are driving whilst unfit to drive through drugs.

## Excess alcohol

- 2.24.** By virtue of section 5(1)(a) of the Traffic Act, it is an offence to drive or attempt to drive a motor vehicle on a road or other public place after consuming so much alcohol that the proportion of it in the person's breath, blood or urine exceeds the prescribed limit. This is referred to in this Report as the 'excess alcohol offence'. This offence is based on the relationship between the legal BAC level and impairment, thus providing a legal short cut by removing the need to prove that the driver was impaired as a result of consuming alcohol. Section 5(1)(b) similarly provides for being in charge of a motor vehicle when over the prescribed limit. Unlike the impairment offence, separate evidence of impairment or impaired driving is not required for a successful prosecution.
- 2.25.** The statutory prescribed limit is set out in section 11(2) of the Traffic Act and means:
- (a) 35 microgrammes of alcohol in 100 millilitres of breath, or
  - (b) 80 milligrammes of alcohol in 100 millilitres of blood, or
  - (c) 107 milligrammes of alcohol in 100 millilitres of urine.
- 2.26.** No preference is given in the Traffic Act to any one of the above limits. However, as a consequence of the use of evidential breath testing machines, the cited reading for a prosecution will normally be given in breath, unless the accused has provided a blood or urine sample.

## Preliminary testing

- 2.27.** The police have a general power under section 163 of the Traffic Act to stop any vehicle at any time. Although in practice the manner of a person's driving or a road traffic contravention may alert the police and cause them to stop a particular driver, no such grounds are, in law, required.
- 2.28.** There is no similar general power to require a person to cooperate with a preliminary test for the presence of alcohol (or drugs). Section 6 of the Traffic Act provides the police with a power to administer one or more of three types of preliminary test in the following circumstances:
- (a) Where a constable reasonably suspects that the person –
    - (i) is driving, attempting to drive or in charge of a motor vehicle on a road or other public place, and
    - (ii) has alcohol or a drug in his body or is under the influence of a drug.
  - (b) Where a constable reasonably suspects that the person –

- (i) has been driving, attempting to drive or in charge of a motor vehicle on a road or other public place while having alcohol or a drug in his body or while unfit to drive because of a drug, and
  - (ii) still has alcohol or a drug in his body or is still under the influence of a drug.
- (c) Where a constable reasonably suspects that the person –
- (i) has been driving, attempting to drive or in charge of a motor vehicle on a road or other public place, and
  - (ii) has committed a traffic offence while the vehicle was in motion.<sup>14</sup>
- (d) Where an accident occurs owing to the presence of a motor vehicle on a road or other public place, and a constable reasonably believes that the person was driving, attempting to drive or in charge of the vehicle at the time of the accident.

**2.29.** Where one or more of the circumstances described in paragraph 2.28 arises, a constable has the power to require a person to cooperate with a preliminary breath test under section 6A and/or a preliminary impairment test under section 6B. The third available test under section 6C is a preliminary drug test. This is considered in Chapters 5 and 6. Where the constable suspects that the person may have alcohol in their body, the obvious first step would be to require the person to cooperate with the breathalyser test. The requirement to cooperate with a preliminary test may be made by a constable in any place.

### Preliminary breath test

**2.30.** As explained in paragraph 1.9, the preliminary breath test administered under section 6A of the Traffic Act will be recognised as the roadside breathalyser. The breathalyser test may be used for the purpose of obtaining an indication of whether the proportion of alcohol in the person's breath or blood is likely to exceed the prescribed limit (section 6A(1)). It may only be administered at or near the place where the requirement to cooperate with the test was imposed. Thus, where the requirement is made at the roadside, the test must be administered at the roadside or nearby; if the requirement is made at a hospital, the test must be administered at the hospital or nearby. Where the test is administered following an accident, there is specific provision for the test to be administered at a police station (section 6A(2) and (3)). The breathalyser device used must be of a type approved by the Secretary of State (section 6A(1)).

### Preliminary impairment test

**2.31.** Section 6B of the Traffic Act provides for a preliminary impairment test. This is a screening test which must be designed to indicate whether a person is unfit to drive and whether the unfitness is likely to be due to drink (or drugs).

**2.32.** The test, known as the Field Impairment Test (FIT), may be administered either following, or as an alternative to, the breathalyser test. In the case of

<sup>14</sup> For example, not wearing a seatbelt, having a broken headlight, contravening a traffic sign, failing to stop at a red traffic light or speeding.

alcohol, the police may choose to administer this test where the breathalyser test indicates that the proportion of alcohol in the person's body is below the prescribed limit but the person is still showing signs of unfitness to drive that may be caused by alcohol, drugs or a combination of the two.

- 2.33.** Section 6B(2) of the Traffic Act provides that the Secretary of State must issue a Code of Practice setting out the kinds of tasks and observations that may form part of the FIT test, the manner in which the test should be carried out and the inferences that may be drawn from the observations made in the course of the test.
- 2.34.** In accordance with this sub-section, the Code of Practice for Preliminary Impairment Tests (the Code) was issued by the Secretary of State for Transport in 2004. As required under section 6B(3), the tests set out in the Code are designed to indicate whether a person is unfit to drive and, if so, whether that person's unfitness is likely to be due to drink or drugs.
- 2.35.** The FIT test consists of a pupillary examination and a series of separate physical tasks set by the constable in accordance with the Code. By observing the person's ability to perform these tasks and making such other observations as to the person's physical and cognitive state as the constable thinks expedient, the constable can obtain an indication whether the person is unfit to drive and, if so, whether that person's unfitness is likely to be due to drink (or drugs).
- 2.36.** The FIT test may only be administered at or near the place where the requirement to cooperate with the test is imposed or, where the constable thinks it expedient, at a police station. There is no requirement for the police to administer the FIT test, but where it is administered, it may only be conducted by a constable who has been approved to carry out such tests (section 6B(6)).
- 2.37.** The FIT test is of particular relevance in relation to persons suspected of being unfit to drive through drugs and is therefore considered in more detail in Chapters 5 and 6.

### **Failure to cooperate with a preliminary test**

- 2.38.** By virtue of section 6(6) of the Traffic Act, a person commits an offence if they fail, without reasonable excuse, to co-operate with any preliminary test in pursuance of a requirement imposed under section 6.
- 2.39.** A reasonable excuse must generally arise from a physical or mental condition which prevents the person from taking the test or providing a specimen, together with medical evidence to support any such claim.

### **Arrest following a preliminary breath (breathalyser) test**

- 2.40.** Section 6D(1) of the Traffic Act provides an explicit power of arrest where, following the breathalyser test, the constable reasonably suspects that the proportion of alcohol in the person's breath or blood exceeds the prescribed limit. Such a suspicion will arise where the result of the breathalyser test indicates that a person has over 35 mcg of alcohol per 100 ml of breath;

and the arrested person will be taken to a police station to provide further, evidential, specimens of breath.

### **Arrest on suspicion of driving, attempting to drive or being in charge of a mechanically propelled vehicle when unfit due to drink**

- 2.41.** Where, a constable has reasonable grounds for believing that the person may be driving while unfit to do so through drink (or drugs), either as a result of the FIT test or, where a constable has formed such a suspicion on account of other observations, the constable may arrest the person concerned under the general power of arrest contained in section 24 of the Police and Criminal Evidence Act 1984 (PACE) in order to continue with the investigation by way of obtaining a specimen of blood or urine to submit for analysis.
- 2.42.** In Scotland, there is an explicit power of arrest in relation to the impairment offence in section 4(6) of the Traffic Act. This sub-section was repealed in relation to England and Wales by the Serious Organised Crime and Police Act 2005 but remains in force in relation to Scotland.

### **Provision of breath and other specimens for analysis (evidential test)**

- 2.43.** In the course of an investigation into whether a person has committed the impairment offence or the excess alcohol offence, an officer has the power under section 7(1) of the Traffic Act to require the provision of two specimens of breath for analysis on a device type approved by the Secretary of State or the provision of a specimen of blood or urine for laboratory analysis.
- 2.44.** Specimens of breath, blood or urine provided in accordance with section 7(1) are used for evidential, rather than screening, purposes.
- 2.45.** The requirement to provide two specimens of breath may be made at a police station, at a hospital or at or near a place where the breathalyser test was carried out or would have been carried out had the person complied with it, such as at the roadside (section 7(2)). As explained in paragraph 2.43, in 2005 the power to carry out an evidential breath test at a police station was widened to enable such testing to be carried out a hospital or at or near a place where the breathalyser test was carried out (or would have been carried out but for the person's refusal), such as at the roadside. However, portable evidential breath testing equipment that would facilitate testing in such places has still to be approved by the Secretary of State for use in Great Britain. This is a process known as type approval and is considered in Chapter 3. Consequently, all evidential breath specimens may, at the moment, only be provided at a police station using fixed equipment.
- 2.46.** There is an issue which will need to be addressed when portable evidential breath testing devices are type-approved for use in Great Britain in relation to the use of such test equipment without a prior screening test. There is no problem if the police choose to use the evidential testing equipment at a police station or a hospital. They can do so without having done a prior screening test. However, if they wish to use the evidential equipment elsewhere, e.g. at the roadside, it is currently the case that they can only do

so in accordance with section 7(2)(c), that is, at or near a place where the breathalyser test has been administered (or would have been but for the person's failure to cooperate). This means that the police are obliged under section 7(2)(c) to first administer the screening breathalyser test before proceeding with the evidential test.

**2.47.** The requirement to provide a blood or urine sample may be made either separately or following the provision of two specimens of breath. The requirement may only be made at a hospital or a police station (section 7(2)). However, it may not be made at a police station, unless one of the following circumstances applies:

- (a) the constable has reasonable cause to believe that the accused cannot or should not be required to provide an evidential breath sample for medical reasons, or
- (b) specimens of breath have not been provided elsewhere and at the time the requirement is made a device or reliable evidential breath testing device is not available at the police station or it is not practicable to use such a device there, or
- (c) the constable has reasonable cause to believe that the specimens of breath that have been taken have not provided a reliable indication of the proportion of alcohol in the breath of the accused, or
- (d) where the accused is suspected of an offence under section 4 of the Traffic Act of driving while impaired (or section 3A – causing death by careless driving when under the influence of drink or drugs), the constable has been advised by a medical practitioner that the suspect's condition might be due to some drug, or
- (e) as a result of the administration of a preliminary drug test, the constable making the requirement has reasonable cause to believe that the person required to provide a specimen of blood or urine has a drug in his body.

**2.48.** Conditions (a), (b) and (c) permit a specimen of blood or urine to be required for analysis where it has not been possible to conduct a relevant preliminary test, for example where the person is not medically capable of blowing into the breathalyser, for instance where they have been injured in a road traffic accident or where the breath testing equipment is not available or not functioning.

**2.49.** Conditions (d) and (e) are only relevant to drug driving and are considered in Chapters 4 and 5.

**2.50.** Where the circumstances permit a specimen of blood or urine to be taken, the decision which specimen it is to be lies with the constable making the request (section 7(4)). However, where the constable opts for a blood specimen, the constable's discretion may be overridden where a medical practitioner or registered healthcare professional<sup>15</sup> is of the opinion that

<sup>15</sup> A registered healthcare professional is defined in section 11 of the Traffic Act as a person (other than a medical practitioner) who is a registered nurse or a registered member of a health care profession who is designated for the purposes of section 11(2) of the Traffic Act by an order made by the Secretary of State. The Health Care Profession (Designation No 2) Order 2003 (S.I. 2003/2462) designated the profession of paramedics.

blood cannot or should not be taken for medical reasons (section 7(4)). Where the person is in hospital, a specimen of blood may not be taken unless the medical practitioner in immediate charge of the person's case has been notified and does not object. This is considered in more detail in paragraph 2.63.

- 2.51. Except for urine (and dental impressions), intimate samples, including blood, may only be taken at a police station by a registered medical practitioner or a registered health care professional (section 62(9A) of PACE or taken elsewhere, such as at a hospital, by a medical practitioner (section 15(4) of the RTOA).
- 2.52. Where a specimen of blood or urine is taken, in order for it to be admissible as evidence of the proportion of any alcohol (or drug) found in the specimen on behalf of the prosecution, the specimen must be divided into two parts at the time it is provided by the accused and one part must be supplied to the accused (section 15(5) of the RTOA).
- 2.53. Where the accused opts to take a part of the specimen, they may have it independently analysed at their own expense and are provided with information from the Royal Society of Chemistry on details of laboratories to contact.

### **Failure to provide an evidential specimen**

- 2.54. It is an offence under section 7(6) of the Traffic Act for a person to fail, without reasonable excuse, to provide the required specimens for analysis under section 7(1).
- 2.55. A reasonable excuse must generally arise from a physical or mental condition which prevents the person from taking the test or providing a specimen together with medical evidence to support any such claim. This could include a phobia of needles, provided that medical evidence can support such a claim. Where a person is medically incapable of providing a specimen of breath, section 7(3)(a) makes specific provision for that person to be required to provide a specimen of blood or urine instead. Therefore, this offence will usually involve the refusal to provide a specimen of blood or urine.
- 2.56. It may be difficult for a constable to determine whether a person's claim that they are unable to provide a specimen of, for example, blood, is genuine or simply an attempt to delay or avoid providing a specimen, particularly when one considers the drunken or drugged state that a suspect may be in. In such circumstances, a constable has to decide whether it is appropriate to charge the person with failing to provide a specimen under section 7(6) of the Traffic Act. It is within the power of a constable to default to requiring an alternative specimen, for example urine, should the constable consider that to be appropriate. A continued refusal to cooperate should properly result in charges being brought.

### **The choice of specimens of breath (statutory option)**

- 2.57. Where a person is required to provide two specimens of breath under section 7(1) of the Traffic Act and the lower of those two specimens contains



no more than 50 mcg of alcohol in 100 ml of breath, section 8(2) provides that the person providing those specimens is entitled to opt to have that lower specimen replaced by either a specimen of blood or urine. As with the procedure under section 7(4), the discretion as to whether the replacement specimen is blood or urine lies with the constable, again subject to any professional medical opinion that blood cannot or should not be taken. Where a blood or urine specimen is provided, neither breath specimens may be subsequently used as evidence. This is commonly known as, and is referred to in this Report as, the 'statutory option'.

### **Specimens of blood taken from a person incapable of consenting**

- 2.58.** Section 7A of the Traffic Act makes provision for blood to be taken from a person irrespective of whether that person consents where the following conditions are met:
- (a) the person concerned is someone from whom the constable would be entitled to require a specimen of blood under section 7 if they were not incapacitated,
  - (b) it appears to the constable that the person concerned has been involved in an accident that constitutes or is comprised in the matter under investigation,
  - (c) it appears to the constable that the person concern is or purports to be incapable of giving valid consent to the taking of a specimen of blood, and
  - (d) it appears to the constable that the person's incapacity is due to medical reasons.
- 2.59.** The legislation allows for blood to be taken from a person without their consent where all four conditions are met. However, a sample cannot be sent to a laboratory for analysis unless the person from whom it was taken has been informed that the sample has been taken and has consented to the analysis of the sample (section 7A (4)).
- 2.60.** A sample of blood may only be taken under section 7A by a police medical practitioner (section 7A(2)(b)) unless it is not reasonably practicable for a police medical practitioner to do so, in which case it may be taken by another medical practitioner, provided that the medical practitioner is not responsible for the person's clinical care (section 7A(2)(a)). In practice, the sample is sent to the laboratory in accordance with normal police protocol save that the laboratory will be instructed not to analyse the sample without further authorisation. This is to ensure that the sample is properly stored and preserved prior to consent being obtained for it to be analysed.

### **Failure to give permission for a specimen of blood to be analysed at a laboratory**

- 2.61.** Where a sample of blood is taken without the person's consent under section 7A(1), failure, without reasonable excuse, to give subsequent permission for that sample to be analysed is an offence under section 7A(6) of the Traffic Act.

2.62. Section 7A also applies in cases involving drug driving.

### Hospital patients

2.63. Section 9 of the Traffic Act provides protection for hospital patients. Under section 9(1) and 9(1A) a patient in hospital is not required to cooperate with a preliminary test, to provide a specimen of blood for a laboratory test (with or without consent) or be required to give permission for a specimen to be analysed, unless the medical practitioner in immediate charge of that patient's case has been notified of the proposal to make such a requirement and does not object. The medical practitioner may object to a request under such a request on the grounds that the request would be prejudicial to the proper care and treatment of the patient.

2.64. Section 9 also applies in cases involving drug driving.

### Other procedural issues

#### Police and Home Office policy regarding 40 mcg

2.65. The first evidential breath testing devices were type approved for use in 1983 by virtue of the Breath Analysis Devices (Approval) Order 1983. Since that time, it has been agreed police and Home Office policy that, notwithstanding the legal BAC limit of 35 mcg of alcohol in 100 ml of breath, no proceedings will be brought against an offender with an evidential breath test reading of less than 40 mcg of alcohol per 100 ml of breath. In relation to England and Wales this policy is set out in Home Office Circular 1983/43 and states –

*“to cater for those occasions where the machine may be reading high, albeit within this range (i.e. 32-38ug inclusive) the police will not proceed against the offence with a result of less than 40ug. This will ensure that the offender prosecuted will have a result in excess of the prescribed limit. This allowance is comparable with the allowance currently subtracted from specimens analysed in the laboratory”.*

2.66. In Scotland, an identical policy is set out in a letter from the Crown Agent to the Law Society of Scotland and is reproduced in *Lockhart v Deighan*.<sup>16</sup>

#### Laboratory margin of error

2.67. The allowance, referred to in the Home Office Circular, which is subtracted from specimens of blood and urine samples sent for laboratory analysis is 6 mg/100 ml from specimens containing up to 100 mg/100 ml of alcohol and 6% from specimens containing over 100 mg/100 ml of alcohol. Thus, a sample containing 83 mg of alcohol/100 ml of blood will result in an outcome which is then reported as being a blood alcohol concentration of “not less than 77 mg of alcohol/100 ml of blood” and, consequently, this will not result in a prosecution.

## Forensic physician

- 2.68.** Forensic physician (FP), formerly known as forensic medical examiner or police surgeon and also described in the Traffic Act as police medical practitioner, is the collective name for doctors working in the field of clinical forensic medicine. Most FPs are general practitioners and work as FPs on a part-time or rotational basis but a few work as FPs full-time. FPs are contracted by their local police force or in some cases by medical companies that hold a contract with a police force.
- 2.69.** The role of the FP is varied and involves providing medical care and forensic assessment of detainees in police custody, complainants and police officers injured whilst on duty, interpreting findings of medical assessments for the police, courts and social services, attending scenes of death to pronounce life extinct and providing evidence in court. FP assessments will involve obtaining background information from the detainee, taking a general medical history and making a physical examination. FPs will determine whether detainees are fit to be held in custody and whether they are fit to be released, charged, transferred or interviewed. FPs also assess whether a detainee is intoxicated through alcohol and drugs or suffering from withdrawal of those substances. FPs also undertake intimate body searches for drugs.

## Custody nurse practitioners

- 2.70.** Custody nurse practitioners (custody nurses) are employed either by a police force to work permanently in the police station or are supplied under contract by a healthcare agency. The role of the custody nurse is in many respects very similar to that of the FP and will include making a clinical assessment of the health and medical needs of the detainee, identifying emergencies as soon as possible, obtaining consent for healthcare interventions, providing forensic examinations, treating minor injuries and administering medications. Custody nurses also advise on the fitness of individuals to be detained, interviewed, transferred or released from police custody, conduct intimate body searches and physical examinations and obtain forensic samples.
- 2.71.** Custody nurses, particularly when based permanently at the police station, have the advantage of being able to respond to incidents much quicker than FPs who have to be called out and may need to travel a considerable distance to the police station.
- 2.72.** Section 62 of PACE was amended by the Police Reform Act 2002 to allow registered nurses to take intimate samples, including blood, from detainees and complainants. Prior to this, only FPs were able to carry out such procedures.
- 2.73.** In the context of drink driving, FPs and custody nurses have a specific gatekeeper role in assessing whether the detainee is medically fit to be required to provide a specimen of blood or urine for analysis under section 7(1) of the Traffic Act. FPs have a further role in relation to drug drive cases and this is discussed in Chapter 5.

## Police and Criminal Evidence Act 1984

- 2.74.** The use of portable evidential breath testing equipment in a police station is discussed in paragraph 2.43. These paragraphs refer to the requirements under the PACE relating to custody and detention of persons by a police officer.
- 2.75.** PACE and the accompanying PACE Codes of Practice require persons who are detained at a police station (that is, within the boundary of any building or enclosed yard that forms part of that police station) to be brought before a custody officer as soon as practicable after their arrival at the station. The custody officer must open a custody record for that person. The custody officer must also ensure that the detained person is told clearly and given written notice of their continuing rights which may be exercised at any stage during the period in custody, including the right to have someone informed of their arrest and the right to consult privately with a solicitor.
- 2.76.** Once a type approved device is available, a portable evidential breath testing machine could be a useful and flexible tool for use in a police station by providing the police with an alternative to the fixed evidential breath testing equipment that is currently used.

## The current penalty regime for drink driving offences

### Obligatory disqualification

- 2.77.** The current penalty regime for drink drive related offences is set out in Schedule 2 to the RTOA. A table showing the individual offences and their corresponding penalty ranges is in Annex H.
- 2.78.** Section 34(1) of the RTOA provides that, on conviction for an offence involving obligatory disqualification, that is an offence under sections 4(1) (driving or attempting to drive whilst unfit – the impairment offence), 5(1) (a) (driving or attempting to drive with excess alcohol – the excess alcohol offence), 7(6) (failing to provide a specimen) and 7A(6) (failing to allow a specimen to be subjected to a laboratory test), the court must order that the offender be disqualified for holding or obtaining a licence to drive a motor vehicle for not less than 12 months. The Magistrates' Court Sentencing Guidelines (the Guidelines), described more fully in paragraph 2.82 below, provide the courts in England and Wales with the discretion to set a shorter, or no, disqualification period in exceptional circumstances. The Guidelines cite driving a very short distance, genuine emergency or where the defendant had had their drink spiked, as being examples of where that discretion may be exercised. However, a court will only consider such factors in exceptional circumstances and a disqualification period less than the statutory minimum is very rarely imposed by the court.
- 2.79.** Section 34(4)(b) of the RTOA also provides that the minimum 12 month disqualification period is substituted by a minimum period of two years for certain offences (which are not within the scope of the Review) and for certain offenders. The offenders who will be subject to a two year minimum disqualification period are persons who have had more than one disqualification for a fixed period of 56 days or more within the three years

immediately prior to the commission of an offence involving obligatory disqualification.

- 2.80.** Section 34(2) of the RTOA makes specific provision in relation to repeat drink and drug driving offenders. Where a person is convicted of an offence involving obligatory disqualification under sections 4(1), 5(1)(a), 7(6) or 7A(6) for a second or more time within a 10 year period, the minimum mandatory disqualification period increases to 3 years. The ten year period is calculated from the date that the second offence was committed back to the date when the person concerned was convicted of the earlier offence. This prevents an offender attempting to avoid the longer, 3 year, ban by seeking an adjournment of the hearing.

### **Discretionary disqualification**

- 2.81.** In the case of the, usually, less serious offences of being in charge whilst unfit (section 4(2)), in charge with excess alcohol (section 5(1)(b)) and failing to cooperate with a preliminary test (section 6(6)), disqualification is at the discretion of the court. Schedule 2 to the RTOA provides that endorsement is obligatory for such offences and the court must therefore endorse the offender's licence with penalty points within the range provided in the Act. Where the offender is not disqualified, the maximum number of penalty points must be imposed.

### **Magistrates' Court Sentencing Guidelines in England and Wales**

- 2.82.** In addition to the statutory provisions contained in section 34 of and Schedule 2 to the RTOA regarding the minimum periods of mandatory disqualification, in England and Wales the Magistrates' discretion as to sentencing must be exercised within the parameters set by the Sentencing Council (formally the Sentencing Guidelines Council) in the Guidelines, by virtue of section 172(1) of the Criminal Justice Act 2003. If a court imposes a sentence of a different kind or outside the range indicated in the Guidelines, section 174(2) (a) of that Act provides that it is obliged to state its reasons for doing so. These Guidelines are at Annex I.
- 2.83.** The Guidelines provide a starting point for sentencing. The Guidelines set out the key decisions that must be made in the sentencing process, namely, the assessment of the seriousness of the offence, consideration of any aggravating or mitigating factors in relation to the offence, assessment of the appropriate sentence, consideration of any mitigating factors in relation to the offender (such as remorse), consideration of a reduced sentence for a guilty plea, consideration of any ancillary orders and then a determination of the final sentence.
- 2.84.** Sentences for drink drive related offences which command a mandatory disqualification period will always consist of a period of disqualification not less than the statutory minimum (unless there are special circumstances which the court takes into account).
- 2.85.** Aggravating levels of alcohol (in the excess alcohol offence) are divided into bands corresponding to a range of penalties which graduate upwards.

- 2.86.** For instance, the Guidelines indicate that in the case of a first time offender:
- a breath alcohol level of between 36 mcg and 59 mcg of alcohol/100 ml of breath (81 mg and 137 mg of alcohol/100 ml of blood) carries a band C fine and a period of disqualification between 12 and 16 months;
  - a breath alcohol level of between 60 mcg and 89 mcg of alcohol/100 ml of breath (138mg and 206 mg of alcohol/100 ml of blood) carries a band C fine and a period of disqualification of between 17 and 22 months;
  - a breath alcohol level of between 90 mcg and 119 mcg of alcohol/100 ml of breath (207 mg and 275 mg of alcohol/100 ml of blood) carries a community order and a period of disqualification between 23 and 28 months; and
  - a breath alcohol level of between 120 mcg and 150 mcg of alcohol/100 ml of breath and above (276 mg of alcohol/100 ml of blood and above) carries a high level community order or up to 26 weeks custody and a period of disqualification between 29 and 36 months.
- 2.87.** Similar bands apply to increasing levels of impairment in relation to the impairment offence. Evidence of higher levels of impairment will result in longer periods of disqualification. In the case of both the impairment offence and the excess alcohol offence, evidence of very high levels of impairment or levels of alcohol may result in community orders or custodial sentences.
- 2.88.** The same graduated approach applies to sentences for offenders convicted under sections 7(6) and 7A of the Traffic Act (failing to provide a specimen for analysis and failing to permit a specimen to be tested). Factors such as deliberately failing to provide a specimen and evidence of serious impairment may be considered to be aggravated behaviour and result in a sentence at the higher end of the applicable scale. A table indicating the applicable penalty ranges is at Annex J.
- 2.89.** In addition to aggravating levels of impairment or alcohol, further aggravating factors which may affect the sentence available within the applicable range for the level of impairment or level of alcohol in question, include:
- the defendant was driving a larger goods vehicle, heavy goods vehicle or public service vehicle;
  - driving for hire or reward;
  - poor road or weather conditions;
  - carrying passengers;
  - evidence of an unacceptable standard of driving;
  - involvement in an accident;
  - location (e.g. near to a school);
  - high level of traffic or pedestrians in the vicinity.

## Sentencing guidelines in Scotland

**2.90.** There is currently no system of sentencing guidelines for the Sheriffs' Court in Scotland. Whilst sentencing in Scotland is consistent and the courts take a range of factors into consideration when sentencing, it is the case that sentencing is currently done on a case by case basis at judicial discretion rather than in accordance with published guidance. Following a consultation on the creation of sentencing guidelines in Scotland, there are currently provisions in the Criminal Justice and Licensing (Scotland) Bill for the establishment of a judicially-led Scottish Sentencing Council which would be tasked with creating sentencing guidelines. Accordingly, any references in this Report to the Magistrates' Court Sentencing Guidelines only apply to England and Wales and there is currently no equivalent provision in Scotland (although this may change in the near future).

## Application for removal of disqualification

**2.91.** Section 42(1) of the RTOA provides that drivers who are disqualified for more than 2 years may make an application to the court to remove or reduce the period of disqualification. In the case of convicted drivers disqualified for less than four years, an application may not be made until two years of the disqualification period has expired. In the case of convicted drivers disqualified for between 4 and 10 years, an application may not be made until half of the years of the disqualification period have expired. In any other case, the convicted driver must wait 5 years before being permitted to apply for an order.

**2.92.** Where such an application is made under section 42 of the RTOA, the court may, as it thinks proper, have regard to the character of the person disqualified and their subsequent conduct, the nature of the offence and any other circumstances that are relevant to the case.

**2.93.** Disqualified drivers are permitted to make more than one application to the court but, where an application is refused, the offender must wait for 3 months before making a new application.

## Fines

**2.94.** Sentences for drink-drive offences, including those involving discretionary disqualification, will almost always result in a fine. In England and Wales, fines are based on one of 3 bands, with bands A, B or C being relevant to offences under sections 4–11 of the Traffic Act. The amount of the fine is means tested and calculated as a proportion of the offender's relevant weekly income, taking into account individual circumstances such as whether the offender is in receipt of benefit, has low outgoings, has a very high income or savings. The applicable band of fine is determined by the Sentencing Council and set out in the Guidelines. A fine must not, however, exceed the specified level for the offence in question on the standard scale of fines for summary offences (the standard scale). The standard scale for England and Wales is contained in section 37 of the Criminal Justice Act 1982 and, in Scotland, is to be found, for offences triable only summarily, in section 225(1) of the Criminal Procedure (Scotland) Act 1995. The standard scale is expressed in the form of five levels shown below:

Level 1: £200

Level 2: £500

Level 3: £1,000

Level 4: £2,500

Level 5: £5,000

- 2.95.** The applicable level for the Traffic Act offences is set out in Schedule 2 to the RTOA and is reproduced in Annex G. The principal offences (i.e. the impairment offence and the excess alcohol offence) are level 5 on the standard scale.

### Ancillary orders – confiscation of vehicles

- 2.96.** In England and Wales, the courts have a power under section 143 of the Powers of Criminal Courts (Sentencing) Act 2000 to deprive an offender of property used or intended to be used to commit or facilitate the commission of any offence. The power is exercised upon conviction in the Magistrates' or Crown Court following a successful application for a deprivation order by the prosecution or of the court's own motion.
- 2.97.** Deprivation orders are most commonly used following convictions for offences involving dishonesty, for example the theft of property. In the context of a drink or drug driving conviction, a deprivation order is available in relation to the vehicle used to commit the offence. However, the court will only grant such an order, in any context, where a full and proper investigation has been carried out and adequate supporting evidence is submitted. Consideration will be given to factors including the ownership of the property, multiple ownership, any encumbrances the property is subject to, any undue hardship that would result from such an order and whether the order, together with other sentences, would create an excessive overall penalty. These issues raise practical difficulties in relation to the seizure of an offender's vehicle as part of a drink and drug driving conviction. It is, therefore, very rare that such orders are sought in this context.

### Forfeiture of vehicles

- 2.98.** Section 33A of the RTOA provides a specific power, applicable only in Scotland, for the court to order a vehicle to be seized and forfeited in certain circumstances.
- 2.99.** The offences to which this provision applies and which are relevant to the scope of this Review are offences under the Traffic Act which are punishable with imprisonment and which involve:
- (a) driving, attempting to drive, or being in charge of a vehicle; or
  - (b) (failing to comply with a requirement to provide a specimen for analysis (section 7(6) of the Traffic Act) in the course of an investigation into whether an the offender has committed an offence while driving, attempting to drive or being in charge of a vehicle.
- 2.100.** Thus this section may be exercised in relation to offences under sections 4(1), 5(1)(a), 7(6) and 7A(6) of the Traffic Act which involve repeat offenders,



high levels of intoxication (over 3 times the prescribed limit) or impairment or deliberate refusal or failure to provide a sample together with evidence of high levels of intoxication or impairment.

- 2.101.** For the court to make such an order, an application for forfeiture must be made by the Crown and the court must be satisfied that proceedings for the relevant offence have been or are likely to be commenced against the person in Scotland and that there is reasonable cause to believe that the vehicle specified in the application is to be found in a place or the premises specified (section 33A(4) of the RTOA). If those criteria are met, the court may grant a warrant to authorise the place or premises to be entered and searched and the vehicle seized.
- 2.102.** Subsection (5) provides the court with a further power to issue such a warrant where it is satisfied on evidence on oath that there is reasonable cause to believe that the vehicle is to be found in a place or premises and the admission to the whereabouts of the vehicle has been refused or that a refusal of such an admission is apprehended.
- 2.103.** The Scottish Drink Drive Vehicle Forfeiture Initiative has used this power in relation to repeat drink drive offenders as part of the Scottish Police's Christmas 2009 drink drive enforcement campaign. The administration of the initiative requires the detention in custody of suspects to allow the police control of at least one set of keys and to ascertain the whereabouts of the vehicle. The Lord Advocate's Guidelines to Chief Constables relating to Liberation by the Police have been amended to provide that all repeat drink drivers should be held in custody for appearance in court the next lawful day.
- 2.104.** Upon arrest and following determination by the police that the accused has a previous drink drive conviction (within the past 5 years) or a case pending, the accused will be interviewed under caution to establish who the legal owner of the vehicle is.
- 2.105.** The court will also take into account all relevant issues in considering whether to grant a warrant and is unlikely to make such an order where the vehicle is, for example, jointly owned or where seizure would be otherwise disproportionate or inappropriate.
- 2.106.** Where a not guilty plea is entered, the Crown may apply for a warrant to seize the vehicle pending conviction.

### **Bail conditions**

- 2.107.** In England and Wales, the Magistrates' Court and Crown Court are able to impose bail conditions under section 3 of the Bail Act 1976. The normal conditions of bail that may be imposed include, inter alia, such conditions as the court considers necessary to secure that the defendant does not commit an offence while on bail. In the context of drink (or drug) driving cases, it is possible to impose a bail condition that the defendant must not drive. In practice, because there is a presumption of innocence unless and until a person is convicted, magistrates' will impose such a condition extremely cautiously and only where there is evidence that the defendant

was continuing to drive under the influence of drink whilst awaiting trial on one or more drink or drug driving charges. Similarly in Scotland, sheriffs will generally only apply interim bail conditions of not driving if the defendant had pleaded guilty initially and background reports are being completed prior to sentencing.

### High Risk Offender Scheme

- 2.108.** The High Risk Offender Scheme (HRO Scheme) has existed since 1983. The HRO Scheme is aimed at dealing with drivers whose dependence on, or persistent misuse of, alcohol presents a serious road safety risk. The HRO Scheme relies in part on statute, in part on the Guidelines and in part on regulations relating to the driver licensing regime.
- 2.109.** Under the HRO Scheme, where an HRO is disqualified for certain drink driving offences, their driving licence is not automatically returned at the end of the period of disqualification. The HRO Scheme applies to offenders in the following categories:
- (a) those disqualified twice, within a ten-year period, for drink drive offences involving mandatory disqualification;
  - (b) those disqualified for driving or attempting to drive with a proportion of alcohol in the body at least two and a half times the legal limit;
  - (c) those disqualified for failing, without reasonable cause, to provide a specimen of breath, blood or urine for analysis.
- 2.110.** By virtue of section 34(3) of the RTOA, the statutory minimum disqualification period for offenders under (a) is, in England, Wales and Scotland, automatically increased to 3 years.
- 2.111.** In England and Wales, in relation to (b), the Guidelines provide that conviction should carry a period of disqualification of between 36 – 60 months.
- 2.112.** Under (c), section 34(1) of the RTOA provides for obligatory disqualification for a minimum period of 12 months, though, in England and Wales the Guidelines suggest disqualification for a minimum of 29 months where “serious impairment” is involved.
- 2.113.** Under regulation 74(1) of the Motor Vehicle (Driving Licences) Regulations 1999<sup>17</sup> (the 1999 Regulations), a person disqualified for one of the three reasons cited above is considered to have a disability. A disability is defined in section 92(2) of the Traffic Act as including the persistent misuse of drugs or alcohol, whether or not such misuse amounts to dependency.
- 2.114.** In Great Britain, by virtue of section 94(4) of the Traffic Act, persons to whom the 1999 Regulations apply are required to submit themselves for a medical examination with a Department for Transport approved medical practitioner for the purpose of determining whether or not they are physically or psychologically dependent on alcohol and are therefore safe to be allowed to drive before their licence is returned. There is a charge for applying for the

17 S.I. 1999/2864

restoration of the licence. A fee must also be paid for the necessary medical examination.

- 2.115.** In the case of category (c) above, whilst it does not automatically follow that a person who refuses to comply with the requirement to provide a specimen for analysis has an alcohol problem, it is necessary to include such offenders in the HRO Scheme in order to prevent offenders who have very high levels of alcohol in their system avoiding the more severe penalties that apply to such high BACs by refusing to be tested.
- 2.116.** The HRO Scheme only applies to convictions involving drink driving. However, it is not possible to determine whether an offender who is driving whilst unfit due to drugs may be caught by the HRO Scheme if they are convicted under section 7(6) of the Traffic Act of failing to provide a specimen, as in such circumstances it is clearly not possible to determine how many of such offenders are, in fact, drug drivers by virtue of their refusal to provide a specimen.
- 2.117.** Section 88(1) of the Traffic Act allows HROs to drive when they have applied for their licence back, regardless of whether they have been cleared by the doctor. This is clearly not in the best interests of public safety and is a loophole of which the Government is aware. It moved to close the loophole, obtaining powers to do so under the Road Safety Act 2006, but the relevant provisions have not yet been brought into force.

### **Administrative licence suspension**

- 2.118.** In Great Britain, drink (and drug) driving violations are criminal offences and, as such, dealt with under the criminal law. Some jurisdictions have a different approach and deal with such offences with administrative sanctions, either alongside or entirely in place of criminal sanctions.
- 2.119.** The nature of, or combination of, sanctions will depend on the seriousness of the offence. The most common type of administrative sanction is licence suspension and this is used commonly in the United States and Canada, as well as in some European countries. This involves the immediate confiscation and suspension of driving licences following a failed breath, blood or urine test or where the person refuses to cooperate with such a test. The length of the suspension varies considerably between jurisdictions with suspensions lasting for just a few hours and others for periods of months. Significantly, these sanctions are imposed by the police without any involvement by the courts. The regime therefore presumes the person concerned is guilty on the basis of a positive test result (or refusal to comply with a test). Where an administrative licence suspension regime is in operation, an administrative appeal process may be available.

### **Alcohol ignition interlocks**

- 2.120.** Alcohol ignition interlocks ('interlocks') are fitted to vehicle ignitions and require the driver to blow into a tube connected to the ignition of the vehicle. The interlock is set to a particular threshold, usually 20 mcg/100 ml, and will prevent the engine from starting if it detects a breath alcohol concentration above the specified threshold.

- 2.121.** Section 16 of the Road Safety Act 2006 inserted section 34D in to the RTOA. Section 34D provides the courts with a power in certain circumstances to offer offenders the opportunity to participate in an alcohol ignition interlock programme, at the offender's own expense. The provision provides that participation in such a programme may result in a reduction in the period of disqualification. This section has not been brought into force and interlocks are not in the sentencing toolkit of courts in Great Britain. They are used, however, in some parts of the passenger transport industry.

### Road Traffic (New Drivers) Act 1995

- 2.122.** Chapters 3 and 4 of the Report consider young and novice drivers and make reference to the provisions in the Road Traffic (New Drivers) Act 2005 (New Drivers Act) concerning new drivers.
- 2.123.** The New Drivers Act applies a statutory probationary period of two years to all drivers beginning on the day that the driver becomes a qualified driver (section 1 of the New Drivers Act).
- 2.124.** Under section 2 of the New Drivers Act, where a person reaches six or more penalty points within the probationary period, their driving licence is revoked and they will need to reapply for a probationary driving licence and re-sit their driving test. Any points accrued on a provisional driving licence will count towards the six points.

### Drink Driver Rehabilitation Scheme

- 2.125.** The procedure for the operation of the drink driver rehabilitation scheme (the rehabilitation scheme) is set out in sections 34A to 34C of the RTOA.
- 2.126.** Section 30 of the Road Traffic Act 1991 amended the RTOA by adding three new sections (sections 34A to 34C) providing for courts<sup>18</sup> to refer those disqualified for drink-drive offences under sections 3A, 4, 5 or 7 of the Traffic Act to approved courses.
- 2.127.** Under section 34A, courts may reduce the period of disqualification for a drink driving offence if the offender satisfactorily completes an approved course, where the original period of disqualification is not less than 12 months. In the case of a 12-month period of disqualification, the reduction will be 3 months. For longer periods of disqualification, the period of reduction will be up to one quarter as determined by the court.
- 2.128.** An approved course is one approved by the Secretary of State for the purposes of dealing with certain road traffic offenders. Currently, the only approved courses are for the purposes of dealing with drink driving offenders. The intention is to enable people convicted of drink driving offences to benefit from training about the problems associated with their offence in order to reduce the likelihood that they will reoffend. Although

<sup>18</sup> Magistrates and Crown Courts in England and Wales and, in Scotland, Sheriff and District Courts (when constituted by a Stipendiary Magistrate) plus the High Court of Justiciary, unless there is specific reference to a 'supervising court' which is defined in section 34C(2) RTOA as meaning in England and Wales, a magistrates' court acting for the petty sessions area named in the order as the area where the offender resides or will reside and in Scotland, the sheriff court for the district where the offender resides or will reside or, where the order is made by a stipendiary magistrate and the offender resides or will reside within his commission area, the district court for that area.

some of the above offences relate to both drink- and drug driving, the Secretary of State has approved no courses in respect of drug driving and people convicted solely of drug driving offences may not be referred to approved drink-drive courses.

- 2.129.** The Department for Transport issues guidance to organisers of approved courses in England, Wales and Scotland under the Secretary of State's powers in section 34C(1) of the RTOA and, by virtue of sub-section (1)(a) of that section, all course organisers are required to have regard to it. Its aim is to provide advice about the legislative provisions and identify best practice for the operation of approved courses under the Act. Section 34C(1)(b) states that for the purposes of section 34B(6), in determining whether any instructions or requirements of a course organiser were reasonable, a court shall have regard to any guidance given to the course organiser. Copies of this guidance have therefore been distributed to all courts.
- 2.130.** The rehabilitation scheme became permanent in 1999 following a 6 year experimental period. It is aimed at providing drink-drive offenders referred to an approved course with expert training in a group situation about the problems associated with drink driving enabling them to develop future non-offending behaviour and thereby reduce re-offending.
- 2.131.** Offenders who come within the criteria laid down for the High Risk Offenders Scheme (i.e. a person who is disqualified for being 2 ½ times or more over the prescribed limit; or who is disqualified for refusing to provide a specimen or is disqualified for a second drink-drive offence in ten years) may also be referred to an approved course. Offenders who are referred to and complete an approved course but who fall within the HRO criteria will still have to meet the requirements of that scheme.
- 2.132.** Attendance at a rehabilitation scheme is voluntary. Once the court has made a referral order, an offender may undertake a course any time before the completion date set, which must be at least 2 months before the end of the reduced period of disqualification. There is no additional penalty if an offender decides either not to accept a referral order or to accept an order but fails to attend a course, in which case the offender's disqualification period is not reduced.

## **Coroners and procurators fiscal**

- 2.133.** As Chapter 3 explains, the current data on BAC levels of drivers killed in road traffic fatalities is provided by coroners in England and Wales and procurators fiscal in Scotland.
- 2.134.** Coroners are independent judicial office holders, whose statutory duty in cases of violent, unnatural or sudden death of unknown cause is to determine who the deceased was and how, when and where the deceased came by their death. In Scotland, the equivalent function to the coroners in England and Wales in road traffic accidents is performed by the procurators fiscal.
- 2.135.** Operational decisions about how coroners discharge that duty, such as the ordering of post mortem examinations and toxicology tests, have

been left largely at their discretion. There is no statutory obligation for the coroners or procurators fiscal to test for and provide information on the presence of alcohol in road fatalities. However, there has been a long-established procedure to provide this information and it is fair to say that it is an inexpensive and straightforward process and most coroners and procurators fiscal do supply this information. In relation to testing for drugs, more work is required, and this is currently being taken forward by the Department for Transport and the Coroners' Society. There are likely to be resource implications for local authorities, in England and Wales, which fund the coroner service, as testing for drugs is more expensive than testing for alcohol.

- 2.136.** The Coroners and Justice Act 2009 provides, in England and Wales, for the appointment of a Chief Coroner. Under section 36, the Chief Coroner must give the Lord Chancellor a report for each calendar year covering both matters that the Chief Coroner wishes to bring to the attention of the Lord Chancellor and matters that the Lord Chancellor has asked the Chief Coroner to cover in the report. The Chief Coroner has not yet been appointed by the Lord Chancellor and section 36 has therefore yet to be brought into force.
- 2.137.** The Ministry of Justice is currently carrying out a public consultation ahead of the commencement of the Coroners and Justice Act, planned for 2012. Under the new system, the new Chief Coroner may choose to issue national guidance for coroners on testing for drugs from road traffic fatalities. The Chief Coroner may also consider making it a requirement for alcohol and drug results from road traffic fatalities to be reported to him as part of his Annual Report to the Lord Chancellor under section 36 of the Coroners and Justice Act 2009.
- 2.138.** At present, there does not appear to be any evidence of an intention to change the responsibilities or powers of procurators fiscal in Scotland.

## **The current law in relation to drink and drugs and operating other modes of transport**

- 2.139.** This section discusses the approach to drink and drugs taken in relation to the operation of other modes of transport, particularly railways, shipping and aviation. The following paragraphs briefly outline the relevant statutory position concerning these sectors.
- 2.140.** Save for aviation, the legislation applicable to persons working on ships or trains either mirrors the provisions of the Traffic Act or applies the relevant sections of the Traffic Act directly.

### **Railways**

- 2.141.** The Transport and Works Act 1992 makes provision for the regulation of alcohol and drug consumption by safety critical staff on railways and related guided transport systems. It also creates an alcohol and drug testing regime specific to this sector. The prescribed limit is set at the same level as under the Traffic Act for road users.

## **Ships**

**2.142.** In relation to ships, the Railways and Transport Safety Act 2003 makes provision for the regulation of alcohol and drug consumption in the maritime industry by creating a statutory alcohol limit for mariners (professional, recreational and fishermen) and alcohol and drug testing regimes. These provisions largely mirror those in the Traffic Act, the RTOA and the Transport and Works Act 1992. The prescribed limit is the same as for road users.

## **Aviation**

**2.143.** The Railways and Transport Safety Act 2003 also makes provision for the regulation of alcohol and drug consumption by aircraft flight and cabin crew, air traffic controllers, licensed aircraft maintenance engineers in the United Kingdom as well as by the crew of an aircraft registered in the United Kingdom wherever it may be in the world. It also puts in place an alcohol and drug testing regime which is similar to that which exists for other transport modes, largely mirroring the Traffic Act, the RTOA and the Transport and Works Act 1992.

**2.144.** One important difference, however, is that the prescribed limit for aviation workers (except for licensed aircraft maintenance engineers) is:

- (a) in the case of breath, 9 microgrammes of alcohol in 100 millilitres,
- (b) in the case of blood, 20 milligrammes of alcohol in 100 millilitres, and
- (c) in the case of urine, 27 milligrammes of alcohol in 100 millilitres.

**2.145.** The prescribed limit for licensed aircraft maintenance engineers is the same as for drivers under the Traffic Act.

# Chapter 3: Drink driving – Evidence, issues and opinion

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## Introduction

- 3.1. This chapter deals with the evidence, issues and opinions related to drink driving and includes the following:
- Current statistics;
  - Research findings;
  - Applications and implications of science;
  - Issues and opinions.

## Current statistics

### Data sources and completeness

- 3.2. When producing the Department for Transport estimates of the total number of drink drive casualties in Great Britain, two sources of data are used. These are:
- (a) Data from coroners and procurators fiscal: Information about the level of alcohol in the blood of road accident fatalities aged 16 or over who die within 12 hours<sup>19</sup> of a road accident is provided by coroners in England and Wales and by procurators fiscal in Scotland.
  - (b) STATS19 breath test data: The reported personal injury road accident reporting system (STATS19) provides data on injury accidents in which the driver or rider survived and was also breath tested at the roadside. If the driver or rider refused to provide a breath test specimen, then they are considered to have failed the test unless they are deemed unable to take the test for medical reasons. This data is provided by the police.
- 3.3. Information from coroners and procurators fiscal is subsequently added to the STATS19 record for relevant fatalities in order to create a fuller picture. However, both sources of data are incomplete. In the case of the STATS19 data, not all drivers are breath tested; some drivers may have left the scene (hit and run accidents) or may be too seriously injured to provide a breath test. In the case of the data provided by coroners and procurators fiscal, a post mortem alcohol test may not be available because the casualty died more than 12 hours after the accident, no test was carried out or because some of the data are not reported to the Department.

### *Role of coroners and procurators fiscal in collecting road casualty alcohol data*

- 3.4. As detailed above, coroners provide information about BAC in fatal road casualties in England and Wales; however, there is no statutory requirement for them to provide this information to the Department for Transport. At present, this is done on a voluntary basis via a third party that collates the information. In practice, approximately 74% of road traffic fatalities blood

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<sup>19</sup> Approximately 80% of all fatalities die within 12 hours of the accident. Reference: Transport Research Laboratory Leaflet 2080. Time interval between road accident and death - 1997. Published 2000.



alcohol levels are reported<sup>20</sup> which then allows subsequent estimated adjustment for the missing case details. Procurators fiscal report the corresponding data for Scotland, also on a voluntary basis, in approximately 69% of cases.<sup>21</sup>

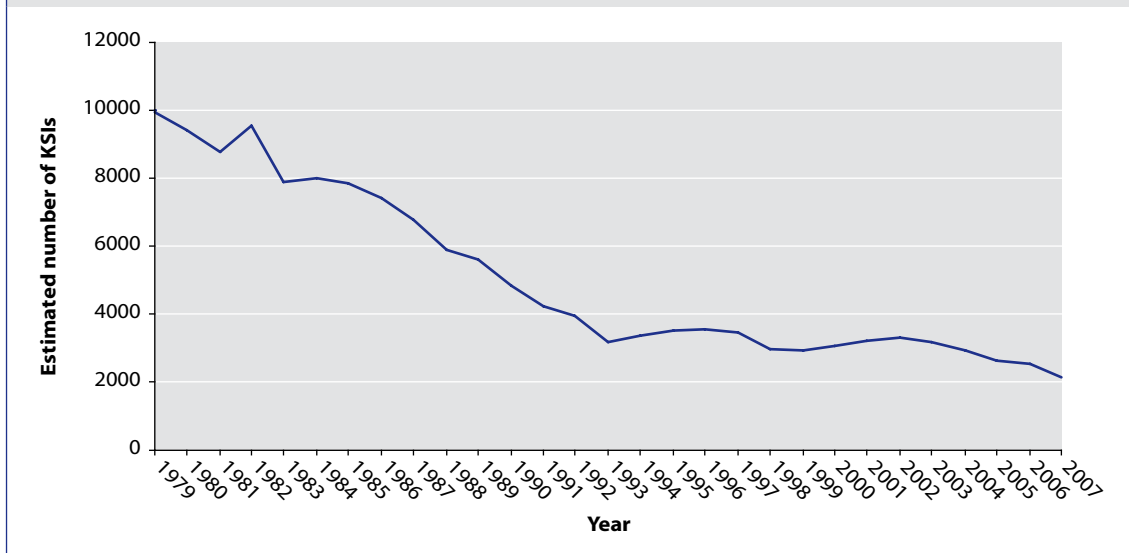
3.5. Further details regarding the methods for estimating drink drive statistics in Reported Road Casualties of Great Britain (RRCGB) are in Annex K.

### Casualties

3.6. In 1967, nearly a quarter (22.4%) of road fatalities was associated with drink driving – that is 1640 out of a total of 7319.<sup>22</sup> Over forty years later in 2008,<sup>23</sup> the comparable figure had fallen to approximately a sixth (17%) – that is, 430 out of a total of 2538 road fatalities – although an increase of 20 fatalities compared to 2007.<sup>24</sup>

3.7. Drink drive injuries represent a far smaller proportion of all road injuries than the corresponding proportions of fatalities. Nevertheless, in 2008,<sup>25</sup> it was estimated that 1,630 reported serious injuries (6.3% of all serious road casualties) occurred when someone was driving whilst over the legal alcohol limit and 10,970 reported slight injuries (5.4% of all slight injuries) occurred. Provisional figures for the total number of casualties in 2008 show that 5% of all reported road casualties were related to drink driving.

Chart 3.1: Estimated KSI casualties in reported road accidents involving drivers and riders over the legal alcohol limit: GB 1979–2007



Source: DfT Road Safety Statistics – 2010

20 TRL. Based on 2007 data (the most recent and complete year for which BAC data are available). Email correspondence. March 2010.

21 TRL. Based on 2007 data (the most recent and complete year for which BAC data are available). Email correspondence. March 2010.

22 Department of the Environment (1976) Drinking and Driving. TSO Ltd (paragraph 1.3)

23 The 2008 figure is provisional. It is to be noted that significant changes from the final figure are common.

24 Department for Transport. Reported Road Casualties Great Britain: 2008. Available at: <http://www.dft.gov.uk/adobepdf/162469/221412/221549/227755/rrcgb2008.pdf>

25 Department for Transport. Reported Road Casualties Great Britain: 2008. Available at: <http://www.dft.gov.uk/adobepdf/162469/221412/221549/227755/rrcgb2008.pdf>

3.8. Chart 3.1 displays the estimated number of killed and seriously injured (KSI) casualties for the reported incidents (STATS19 data). It shows a downward trend for killed and serious injuries resulting from crashes involving illegal alcohol levels for Great Britain since 1979. Whilst this shows a welcome reduction in the number of drink-related fatalities and serious injuries over a 30 year period, it is still the case that over 2000 are killed or seriously injured annually.

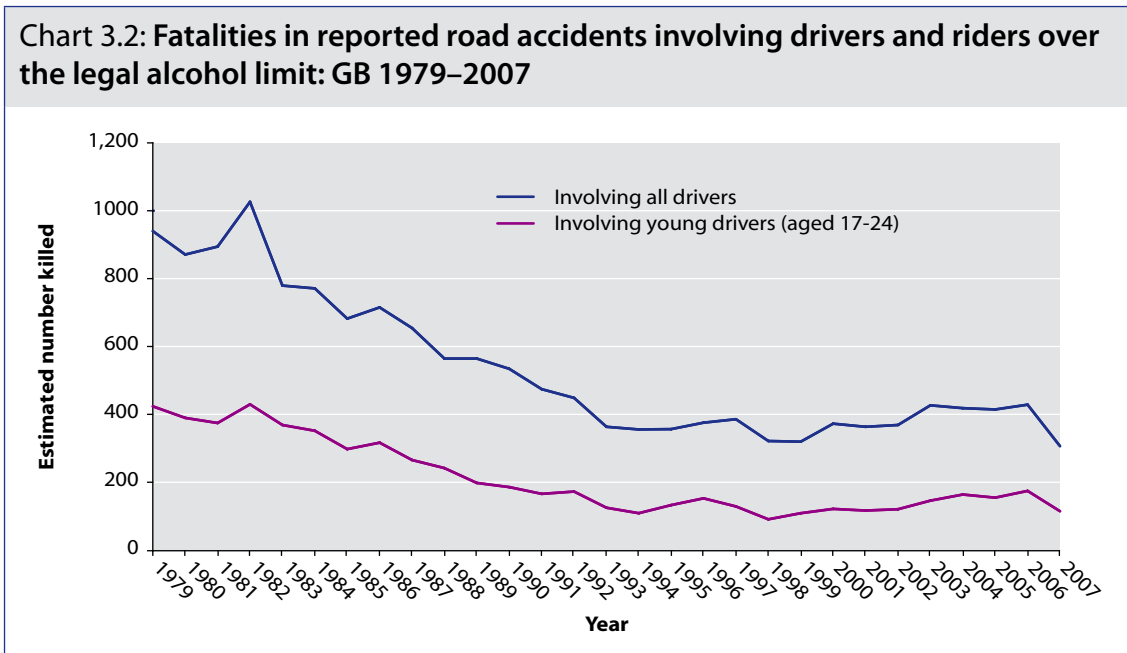
### The people who are drinking and driving

#### Gender

3.9. Department for Transport figures show that 84% (in 2007) of car driver fatalities who were over the limit were male. Women are much less likely to be involved in reported drink drive incidents as drivers than are men although this difference reduces slightly as men and women get older. In 2008, analysis of breath testing data after involvement in an accident, revealed that of those between 17 and 34 years old, men were 2 ½ times more likely to fail their breath test whereas, from 40 years onwards, men were just twice as likely as women to fail their breath test. Interestingly, amongst high risk offenders, women were more highly represented than men at the higher BACs (i.e. over 2 ½ times the legal limit).

#### Age

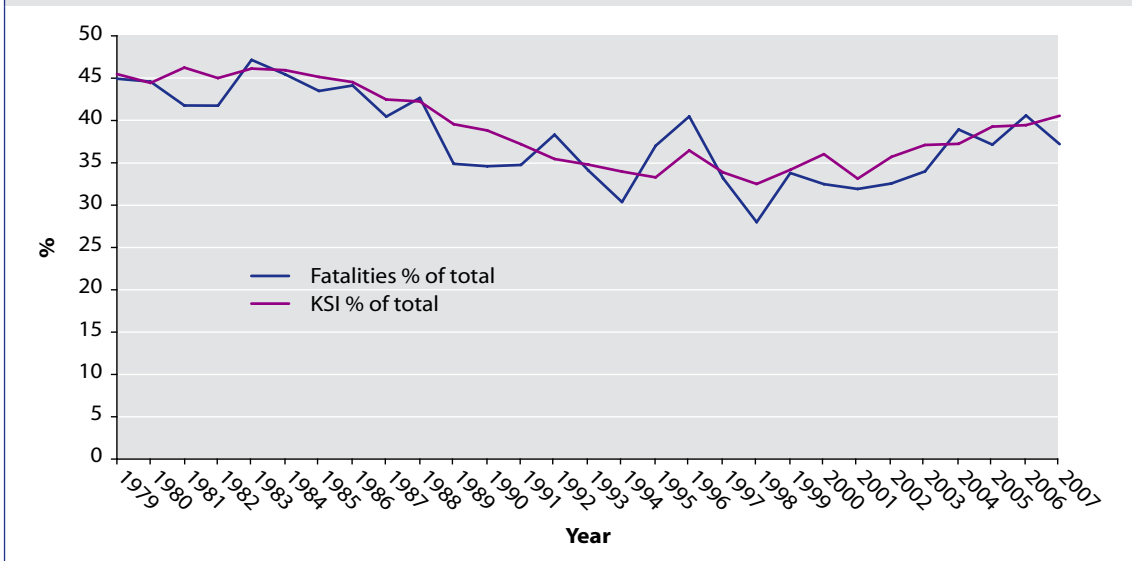
3.10. Chart 3.2 shows that, while the general trend has been for a fall in the number of drink driving related fatalities, the fall over the last decade in the number of fatalities in accidents involving a young driver (age 17–24) has been smaller.



Source: DfT Road Safety Statistics – 2010

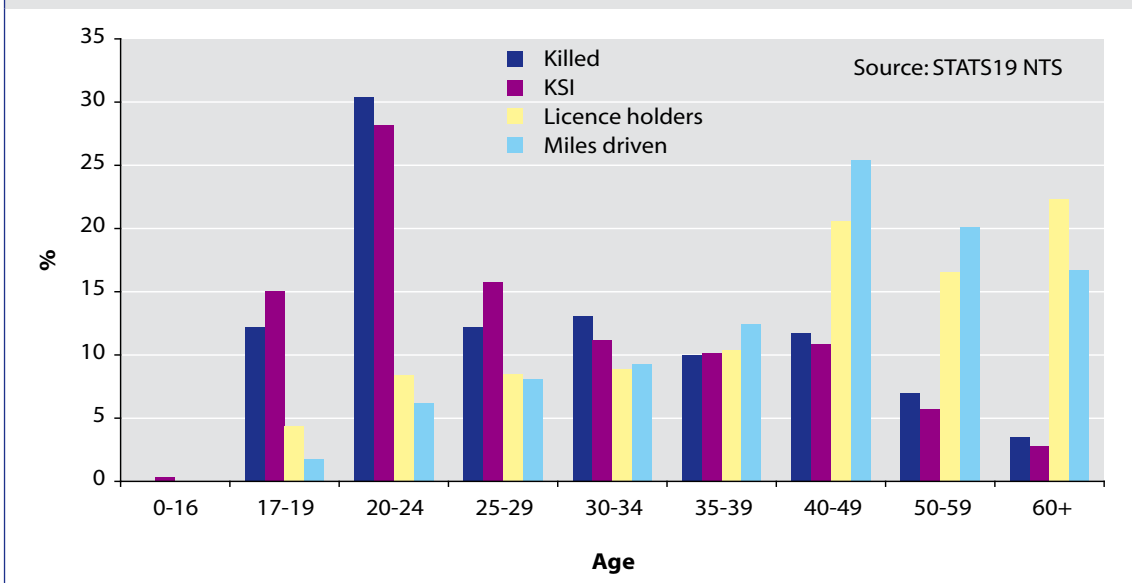
**3.11.** Chart 3.3 shows that in 2007, KSIs in accidents involving a young driver now also represent a greater proportion of all drink-related KSIs than a decade earlier. In 1979, KSIs in accidents involving young drivers represented 46% (45% for fatalities) of all drink driving KSI injuries. This proportion fell to its lowest (34% (33% for fatalities)) level in 1998 before steadily increasing until 2007 to 41% (37% for fatalities).

**Chart 3.3: Fatalities and KSIs in reported road accidents involving at least one young (age 17–24) driver as a percentage of all accidents involving drivers and riders over the legal alcohol limit: GB 1979–2007**



Source: DfT Road Safety Statistics – 2010

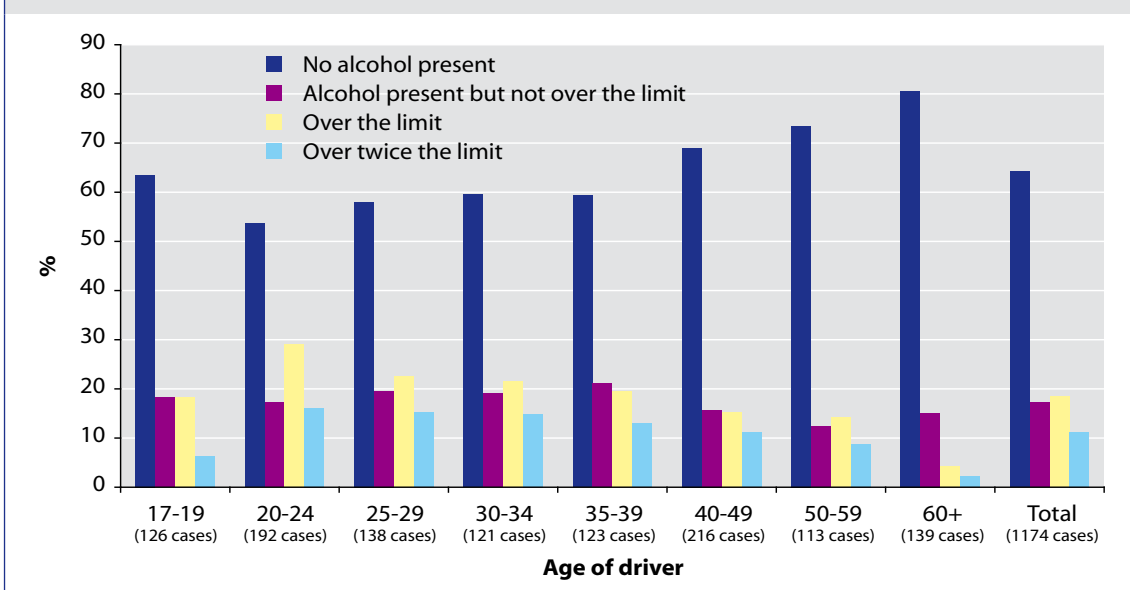
**Chart 3.4: Reported casualties from accidents involving a driver in each known driver age group as a proportion of total casualties from accidents involving a car drink driver. Licence holders in, and miles driven by, each age group as a proportion of the total: GB 2007**



Source: DfT Road Safety Statistics – 2010

3.12. Chart 3.4 compares the proportion of casualties (killed and seriously injured) arising from accidents involving drivers who were over the blood alcohol limit by the age group of that driver with the proportion of total mileage driven by that driver age group and the proportion of all licences held by that driver age group. It shows that not only do young people, particular the 20–24 age group, represent a high proportion of those killed and seriously injured through drink-related injuries but that this is in spite of relatively fewer miles driven and fewer of them holding driving licences in comparison to older adults.

Chart 3.5: Proportion of all killed drivers in each BAC category, by age: GB 2007



Source: Coroners and procurators fiscal

3.13. Chart 3.5 shows the percentage of killed drivers/riders within each band of blood alcohol concentration (BAC) by age. People aged 50–59 years old, and those 60 years old and over, had the highest proportion of killed drivers/riders with *no* alcohol present in their blood (73 and 81% respectively). Conversely, 20–24 year olds had the lowest proportion of killed drivers/riders with *no* alcohol present, but the highest for killed drivers/riders over the legal alcohol limit (29% for those aged 20–24 compared to 4% for 60+ year olds). Drivers/riders killed who were in the 20–24 year old age group also had the highest proportion for blood levels over twice the legal alcohol limit. This suggests that, among those that die, younger drivers are not only more likely than older drivers to have drunk alcohol and driven but that many consume a lot of alcohol and are much more likely to be over the limit and, often, at least twice over the limit. Looking at Chart 3.5 as a whole, it can be seen that approximately 35% of all drivers killed have some alcohol present. 17% of drivers killed have been drinking but their BAC is below the legal limit, measuring between 10 mg/100 ml and 80 mg/100 ml, while 18% of all drivers killed in road traffic accidents are over the limit, with 2% just over the limit with a BAC of between 80 mg/100 ml and 100 mg/100 ml<sup>26</sup> and 11% more than twice the drink drive limit.

### The vehicles involved

**3.14.** In 2007, 58% of fatal drink drive accidents involved only the vehicle whose driver was over the limit. 27% involved two vehicles, and 12% more than two vehicles. This suggests that, although a large proportion of drink drivers are only involving their own vehicle and its occupants, nevertheless, a significant proportion (46%) of these incidents also involved other vehicles and drivers who, themselves, were not over the alcohol limit.

### The casualties involved

**3.15.** Seventy-five per cent of killed or seriously injured (KSI) casualties involved in drink-drive collisions (i.e. where at least one of the vehicle drivers was over the legal limit) are car occupants. Just under half of these car occupants are the offending driver who is over the limit (37% of all KSIs). However, car passengers represent the next largest group of KSIs, representing 30% of all KSIs. Other drivers who are not over the limit make up 7% of the total drink-related road casualties.

**Table 3.1: Estimated number of casualties in reported road accidents where at least one of the drivers or riders involved was over the legal limit: GB 2007**

Table 3.1: Estimated number of casualties in reported road accidents where at least one of the drivers or riders involved was over the legal limit: GB 2007										
				Car drivers			Numbers are rounded to nearest 10			
	Pedestrians	Cyclists	Motor-cyclists	Over limit	Under limit	Car passenger	Other	Male	Female	Total
<b>Killed or seriously injured</b>										
0-15	20	10	10	0	0	30	0	30	40	70
16-24	40	0	110	320	30	340	20	660	190	850
25-59	80	20	160	460	120	220	40	840	260	1,100
60+	20	0	10	20	20	30	10	70	40	110
All ages <sup>2</sup>	160	30	290	800	160	660	60	1,640	530	2,170
<b>Total casualties</b>										
0-15	70	20	20	0	0	460	30	270	330	600
16-24	130	10	300	2,050	490	2,210	140	3,790	1,540	5,330
25-59	210	80	390	2,910	1,730	1,420	390	4,920	2,200	7,120
60+	50	10	10	180	280	190	40	460	290	750
All ages <sup>1</sup>	460	120	730	5,140	2,500	4,480	600	9,590	4,430	14,020

1. Includes age not recorded

Source: Reported Road Casualties of Great Britain: 2008

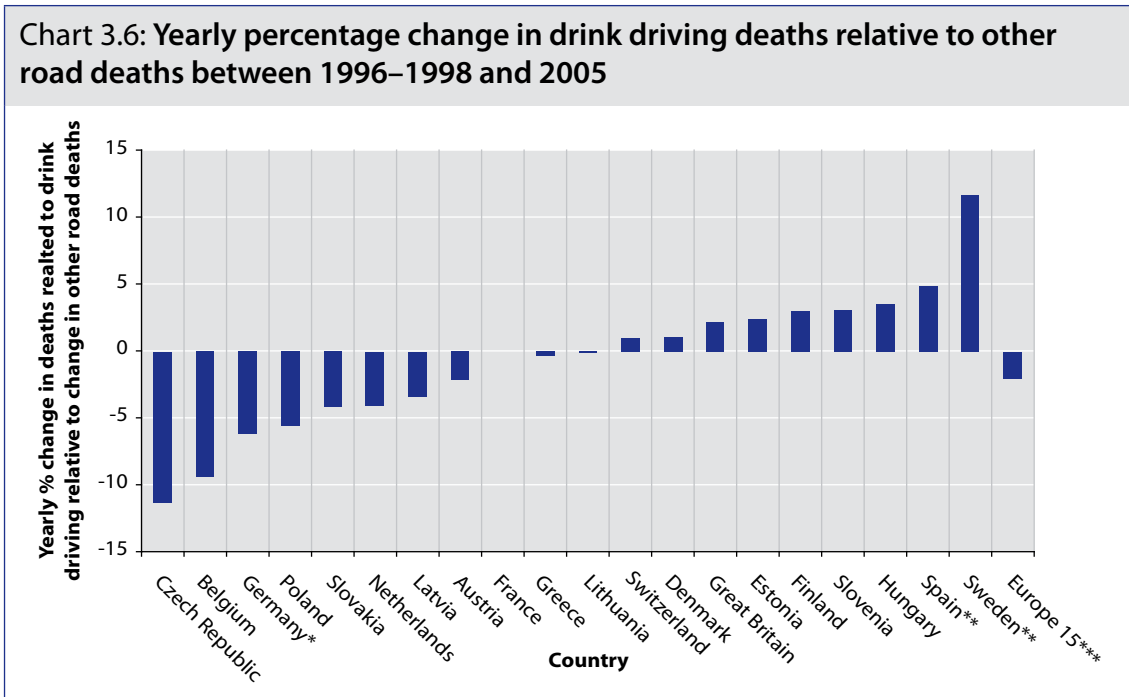
**3.16.** Table 3.1 shows that in 2007 there were 730 motorcyclist casualties (of which 290 were killed or seriously injured (KSIs)). Motorcycle KSIs make up around 13% of KSIs in drink drive accidents and around 70% of these are drivers who are over the limit. There were also around 460 pedestrian casualties (of which 160 were KSIs) and 120 pedal cyclist casualties (of which 30 were KSIs) in accidents with a driver over the legal alcohol limit.<sup>27</sup> While drink drivers may

<sup>27</sup> Department for Transport. Reported Road Casualties Great Britain: 2008.

tend to be male, a large proportion of those who are injured are women; nearly a third of the total casualties in drink drive incidents were women.<sup>28</sup>

### International comparisons of drink driving statistics

**3.17.** A number of institutions within Europe are concerned about drink driving which is still widespread in Europe. However, the recording of drink driving crashes and casualties tends to be patchy, which makes monitoring of drink driving levels difficult. Levels of deaths related to drink driving cannot be compared between countries, as there are large differences in the way in which countries define and record a 'crash related to drink driving'. Countries have therefore been compared on the basis of changes in the number of deaths from drink driving crashes, relative to changes in the number of other road deaths, using each country's own method of identifying 'drink driving related crashes'.



Source: European Transport Safety Council, 2008.<sup>29</sup>

\* Yearly percentage change in drivers involved in fatal drink driving crashes relative to drivers involved in other fatal crashes (Germany)

\*\* Yearly percentage change in driver deaths from drink driving crashes relative to driver deaths from other crashes (Spain, Sweden)

\*\*\* This includes all countries for which timeline data over 1996-98 to 2005 is available: Austria, Belgium, Cyprus, Czech Republic, Denmark, Estonia, Finland, Great Britain, Greece, Greece, Hungary, Latvia, Netherlands, Poland, Slovenia and Switzerland.

28 Department for Transport. Reported Road Casualties Great Britain: 2008.

29 Achterberg F. Raising Compliance with Road Safety Law. 1st Road Safety PIN Report. European Transport Safety Council. 2008.

**3.18.** As demonstrated in Chart 3.6, despite being among the leaders in road safety in Europe, Great Britain's recent changes in the number of drink driving deaths have not contributed their proportionate share to overall reductions in traffic deaths in comparison to countries such as Belgium, the Netherlands or Germany. This may mean that the road casualty gains in Great Britain may be due to other factors amongst which one would include safer road infrastructure and safer cars rather than the gains being simply due to a reduction in drink driving.

### Breath testing statistics

**3.19.** Table 3.2 describes the trend in the numbers of all screening breath tests undertaken in England and Wales between 1999 and 2008 and the proportion of these which were positive.

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Number of tests (in thousands) of which:										
positive/refused <sup>1</sup> (in thousands)	94	95	100	104	106	103	104	106	98	92
% of total tests	12	13	16	18	20	18	17	18	16	13
Convictions (in thousands)	89	86	85	90	94	96	94	92	*	*

1. Includes persons unable to provide a breath test specimen  
\* Conviction data is unavailable

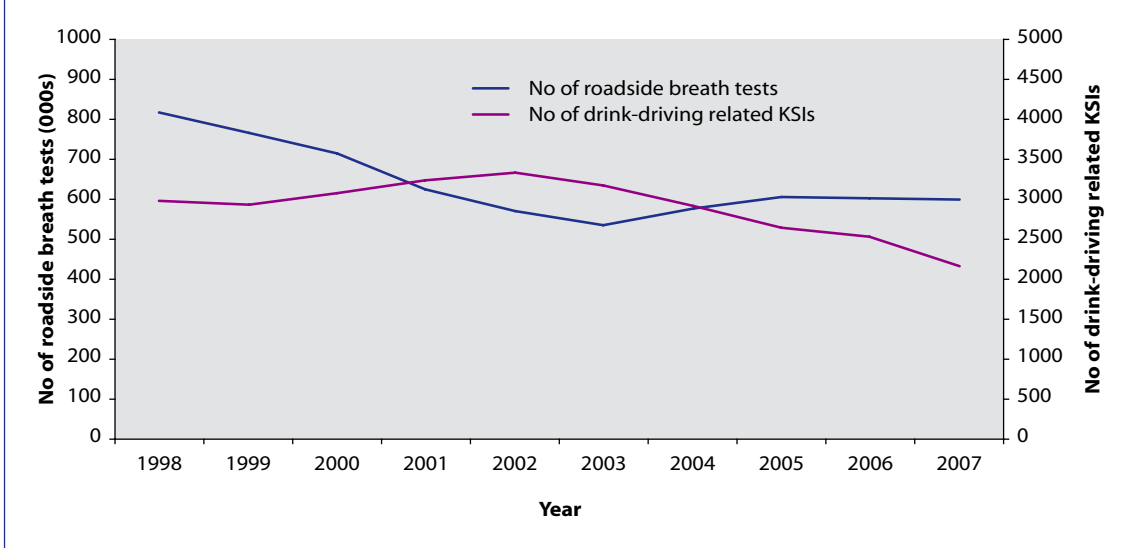
Source: Home Office.<sup>30</sup>

**3.20.** Chart 3.7 shows the relationship between the number of roadside breath tests and the drink driving-related KSI casualties in Great Britain between 1998 and 2007. They show an inverse relationship in that a greater number of breath tests are associated with a relatively lower number of drink driving-related KSI casualties. The underlying cause of this relationship is not clear; however, it might suggest that, in Great Britain, there may be benefits from the police performing a greater number of roadside breath tests. This is supported by experience in Australia where it was estimated that in Queensland every increase of 1,000 in the number of daily tests corresponded to a decline of 6% in all serious crashes, and of 19% in single-vehicle night-time crashes.<sup>31</sup>

<sup>30</sup> Povey et al. Police Powers and Procedures 2008/09. Home Office Statistical Bulletin. 2010.

<sup>31</sup> J Henstridge, R Homel & P Mackay. The Long-Term Effects of Random Breath Testing in Four Australian States: A Time Series Analysis. Canberra: Federal Office of Road Safety, 1997.

Chart 3.7: Chart showing the relationship between number of roadside breath tests and drink driving related KSIs in GB 1998–2007



Source: RRCGB, 2008.

#### *Breath testing statistics for professional drivers*

**3.21.** In 2008, professional drivers, (those that drive HGVs, buses, coaches, minicabs and taxis) had a lower proportion of positive breath testing when tested than ordinary motorists. Table 3.3 compares breath tests and breath test failures of drivers tested after being in a reported personal injury accident by road user type. This reveals 2 main variables for each road user type; the likelihood of being tested after involvement in an accident and the likelihood of failing a breath test. For example, coach and bus drivers were tested in 38% of accidents, whereas HGV drivers were tested in 68% of accidents. Car drivers were tested in 56% of accidents. In terms of likelihood of failing a breath test, of those tested, 0.4% of bus or coach drivers failed and 0.6% of HGV, taxi and private hire drivers failed. In contrast, 3.8% of car drivers tested failed which was more than 6 times the likelihood of a taxi driver failing a breath test.



**Table 3.3: Reported breath tests and breath test failures of drivers tested after being in a reported personal injury accident, by road user type: 2008 Great Britain**

	Involved in accident	Tested <sup>1</sup>	Tested as % of those involved	Failed <sup>2</sup>	Failed as % of involved	Failed as % of tested	Drivers killed – number over the legal blood alcohol limit: 2007 over 80mg/100ml
Motorcycle	22,427	11,569	52%	314	1.4%	2.7%	46
Car	230,852	129,433	56%	4,872	2.1%	3.8%	159
Taxi/Private Hire Car	5,144	2,714	53%	17	0.3%	0.6%	0
Minibus	927	561	61%	10	1.1%	1.8%	0
Bus or Coach	8,375	3,218	38%	13	0.2%	0.4%	0
Other Motor Vehicle	4,056	1,744	43%	47	1.2%	2.7%	0
LGV	13,621	7,594	56%	208	1.5%	2.7%	10
HGV	9,040	6,136	68%	39	0.4%	0.6%	0
Total	294,442	162,969	55%	5,520	1.9%	3.4%	215
Source: STATS 19							Source: Coroners data only
1. Excludes cases where test not requested (53,377), driver not contacted (67,203) or not provided for medical reasons (11,889) 2. Failed breath test or refused to provide a specimen							

### *International comparison of breath testing statistics*

- 3.22.** A number of studies have compared the use of breath testing in different countries in an attempt to evaluate the effectiveness of each country's enforcement of their drink driving laws. In 2004, the SARTRE 3<sup>32</sup> study showed that only 3% of drivers in the UK had been stopped and tested for alcohol in the previous 3 years. This was in contrast to the European average of 16% which includes several countries in the study where random breath testing is permitted.
- 3.23.** A recent European Transport Safety Council (ETSC) review<sup>33</sup> of European countries' drink driving laws and levels of enforcement showed how widely the breath testing rates varied. Annex L provides a table of drivers across Europe and shows who have been breath tested for alcohol over a one year period between 2005 and 2007.
- 3.24.** There appear to be 3 levels of testing; high levels (approximately 30%+ of drivers are checked in any one year) as used by e.g. Sweden, Norway and France; medium levels (approximately 11–25% of drivers are checked in any one year) e.g. Netherlands, Spain and Denmark and low levels of testing (less than 10% of drivers are checked in any one year), e.g. UK, Italy and Czech Republic. There does not appear to be a consistent relationship between the number of drink driving deaths as a proportion of all road casualties of that country or the number of drink driving offences charged when compared to

32 SARTRE. European drivers and road risk. SARTRE 3 reports. Part 1. Report on principal report and analyses. INRETS, Arcueil, 2004.

33 ETSC. Reducing deaths from drink driving. Road Safety PIN No 5. 2007.

the rate of breath testing, although there is evidence of individual countries' responses to their own drink driving problem.

## Research findings

- 3.25.** This section considers the evidence available on the involvement of alcohol in road fatalities/accidents and reviews the evidence of the interventions that may help reduce road casualties related to drink driving.
- 3.26.** The Centre for Public Health Excellence of the National Institute of Health and Clinical Excellence (NICE) has recently conducted an extensive independent review of the literature which was commissioned by the Department for Transport.<sup>34</sup> The review aimed to assess how effective the blood alcohol concentration (BAC) laws are at reducing road traffic injuries and deaths. It also assessed the potential impact of lowering the BAC limit from 80 mg/100 ml to 50 mg/100 ml.
- 3.27.** Specifically, the NICE Review examined:
- drink driving patterns and the associated risk of being injured or killed in a road traffic accident;
  - how BAC limits and related legislative measures have changed drink-drinking behaviour and helped reduce alcohol-related road traffic injuries and deaths;
  - models estimating the potential impact of lowering the BAC limit from 80 mg/100 ml to 50 mg/100 ml in England and Wales;<sup>35</sup>
  - lessons from other countries on using BAC laws as part of overall alcohol control and road safety policies.
- 3.28.** Much of the subsequent research evidence that this Report refers to is drawn from the NICE review.

## Drink driving and the risk of a road traffic accident

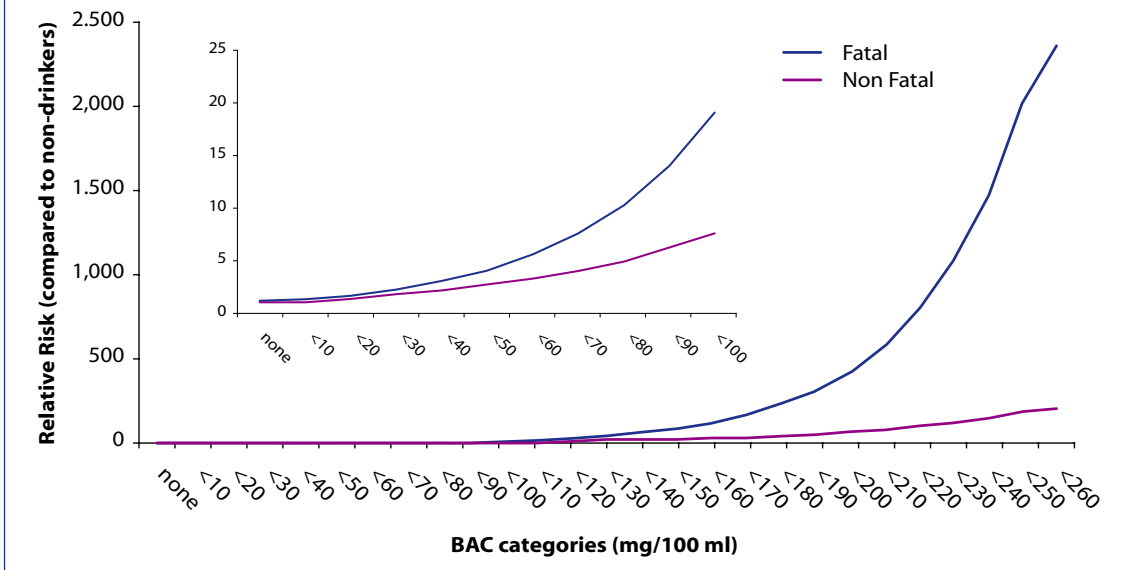
- 3.29.** NICE concluded that there is strong evidence that someone's ability to drive is affected if they have any alcohol in their blood. Studies consistently demonstrate that the risk of having an accident increases exponentially as more alcohol is consumed. Drivers with a BAC of between 20 mg/100 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.
- 3.30.** Younger drivers are particularly at risk of crashing whenever they have consumed alcohol – whatever their BAC level – because they are less experienced drivers, are immature and have a lower tolerance to the effects of alcohol than older people. Younger drivers may also be predisposed to risk-taking – regardless of whether or not they have drunk alcohol.<sup>36</sup>

34 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

35 NICE was commissioned to provide an estimate of casualties prevented only for England and Wales.

36 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

**Chart 3.8: Relative risk of being involved in a fatal or non-fatal accident in England and Wales<sup>37</sup>**



Source: RRCGB, 2008.

- 3.31.** Chart 3.8 shows the relationship between alcohol consumption and the relative risk of fatal and non-fatal accidents when compared to non-drinkers and is based on data from England and Wales as reported by Maycock<sup>38</sup> in 1991. While there may be small methodological limitations, it represents the only study of its kind completed in the UK. In Maycock’s study, the time period when data were collected may not reflect alcohol consumption today given current alcohol accessibility or the current risk of accidents given improvement in road infrastructure. Also, the method of calculating risk assumes that there is no separation by age and gender (whereas studies in other countries have shown that the risk between young and old adults was very different).
- 3.32.** Unlike other studies, Maycock observed that there was no small benefit for drivers with a low BAC over those who had consumed no alcohol. Maycock’s findings are broadly similar to those of studies from other countries, such as the seminal Grand Rapids<sup>39</sup> study which, conducted in the early 1960s in the USA, was the largest study of alcohol-related car accidents used to determine the relative risk of crashing related to BAC.

**Effectiveness of BAC laws**

- 3.33.** Overall, NICE concluded that there was sufficiently strong evidence to indicate that reducing the BAC limit from 80 mg/100 ml to 50 mg/100 ml is effective in certain contexts in reducing road traffic injuries and deaths.

37 R Rafia, A Brennan. Modelling methods to estimate the potential impact of lowering the blood alcohol concentration limit from 80 mg/100 ml to 50 mg/100 ml in England and Wales. Report to the National Institute for Health and Clinical Excellence. School of Health and Related Research (ScHARR), University of Sheffield. 2010.  
 38 Maycock G Drinking and Driving in GB -a review Transport Research Laboratory TRL report 232 1991.  
 39 Borkenstein RF, Crowther RP, Shumate WB *et al.* (1974) The role of the drinking driver in traffic accidents. Blutalkohol 11 (supplement 1): 1–132.

- 3.34.** In what is the most recent and relevant high quality study, the adoption of a 50 mg/100 ml BAC driving limit that occurred across 15 European countries reduced alcohol-related driving death rates by 11.5% among young people aged 18–25.<sup>40</sup> It also reduced alcohol-related driving fatalities among men of all ages by 5.7%, and among men in urban areas there was a 9.2% reduction. The analysis took account of a large number of factors which could have affected the results, including related policies and enforcement: minimum legal driving age, points-based licensing and random testing. However, there were no significant reductions in deaths or injuries among the broader population when these other factors, such as enforcement and infrastructure quality, were taken into account.
- 3.35.** In Australia, the lowering of the BAC limit from 80 mg/100 ml to 50 mg/100 ml also led to a significant reduction in all fatal accidents, specifically, an 18% reduction in Queensland and 8% reduction in New South Wales.<sup>41</sup> Additionally, in the USA, although relating to a different change of limits, a number of studies indicate that lowering the BAC limit from 100 mg/100 ml to 80 mg/100 ml reduced road traffic injuries and fatalities, although the scale of effect varied.<sup>42</sup>

### Duration of effect of a reduced BAC limit

- 3.36.** NICE considered that there was insufficient evidence to judge what level of effect might be sustained over time by lowering the BAC limit, although certain studies indicate that there could be positive, long-term gains. The effects of the 50 mg/100 ml law in Europe were evident after 2 years and increased over time – with the greatest impact occurring in between 3 and 7 years.<sup>43</sup>

### BAC laws and changes in drink driving behaviour

- 3.37.** There is sufficiently strong evidence to indicate that lowering the BAC limit changes the drink driving behaviour of drivers at all BAC levels. The BAC law appears to act as a general deterrent and the beneficial effects are not just restricted to the drivers at the BAC levels involved.<sup>44</sup>
- 3.38.** Studies have shown that reducing BAC limits to 50 mg/100 ml or lower has an impact on drivers who drink heavily. For example, in 1991 when the BAC limit was lowered from 80 mg/100 ml to 50 mg/100 ml in the Australian Capital Territory, it reduced the incidence of drink driving with a BAC well above the original 80 mg/100 ml limit.<sup>45</sup>

40 Albalade D (2006) Lowering blood alcohol content levels to save lives: the European experience. *Journal of Policy Analysis and Management* 39.

41 Henstridge J, Homel R, Mackay P (1995) The long-term effects of random breath testing in Adelaide. In Kloeden CN and McLean AJ Editors. *Proceedings of the 13th international conference on alcohol, drugs and traffic safety*. 13–18 August 1995. Adelaide, Australia: International Council on Alcohol, Drugs and Traffic Safety.

42 Shults RA, Elder RW, Sleet DA *et al.* (2001) Reviews of evidence regarding interventions to reduce alcohol-impaired driving (Brief record). *American Journal of Preventive Medicine* 21 (4 supplement): 66–88.

43 Albalade D (2006) Lowering blood alcohol content levels to save lives: the European experience. *Journal of Policy Analysis and Management* 39.

44 NICE. *Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths*. 2010.

45 Brooks C, Zaal D (1993) *Effects of a reduced alcohol limit for driving*. Australia: Federal Office of Road Safety.

- 3.39.** Other studies (included in a systematic review) showed that the introduction of an 80 mg/100 ml BAC legal limit reduced the number of alcohol-related deaths involving drivers with a BAC of 100 mg/100 ml or higher.<sup>46</sup> Another study showed that it had a differential impact according to age, with the highest reductions in deaths among younger drivers (14% reduction among 18–20 years, 9.7% among 21–24 years and 6.7% among those aged 25 and older).<sup>47</sup> Although these studies show reductions in drink driving among those with high BAC levels the precise mechanisms that influence their willingness and capacity to change their drink driving behaviour are unclear.<sup>48</sup>

### Estimating casualties saved

- 3.40.** Researchers at Sheffield University<sup>49</sup> have modelled a range of estimates for the number of alcohol-related driving casualties that would be avoided in England and Wales from introducing a 50 mg/100 ml BAC limit. This is based on extrapolating the effect of lowering the BAC limit from 80 mg/100 ml to 50 mg/100 ml in other countries. The predictions take into account the ongoing downwards shift in the distribution of blood alcohol concentration levels in the driving population in the absence of a change in the BAC limit (i.e. that even though people still drink and drive, they are generally drinking less than in the past) and applies the effects of this on all road traffic casualties, not just on drink drive-related casualties. Based on the current downward trend in the number of road traffic casualties, the researchers predicted that in 2010, there would be approximately 215,000 casualties.
- 3.41.** Review of the literature highlighted that there was only limited evidence on the pattern of drink driving in England and Wales (as measured by BAC levels among the driving population). There was also a lack of UK evidence on how reducing the legal limit might change drink driving behaviour and the associated risk of casualties, particularly among those drinking above the current 80 mg/100 ml BAC limit. Consequently, unknown parameters had to be calibrated or estimated from the international literature – mainly from Europe and Australia. The model estimates the casualty savings which could be expected in the first year following implementation of a lower limit and for each year up to six years after implementation.
- 3.42.** Given the many uncertainties related to the data and the assumptions used in the modelling, the figures should be interpreted with considerable caution. However, assuming any change in drink driving policy produces the same relative effect on the BAC distribution. The research modelling indicated that, for *England and Wales*:

46 Shults RA, Elder RW, Sleet DA *et al.* (2001) Reviews of evidence regarding interventions to reduce alcohol-impaired driving (Brief record). *American Journal of Preventive Medicine* 21 (4 supplement): 66–88.

47 Dee TS (2001) Does setting limits save lives? The case of 0.08 BAC laws. *Journal of Policy Analysis and Management* 20 (1): 111–128.

48 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

49 R Rafia, A Brennan. Modelling methods to estimate the potential impact of lowering the blood alcohol concentration limit from 80 mg/100 ml to 50 mg/100 ml in England and Wales. Report to the National Institute for Health and Clinical Excellence. School of Health and Related Research (ScHARR), University of Sheffield. 2010.

- After the first year of implementation of a lower limit, when based on the very successful Australian experience, 144 deaths and 323 serious injuries were estimated to be avoidable. By the sixth year, the model estimates that this annual benefit would have increased progressively to an annual total of 303 deaths and 708 serious injuries which might be avoided. It should be noted that these casualties saved would be across all reported road traffic accidents and may not necessarily be reported as drink drive casualties but they would all be casualties avoided as a consequence of lowering the drink drive limit.
- When using the more conservative estimates taken from the Albalate<sup>50</sup> study (based on the experience of other European countries), each year, 77-168 deaths and 3,611-15,832 injuries were estimated to be avoidable. However, care should be taken in considering the exact impact over time as the time horizon used in Albalate's study was less well-defined than in the Australian study.

**3.43.** These estimates for England and Wales take no account of the possible casualty savings for Scotland. It should be noted that Scotland represented 7% (940 of 14,020) of all drink drive-related casualties in Great Britain in 2008.<sup>51</sup>

**3.44.** A more conservative estimate<sup>52</sup> results from applying Maycock's exponential formulae for risk as a function of BAC to the reported drink drive casualties of Great Britain<sup>53</sup> (i.e. 430 killed and 1630 seriously injured). This results in the estimate that, following a reduction in the BAC limit to 50 mg/100 ml, there would be approximately 43 fewer killed and 280 fewer seriously injured every year. The casualties saved include those who have been dying with BACs between 50 and 80 mg/100 mg; these are within the current BAC limit and would now be saved. It is also calculated that some of those with BACs above 80 mg/100 ml would also be saved.

### Young drivers: zero tolerance laws

**3.45.** NICE concluded that there is sufficiently strong evidence to indicate that zero tolerance laws can help reduce alcohol-related injuries and deaths.<sup>54</sup> One systematic review reported a 9–24% reduction in crash fatalities, while another reported reductions in the range of 11–33%.<sup>55, 56</sup>

**3.46.** Additional evidence is provided by primary evaluation studies of high or good quality. One study found that zero tolerance laws, combined with administrative licence revocation, led to a 4.5% reduction in fatal crashes among young drivers.<sup>57</sup> Another showed that zero tolerance laws reduced

50 Albalate D (2006) Lowering blood alcohol content levels to save lives: the European experience. *Journal of Policy Analysis and Management* 39.

51 Department for Transport. Correspondence Mar 10.

52 Professor Richard Allsop, University College London. Written evidence to the North Review. 2010.

53 Department for Transport. Reported Road Casualties Great Britain: 2008.

54 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

55 Shults RA, Elder RW, Sleet DA *et al.* (2001) Reviews of evidence regarding interventions to reduce alcohol-impaired driving (Brief record). *American Journal of Preventive Medicine* 21 (4 supplement): 66–88.

56 Zwerling C, Jones MP (1999) Evaluation of the effectiveness of low blood alcohol concentration laws for younger drivers (structured abstract). *American Journal of Preventive Medicine* 16 (1 supplement): 76–80.

57 Eisenberg D (2003) Evaluating the effectiveness of policies related to drunk driving. *Journal of Policy Analysis and Management* 22 (2): 249–74.

the proportion of deaths among underage drink-drivers by 24.4%.<sup>58</sup> A further study linked zero tolerance laws to a 12% reduction in alcohol-related fatalities and a 4% reduction in overall crash fatalities.<sup>59</sup>

- 3.47.** Other US studies showed that zero tolerance laws changed the pattern of alcohol consumption and the drink driving behaviour of young people overall. In one, it led to a 19% reduction in the number of young people (aged under 21) driving after drinking any alcohol – and a 23% reduction in the number driving after five or more drinks.<sup>60</sup> The law did not affect overall drinking or binge drinking participation. Another study showed that zero tolerance laws reduced drinking and driving among college students (aged under 21). The main response was to refrain from driving after drinking, with the greatest impact made on those who reported drinking away from home.<sup>61</sup>

### Enforcement of BAC laws and public awareness of enforcement<sup>62</sup>

- 3.48.** The NICE review commented on the evidence available relating to public awareness and enforcement of BAC limit laws. NICE concluded that there is sufficiently strong evidence to indicate that publicity and visible, rapid enforcement is needed if BAC limit 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. High quality review evidence also shows that mass-media campaigns can reduce alcohol-impaired driving and alcohol-related crashes.<sup>63</sup>
- 3.49.** The impact of the 50 mg/100 ml BAC law in Austria and Netherlands was attributed in part to publicity and enforcement measures.<sup>64,65</sup> A European review of enforcement measures<sup>66</sup> showed that countries fulfilling most of the following criteria have the lowest drink driving figures:
- long tradition in drink driving enforcement including low legal limits;
  - relatively high objective risk of detection (as measured by proportion of drivers tested);
  - mass media supporting enforcement.

58 Voas RB, Tippetts AS, Fell JC (2003) Assessing the effectiveness of minimum legal drinking age and zero tolerance laws in the United States. *Accident Analysis & Prevention* 35 (4): 579–87.

59 Villaveces A, Cummings P, Koepsell TD *et al.* (2003) Association of alcohol-related laws with deaths due to motor vehicle and motorcycle crashes in the United States, 1980–1997. *American Journal of Epidemiology* 157 (2): 131–40.

60 Wagenaar AC, O'Malley PM, LaFond C (2001) Lowered legal blood alcohol limits for young drivers: effects on drinking, driving, and driving-after-drinking behaviors in 30 states. *American Journal of Public Health* 91 (5): 801–4.

61 Liang L, Huang J (2008) Go out or stay in? The effects of zero tolerance laws on alcohol use and drinking and driving patterns among college students. *Health Economics* 17 (11): 1261–75.

62 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

63 Elder RW, Shults RA, Sleet DA *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): 57–65.

64 Bartl G, Esberger R (2000) Effects of lowering the legal BAC limit in Austria. Proceedings of 15th Conference on Alcohol Drugs and Traffic Safety Stockholm. International Council on Alcohol, Drugs and Traffic Safety.

65 Mathijssen MP (2005) Drink driving policy and road safety in the Netherlands: a retrospective analysis. *Transportation Research (Part E) Logistics and Transportation Review* 41 (5): 395–408.

66 Makinen T, Zaidel DM 2003 Traffic enforcement in Europe: effects, measures, needs and future. Final report of the ESCAPE consortium. Brussels: European Commission.

*Random and selective breath testing*<sup>67</sup>

- 3.50.** Sobriety checkpoints (random and selective breath testing) can help reduce road traffic injuries and deaths, according to two high-quality reviews.<sup>68,69</sup> In addition, random breath testing had an immediate, substantial and permanent impact on accidents in three out of the four states studied in an Australian study.<sup>70</sup> A further study showed that sobriety checkpoints in US states helped enforce the 80 mg/100 ml law.<sup>71</sup>
- 3.51.** Many countries around the world have introduced random testing<sup>72</sup> to improve apprehension rates and thereby strengthen the deterrent impact of their impaired driving laws.<sup>73</sup> The Scandinavian countries introduced random testing in the mid-1970s, followed by most Australian states by the mid-1980s, and then New Zealand and approximately half of European Union countries.
- 3.52.** Random breath testing is generally recognized as one of the most cost effective road safety measures. For example, a 2004 World Health Organization study reported that each dollar spent on random testing results in a cost saving of \$19.<sup>74</sup> Similarly, a New Zealand study found the cost-benefit ratio was 1:14 for random testing alone (i.e. for every \$1 spent on random testing, the overall savings were measured to be \$14), 1:19 for random testing coupled with a media campaign, and 1:26 for random testing with both a media campaign and “booze buses” (large, specially equipped vehicles used for evidentiary breath testing, which are typically very distinctive in order to attract the attention of nearby road users).<sup>75</sup>

**Administrative licence suspension or revocation**

- 3.53.** A further tool that can be considered in the enforcement of BAC laws is immediate revocation or suspension of the driver’s driving licence (also known as administrative licence suspension or revocation). Such an administrative sanction is currently available in the USA and Canada upon failure of a breath test. This sanction pre-supposes that a BAC limit is in place. According to one study, such a policy (with immediate sanction) can reduce the likelihood of being involved in a fatal, alcohol-related crash by 5%. It affected drivers at all BAC levels. Laws mandating licence suspension

67 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

68 Peek-Asa C (1999) The effect of random alcohol screening in reducing motor vehicle crash injuries (structured abstract). *American Journal of Preventive Medicine* 16 (1 supplement): 57–67.

69 Shults RA, Elder RW, Sleet DA *et al.* (2001) Reviews of evidence regarding interventions to reduce alcohol-impaired driving (Brief record). *American Journal of Preventive Medicine* 21 (4 supplement): 66–88.

70 Henstridge J, Homel R, Mackay P (1995) The long-term effects of random breath testing in Adelaide. In Kloeden CN and McLean AJ Editors. *Proceedings of the 13th international conference on alcohol, drugs and traffic safety*. 13–18 August 1995. Adelaide, Australia: International Council on Alcohol, Drugs and Traffic Safety.

71 Tippetts AS, Voas RB, Fell JC *et al.* (2005) A meta-analysis of .08 BAC laws in 19 jurisdictions in the United States. *Accident Analysis & Prevention* 37 (1): 149–61.

72 Townsend, Achterberg F & Janitzek T *Traffic Law Enforcement across the EU: An Overview*. European Transport Safety Council (ETSC), 2006.

73 Tay R, “General and Specific Deterrent Effects of Traffic Enforcement” (2005) 39 *Journal of Transport Economics and Policy* 209.

74 Peden M, *World Report on Road Traffic Injury Prevention*. Geneva: World Health Organization, 2004.

75 T. Miller, M. Blewden & J. Zhang, “Cost savings from a sustained compulsory breath testing and media campaign in New Zealand”. 2004. 36 *Accid. Anal.*



penalties *after* conviction had little effect, and did not appear to be an effective deterrent.<sup>76</sup>

- 3.54.** Another study<sup>77</sup> showed that administrative licence revocation laws were associated with a 5% reduction in overall mortality and a 5% reduction in alcohol-related crash fatalities. A further study reported that administrative licence revocation was associated with an 8.6% and 10.6% reduction in alcohol-related fatal accidents.<sup>78</sup> A model of the effect of administrative licence revocation legislation, taking into account variables for the business cycle, mileage travelled and demographic characteristics, also showed significant reductions in alcohol-related crash fatalities.<sup>79</sup> However, administrative licence revocation usually has a BAC limit as a criterion, so the authors say the results should be 'properly interpreted as a partial effect conditioned on the existence of a BAC law'.
- 3.55.** NICE concluded that there is sufficiently strong evidence from good and high quality studies to show that administrative licence suspension can help reduce road traffic injuries and deaths; though proper regard would need to be had to human rights concerns.

### Evaluation of the high risk offender scheme

- 3.56.** The High Risk Offender (HRO) scheme is described in Chapter 2. One of the criteria for entry is when a driver is convicted for being more than 2 ½ times over the drink drive limit. For the current BAC limit of 80 mg/100 ml that equates to having a BAC over 200 mg/100 ml. At this BAC, NICE<sup>80</sup> have calculated that the relative risk (based on Maycock's study as described earlier in paragraph 3.31) of a driver dying in a drink-related accident is 501 times that of if they had not been drinking. If the legal limit were reduced to 50 mg/100 ml, this would equate to the HRO 'entry' BAC being 125 mg/100 ml. At this BAC, the corresponding relative risk would be 49 times.
- 3.57.** A study<sup>81</sup> into the effects of the high risk offender programme found that about 30% of high risk offenders re-offend over a subsequent period of 5 to 7 years. This is double the number for 'ordinary' offenders. The high risk offenders were equally likely to reoffend during and after disqualification from driving. Reconviction rates are lower for those high risk offenders who were originally convicted with a blood alcohol level over 200 mg/100 ml than for the other high risk offenders. These results show that the criteria for a high risk offender are to a certain extent, successful in predicting re-offending. However, they do not show that sanctions for high risk offenders

76 Wagenaar AC, Maldonado-Molina MM (2007) Effects of drivers' licence suspension policies on alcohol-related crash involvement: long-term follow-up in forty-six states. *Alcoholism: Clinical & Experimental Research* 31 (8): 1399–406.

77 Villaveces A, Cummings P, Koepsell TD *et al.* (2003) Association of alcohol-related laws with deaths due to motor vehicle and motorcycle crashes in the United States, 1980–1997. *American Journal of Epidemiology* 157 (2): 131–40.

78 Kaplan S, Prato CG (2007) Impact of BAC limit reduction on different population segments: a Poisson fixed effect analysis. *Accident Analysis & Prevention* 39 (6): 1146–54.

79 Freeman D (2007) Drunk driving legislation and traffic fatalities: new evidence on BAC 08 laws. *Contemporary Economic Policy* 25 (3) 293–308.

80 NICE correspondence – May 2010.

81 Davies GP and Broughton J (2002) Criminal and motoring offences of drink-drivers who are High Risk Offenders. TRL Report 551.

are successful in preventing re-offending or that the scheme is successful in preventing drinking and driving by potential high risk offenders.

### Drink driver rehabilitation courses

- 3.58.** Rehabilitation for drink drivers has been used in Great Britain since 2000. This voluntary scheme offers those who complete an approved course a reduction in their disqualification of up to 25% in line with provisions in the law described in Chapter 2. The effects of rehabilitation courses have been studied on the basis of driver reconviction rates. Reconviction rates of drink drivers have been found to be lower for those who attended courses than for those who did not.<sup>82</sup>
- 3.59.** In 2008 in Great Britain, 63,481 drink driving offenders attended courses although only about half of these offenders actually completed their course. The Magistrates' Court Sentencing Guidelines advise that offering referral to a course should be part of the routine consideration for Magistrates in England and Wales.<sup>83</sup> Equivalent sentencing guidelines for Scotland are planned following a recent consultation on the matter. In Great Britain in 2008, approximately 60-65% of drink driver offenders were referred to courses.<sup>84</sup>

### Understanding attitudes, behaviours and motivation of people who drive after drinking

- 3.60.** Research suggests that drinking alcohol and driving cars are both cultural norms that have a powerful grip on some people. They are firmly embedded in daily and weekly routines and in the way some people think and see the world. For those who combine them, "the stereotype of the 'drink driver' is no longer a helpful mirror".<sup>85</sup> Immoderate drink drivers are not concentrated, as some earlier work has assumed, among young males; nor are they necessarily clinically alcohol dependent. They do not all reject the social norms on this issue but fail to comply with them in practice. The problem minorities, who are of wider concern for those combating immoderate drinking, include:
- 'outlaws' – who get drunk and drive without regard for legal limits and guidelines; and
  - 'ostriches' – who drive over the limit much more than they think but blame circumstances and other people.
- 3.61.** There are also some normally responsible people who lapse on impulse. These drivers are from all social classes, various ages and both genders. If driving and drinking are important to them (and they often are), they will do both with few compunctions. Neither group measure their consumption effectively or regulate their behaviour by reference to any limit – either for legal or other personal reasons.

82 Inwood C *et al.* Extended monitoring of drink-drive courses. Final Report. 2007. TRL Report 662.

83 Magistrates' Court Sentencing Guidelines. Sentencing Guidelines Council. Aug 2008. Available at: [http://www.sentencing-guidelines.gov.uk/docs/magistrates\\_court\\_sentencing\\_guidelines\\_update.pdf](http://www.sentencing-guidelines.gov.uk/docs/magistrates_court_sentencing_guidelines_update.pdf)

84 Correspondence with Department for Transport. Apr 2010.

85 Sykes W *et al.* A qualitative study of drinking and driving: Report of findings. Department for Transport. Feb 2010.

- 3.62.** The study's authors concluded that the key to abating the problem of drink driving is to change the behaviour of those who drive impaired so that fewer of them do so and less often and less impaired. The emerging evidence identifies a body of people whose behaviour is entrenched and – because they are not measuring their consumption – perhaps not easily influenced by legal limits. However, the authors were reassured that there is evidence from other countries that tightening the policy can yield a long-term change, provided it is properly backed by enforcement and education.

### Alcohol education

- 3.63.** Alcohol education is discussed as a means to improve the public awareness of the dangers of alcohol, including 'safe' drinking and the general relationship between alcohol, impairment and driving law. The longstanding message from the Department for Transport's *THINK!* campaign on drink driving has been "Don't drink and drive".
- 3.64.** The Department of Health is educating the public about alcohol intake and its impact on health, including potentially harmful effects through increased accidents and injuries. But it is not clear how much the public use the information available. For example, although most drinkers have heard of measuring alcohol consumption in units, only 13% keep a check on the number of units they drink.<sup>86</sup> A recent comparison<sup>87</sup> of HM Revenue and Customs data with the results of the General Household Survey indicated that the actual amount of alcohol being sold is 67%<sup>88</sup> higher than the self-reported information on drinking habits. This may suggest that people may be drinking more than they think they are.
- 3.65.** There also appears to be limited knowledge of driving limits. In a recent Eurobarometer survey, when asked if they knew the legal BAC limit for drivers, the majority of UK respondents replied "don't know" to this question.<sup>89</sup> Recent research<sup>90</sup> of individuals' attitudes and motivations related to drinking and driving highlighted a widespread ignorance, misunderstanding and misconception about the amount of alcohol in different drinks, the effects of alcohol on drivers and the legal limit for driving. The authors concluded that this "represents both a considerable barrier to behaviour change for the well-intentioned and a loophole for those with more feeble or inconsistent resolve – and simply a vacuum for the unaware or disengaged". The researchers concluded that individuals probably break the law more than they would if they were better informed and had a better understanding of these factors.
- 3.66.** Older research suggests that, while there may be a common belief that people will drink "up to the limit" if they are told how much they can drink and remain under the limit, in fact, for the vast majority of social, moderate drinkers, this is untrue. "Most people drink to achieve a desired state and

86 ONS (2006) Drinking: adults' behaviour and knowledge in 2006. Omnibus Survey report No 31.

87 Safe. Sensible. Social. The next steps in the National Alcohol Strategy. Department of Health, Home Office. 2007.

88 Department of Health. Correspondence May 2010.

89 European Commission (EC) 2007a: Attitudes towards alcohol. Special Eurobarometer.

90 Sykes W *et al.* A qualitative study of drinking and driving: Report of findings. DfT Road Safety Research Report 114. Feb 2010.

stop. They balance their consumption against its elimination and are uncomfortable when they exceed their desired state. These drinkers tend to be very cautious about driving afterwards. Telling them they can have another drink and still be legal to drive would not cause them to drink more. There is another group of drinkers who believe they are safe to drive after consuming large amounts of alcohol – i.e. they underestimate the effect of their drinking.” The author concluded that it is possible that the drinking and driving behaviour of the latter group can be altered with accurate and reliable information.<sup>91</sup>

### International comparison

- 3.67.** According to the NICE Review, reducing the legal BAC driving limit is an effective drink driving deterrent and there is a clear trend, especially in Europe, towards introducing a 50 mg/100 ml limit.<sup>92</sup> However, it is not just the overall blood alcohol limit that matters but the use of other interventions and enforcement. Other interventions include lower BAC limits for young, learner, probationary and professional drivers (sometimes called ‘zero tolerance’), and a range of enforcement measures, particularly random breath testing and more consistent and intensive enforcement in general.
- 3.68.** European citizens (including drivers) appear to support drink driving policies already in force, as well as proposals to extend them. The same is true of UK citizens. However, UK citizens are less likely than other Europeans to know what the legal BAC limit is, and are among the least likely to have had their BAC level checked. In common with drivers in other countries that do not permit random breath testing, UK drivers are likely to think that they will never be checked.

## Applications and implications of science

### Breath testing devices – Non-evidential, fixed evidential and portable evidential

- 3.69.** The first practical device for the analysis of alcohol in human breath was developed in the USA in the mid-1950s. The Breathalyzer® instrument gained wide acceptance and was used in traffic law enforcement by police officers in the USA, Canada and Australia over many years.<sup>93</sup> The Breathalyzer® provided a non-intrusive way to determine the driver’s BAC although European nations showed no interest in this method for forensic purposes and instead determined alcohol in blood as evidence for prosecution of drunken drivers. Interest in Europe in evidential breath-alcohol testing arose in the 1980s when more compact, automated and reliable instruments became available.
- 3.70.** Until now, roadside breath testing devices used by the police in Great Britain have been used for screening purposes only. Should the result of the initial screening breath test provide an indication that the driver’s BAC exceeds

91 Beirness DJ (1987). Self-estimates of blood alcohol concentration in drinking-driving context. *Drug and Alcohol Dependence* 19: 79-90.

92 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

93 Wigmore JW, Langille RM. *Can J Forensic Sci J*, 42 (Six generations of breath alcohol testing instruments: changes in the detection of breath alcohol since 1930: a historical review) 276-283 (2009).

the legal limit, the driver may be arrested and taken to a police station for a further, evidential breath test. As explained in Chapter 2, the Traffic Act provides a power also to administer an evidential breath test at, for example, the roadside, but such a portable device is not yet available.

- 3.71.** The Forensic Science Service (FSS) is responsible for developing the design specification that instruments will be required to satisfy in order to be approved, by the Home Office, for use under the Traffic Act, the so-called 'type approval'. The policy is guided by the Home Office Public Order Unit and the Road Crime Section.

### Statutory option

- 3.72.** When the lower of the two results of the evidential breath alcohol test falls between 40 and 50 mcg/100 ml the suspect is given the option to accept the result or to provide a specimen of blood (or urine) for forensic analysis of its alcohol content. If the statutory option is taken the breath test results becomes null and void and cannot be used as evidence against the suspect. The reason stemmed from the fact that evidential breath testing was a new concept in the UK in 1983 and that every attempt was made to ensure that a person should not be disadvantaged by a breath test compared with the position if a blood sample had been taken<sup>94</sup> to ensure public confidence and a concern about the blood breath ratio.
- 3.73.** In 2009, the two main laboratories used by police forces in England and Wales conducted a total of 16,099 laboratory tests (on blood and urine samples) to measure the alcohol concentration of people suspected of drink driving. While the majority of these tests were related to the statutory option provision, the number also includes a small number of tests conducted for reasons such as the evidential breath test device was unavailable for use, or the subject initially blew a sample with an "Interfering Substance" message. 14,142 samples were of blood; of which 73.9% were reported as 'not being less than 81 mg/100 ml' (i.e. over the legal limit for driving) while the remaining 1977 samples were of urine, of which 68.9% were reported as 'not being less than 108mg/100 ml' (i.e. over the legal limit for driving). Police forces in Scotland use the Scottish Police Forces Authority Forensic Services laboratories which do not routinely collate data on the number or results of blood and urine alcohol samples processed.

### *The blood breath ratio*

- 3.74.** The underlying scientific reason for the statutory option primarily relates to the varying relationship between the BAC and the breath alcohol concentration. The concentration of alcohol in breath is approximately 2000 times less than in an equal volume of blood which means that, in any comparison between the two, the concentration in breath must be multiplied by a factor, the blood breath ratio (to be known as 'the ratio'). The ratio was originally thought to be 2100:1 when the Breathalyzer<sup>®</sup> was approved for use in the USA and Canada to give readings in terms of

<sup>94</sup> Jones AW. The relationship between blood alcohol concentration (BAC) and breath alcohol concentration (BrAC): a review of the evidence. Commissioned by DfT 2010. (As yet unpublished.)

estimated BAC.<sup>95</sup> However, after studies in the 1970s showed considerable variation of the ratio both between and within individuals, different countries adopted different ratios. The UK's Home Office adopted a ratio of 2300:1 when the statutory breath alcohol concentration was set.<sup>96</sup>

- 3.75.** Around the time when the statutory breath limit was set, studies showed that people with a ratio less than 2300:1 were disadvantaged by taking a breath test compared with the position if they had given a specimen of blood for analysis. Information from the Paton Report<sup>97</sup> suggested that 26% of offenders would be disadvantaged when a ratio of 2300:1 was used to set the statutory breath alcohol concentration limit. If a ratio of 2000:1 was used to set the UK's breath alcohol concentration limit, only 0.5% of suspects would be disadvantaged compared with a blood test. To allow for both the varying ratio and any instrument error, the actual prosecution limit was set at 40 mcg/100 ml (instead of enforcing the statutory limit of 35 mcg/100 ml) which effectively corresponds to a *de facto* ratio of 2000:1 (rather than the 2300:1 ratio implied in the law in this country). The Paton Report concluded that the variability of the ratio (or factor as it was referred to) justified the allowance of 4 mcg/100 ml over the 35 mcg/100 ml limit and the option of giving a blood (or urine) sample for a suitable range above 40 mcg/100 ml.
- 3.76.** By enacting separate statutory limits for blood (80 mg/100 ml), breath (35 mcg/100 ml) and urine (107 mg/100 ml), no priority was given for one body fluid over the other in any individual case of drink driving. It is, therefore, a matter of convenience as to which specimen the suspect provides under the circumstances of the offence. It has been suggested that no attempt should be made to convert a breath alcohol concentration into a BAC or vice versa because the blood breath ratio is not known at the time the testing is done.<sup>98</sup>
- 3.77.** Other countries have used a different way to tackle the issue of the variable ratio; they have used a lower ratio. The lower the ratio used, e.g. 2000:1 as compared to 2300:1, the lesser the advantage to the blood-tested suspect compared to those who submit to a breath-test. This is because the average ratio in drink drivers (around the world) is 2400:1.<sup>99</sup> For example, a ratio of 2000:1 is used in Austria, France and Spain (where the corresponding breath alcohol concentration and BAC are 25 mcg/100 ml and 50 mg/100 ml respectively). A ratio of 2100:1 is used in Germany, Scandinavian countries, Australia, Canada and the USA.

95 Borkenstein RF, Smith HW. The Breathalyzer and its applications, *Med Sci Law* 1 (1961) 13-23.

96 Emerson VJ, Holleyhead R, Isaacs MD, Fuller NA, Hunt DJ. The measurement of breath alcohol. The laboratory evaluation of substantive breath test equipment and the report of an operational police trial, *J Forensic Sci Soc* 20 (1980) 3-70.

97 Cobb P, Dabbs M. The Paton Review: Report on the performance of the Lion intoximeter 3000 and the Camic Breath Analyser evidential breath alcohol measuring instruments during the period 16 April 1984 to 15 October 1984. 1985.

98 Jones AW. The relationship between blood alcohol concentration (BAC) and breath alcohol concentration (BrAC): a review of the evidence. Commissioned by DfT 2010. (As yet unpublished.)

99 Jones AW. The relationship between blood alcohol concentration (BAC) and breath alcohol concentration (BrAC): a review of the evidence. Commissioned by DfT 2010. (As yet unpublished.)

## Urine blood alcohol concentration ratio

- 3.78.** Since the 1930s, the use of urine predated the use of blood or breath as a biological way to estimate the concentration of alcohol in the body although, as scientific advances were made, blood and subsequently, breath alcohol concentrations were favoured as the main means of estimating blood alcohol concentrations. However, a number of studies started to show the potentially wide variation between the urine and blood alcohol concentrations in individuals and there were a number of legal challenges relating to this in the USA in the 1960s. As a result, in Great Britain, it was stipulated that 107 mg alcohol per 100 ml urine was equivalent to 80 mg alcohol per 100 ml blood, which meant that a urine:blood alcohol concentration ratio of 107/80 or 1.33:1 was adopted for legal purposes.<sup>100</sup>
- 3.79.** In practice, apart from the initial stipulation of the limits for alcohol in urine and blood, this ratio is rarely used in practice because the main use of conversion between different bodily samples occurs between breath and blood as is the case with the statutory option as described above. It has therefore been recommended that no attempt should be made to convert a urine alcohol concentration into a BAC or vice versa.<sup>101</sup>

## Alcohol ignition interlocks

- 3.80.** Breath alcohol ignition interlocks are used in much of the USA and Canada and have been trialled in Australia and Sweden. Managed programmes, involving the use of interlocks, are generally used for repeat offenders, either as an alternative to disqualification or to follow a disqualification. However, even mandatory interlock programmes suffer from low participation rates. Experience suggests that though such devices are effective while in use, drivers revert to offending once they are removed. Better results have been experienced where a programme is closely supervised and supplemented by educational interventions including counselling.<sup>102</sup>

## Issues and opinions

### The case for a reduced blood alcohol limit

- 3.81.** The case for a reduced blood alcohol limit was made by the majority of those organisations which responded to the consultation. These included the AA, Scottish Health Action on Alcohol Problems, the Association of Chief Police Officers (ACPO), the Association of Chief Police Officers in Scotland (ACPOS), the British Medical Association (BMA), Transport for London, Professor Lewis Ritchie, the Scottish Executive, the London Borough of Camden, Thames Valley Police and the Faculty for Forensic and Legal Medicine. The Royal College of Nursing (RCN) were also in support of a reduced BAC limit in giving evidence to the Review. Subsequently, at their Annual Conference,

<sup>100</sup> Jones AW. Urine as a biological specimen for forensic analysis of alcohol and variability in the urine-to-blood relationship. *Toxicol Rev* 2006; 25 (1): 15-35.

<sup>101</sup> Jones AW. Urine as a biological specimen for forensic analysis of alcohol and variability in the urine-to-blood relationship. *Toxicol Rev* 2006; 25 (1): 15-35.

<sup>102</sup> Beirness *et al.* An investigation of the usefulness, the acceptability and impact on lifestyle of alcohol ignition interlocks in drink driving offenders. DfT, Road Safety Research Report No 88. Nov 2008.

RCN members voted that their Council consider adopting a zero BAC limit as the official RCN lobbying position on drink driving.<sup>103</sup>

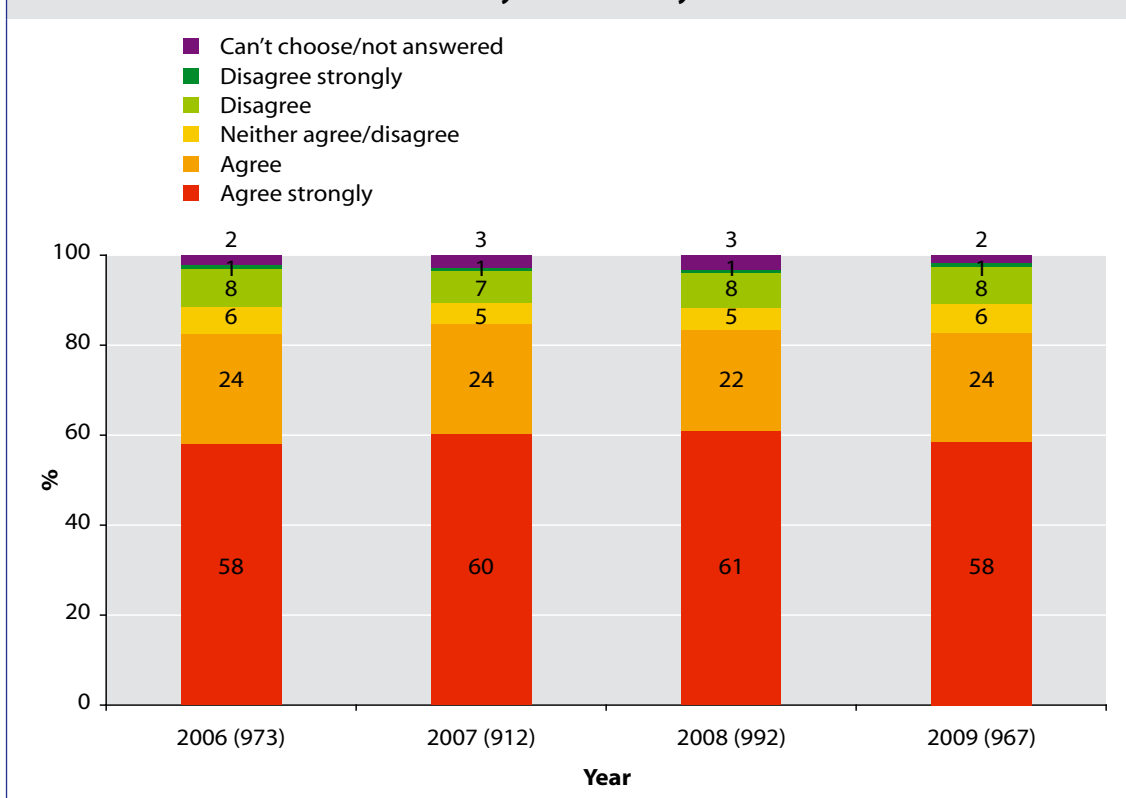
- 3.82.** Those in favour cited the expected casualty savings as the main motivation with Professor Richard Allsop citing his revised estimates of casualty reductions – 43 deaths and 280 serious injuries avoided annually – resulting from a move to a 50 mg/100 ml limit. The British Beer & Pub Association queried Professor Allsop’s earlier estimates citing the critique by Dr John Maloney. Professor Allsop subsequently explained that Dr Maloney’s concerns had been taken into account in revising the casualty estimates which he put to the Review. However, others also cited the public support for a 50 mg/100 ml limit and the fact that the vast majority of European nations now had a limit of 50 mg/100 ml or less.
- 3.83.** Exceptions included the Association of British Drivers, Roadsafes and some of the drinks industry, who were concerned about the perceived disproportionality of a 50 mg/100 ml limit, the fact that those well over the current limit were the greatest problem and the “morning after trap” penalising at 50 mg/100 ml those who had drunk and not driven the night before. The Institute of Advanced Motorists felt that there might be justification for a change, but that it would make sense to wait for two years to allow analysis of the new data available from the police’s new digital breathalysers to assess the accident liability of drivers in the range 50 mg/100 ml to 80 mg/100 ml.
- 3.84.** The Gin and Vodka Association felt that a “continued focus” on three elements – the existing limit, robust enforcement and effective anti drink driving campaigns – was the right approach, having proved effective and that this was preferable to “focussing on the blood alcohol level alone”.
- 3.85.** The British Social Attitudes Survey has, for a number of years, included questions on drinking and driving. Its 2009<sup>104</sup> survey contained three questions relevant to this Review. The first asked for views on a statement that “If someone has drunk any alcohol they should not drive”. Eighty-three per cent of respondents agreed with this statement, with 58% agreeing strongly. Chart 3.9 shows the trend in responses to this question over the last four years.

103 RCN Conference 2010. Motion 13: That this meeting of RCN Congress urges Council to lobby for legislation which reduces to zero the permissible level of alcohol intake before driving.

104 British Social Attitudes survey, 2009, unpublished.



Chart 3.9: 'If someone has drunk any alcohol they should not drive'



Source: National Centre for Social Research<sup>105</sup>

**3.86.** There was consideration, by those who commented, of the case for a 20 mg/100 ml limit for all drivers (a practical 'zero' limit), but most felt that this would be too great a change for the public to accept. The Royal Society for the Prevention of Accidents (RoSPA), for example, felt that it was "certainly not achievable in a single leap from the current limit of 80 mg/100 ml". Brake and Direct Line Insurance, on the other hand, considered 20 mg/100 ml to be the appropriate limit, coming into line with the 'don't drink and drive' message.

### The case for a different blood alcohol limit for driver sub-groups

**3.87.** The Review took a good deal of evidence on the issue of whether to apply a lower drink drive limit, 20 mg/100 ml, to two sub-groups of drivers, but for different reasons. There was a conviction in some quarters that it was right to place a lower limit on young or novice drivers, given their disproportionate association with drink drive casualties. There was also a desire from some to see a lower level applied to classes of professional drivers – drivers for hire or reward of buses, coaches and taxis/mini cabs, and HGV drivers. This was in particular because of their professional duty to protect their passengers.

#### Young drivers/novice drivers

**3.88.** Many stakeholders, such as the Advisory Council on the Misuse of Drugs, made a case for a risk-based measure to apply a lower limit to the young or novice drivers. They argued that it would help to educate new drivers as

<sup>105</sup> British Social Attitudes survey. Unweighted base: all respondents completing self completion module B (indicated in brackets).

they came into the system and instil sensible behaviour in the first years of driving. The BMA argued for such a rule on the basis of the “strong evidence” from international sources of the beneficial effects of lowering the alcohol limit below 50 mg/100 ml for newly qualified drivers.

- 3.89.** Some groups, such as UK Youth, saw no case for a lower limit for the young or novices, feeling that there should be more positive measures to persuade and educate that group instead. Others, such as the British Vehicle Rental and Leasing Association (BVRLA), were opposed to different limits for different classes of drivers and some, such as ACPO, drew attention to the benefits of the simplicity and clarity of the current regime, with its single limit for all with a single minimum period of disqualification.
- 3.90.** RoSPA were concerned about the ‘cliff edge’ effect of drivers reaching an age threshold and believing that they could then drink more and drive. RoSPA and ACPO also observed that there was currently no certain means to check a driver’s age or licence at the roadside, since there was no legal obligation to carry a licence.

#### *Professional drivers*

- 3.91.** By contrast, RoSPA did see a case for a lower limit for professional drivers, if justified by “an analysis of the proportion of crashes who had been drinking alcohol”. The Magistrates’ Association for England and Wales<sup>106</sup> thought that this “could be justified for HGV drivers because of the damage that a heavy vehicle may do if out of control, and for bus and coach drivers for similar reasons and for the protection of their passengers”. Professor Allsop from University College London noted that we have stricter lower limits for other professionals, for example airline pilots, and that it would be consistent to extend it to this group.
- 3.92.** A number of respondents, including the Justices’ Clerks’ Society (England and Wales), commented that the courts do take into account such drivers as the Magistrates’ Court Sentencing Guidelines would consider this as an aggravating factor when sentencing. The Magistrates Association noted that there was no data about how often these aggravating factors are used in sentencing and the degree to which they are taken into account by the courts.
- 3.93.** The relevant trade bodies were not persuaded of the case for a special rule. The Confederation of Passenger Transport felt that the practice of alcohol testing in the bus and coach industry and the threat of a driver losing their job was sufficient deterrent and that the very low levels of drink driving in this class of drivers reflected that. The Licensed Private Hire Car Association felt that “either you are safe to drive or you are not safe to drive” and that there should therefore be a single limit for all. The British Vehicle Rental and Leasing Association agreed, saying that a separate lower limit for professional drivers, “could make enforcement complicated and we would suggest one limit should apply to any category of driver”.

<sup>106</sup> Where the matter has been considered by the Magistrates Association committee, then the committee view is given. In other cases it was the personal view of the attending representative; the timescale having made it impractical to circulate the questions to the committee.

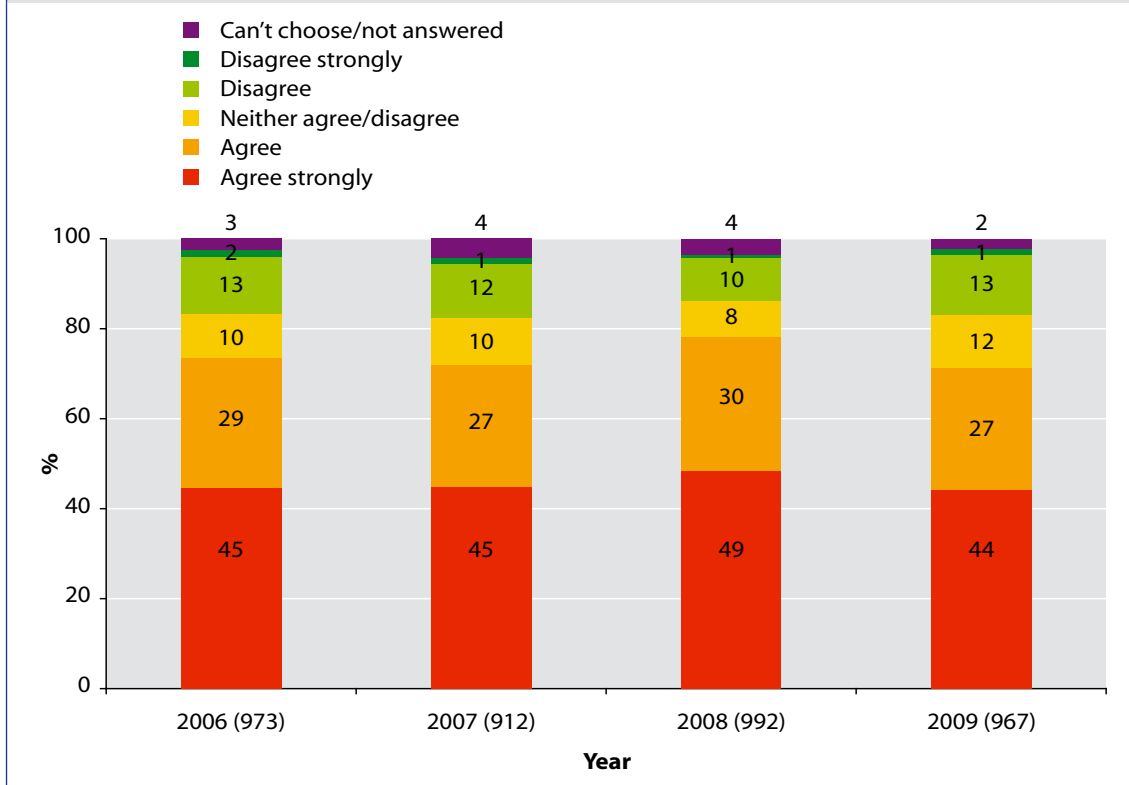
### The appropriate penalties

**3.94.** The Review received views on a number of existing and potential penalties for drink driving, though almost nothing on fines.

#### Disqualification

**3.95.** The British Social Attitudes Survey<sup>107</sup> provides an instructive backdrop on this issue, asking for views on the statement, 'Anyone caught drink driving should be banned for five years'. Seventy-one per cent agreed, down 7% since 2008, while 15% disagreed. See Chart 3.10.

Chart 3.10: 'Anyone caught drink driving should be banned for five years'



Source: National Centre for Social Research

**3.96.** The AA conducted a poll of members through its 'Populus Panel' during the course of the Review.<sup>108</sup> This achieved a sample of more than 20,000 and included a question on the appropriate disqualification for a limit of 50 mg/100 ml. It explained that the current limit was 80 mg/100 ml, that the mandatory disqualification for a breach of that limit was 12 months and then asked if there should be a lower disqualification period of 6 months, the same period of 12 months, a higher disqualification period of more than 12 months or no disqualification but penalty points instead. Nearly half (49%) of respondents were in favour of the same 12 month period applying, 15% favoured a longer disqualification period, 17% a 6 month disqualification and 13% penalty points.

<sup>107</sup> British Social Attitudes survey, 2009, unpublished

<sup>108</sup> Populus interviewed 20,417 AA members online between 16th & 23rd February 2010.

**3.97.** Witnesses to the Review had diverse views on the issue of appropriate penalties at a lower limit. PACTS, for example, felt that a mandatory disqualification at a lower limit would be too harsh, favouring 6 penalty points instead. The AA meanwhile was of the view that “breaking the drink drive law should result in disqualification”, RoSPA felt that the 12 month driving ban should continue to apply at a lower limit and ACPO was “strongly against the introduction of any ‘non-disqualification sentencing option’”. The Scottish Executive shared this view.

#### *Administrative licence suspension*

**3.98.** Other nations operate a system of administrative licence suspension in which a driver who fails an evidential breath test is subject to the immediate suspension of their driving licence.

**3.99.** An important advantage claimed for administrative licence suspension is that it enables the immediate imposition of a significant punishment from the driver’s point of view, thereby reinforcing the deterrent effect of drink driving measures related to legal BAC limits. The disadvantage is that it might be seen to assume a position of guilt before the case has come to court – contrary to a key principle of the criminal justice system.

**3.100.** While defendants in Great Britain who plead guilty are dealt with by the courts in a timely fashion with the mandatory driving ban imposed promptly, the same is not the case for those defendants who plead not guilty. It is understood from District Judges that bail conditions banning driving are rarely applied, even in more serious cases relating to a suspected drink driving incident involving a fatality or serious injury. As a result, there are instances where drivers pleading not guilty (but who are subsequently found guilty of an offence such as ‘causing death by drink driving’) may continue driving for many months after the incident. RoadPeace drew attention to a case in which a young man was killed by a driver found to be over twice the legal alcohol limit. The driver continued driving for 18 months before he was convicted of causing death by dangerous driving.

**3.101.** However, a reason for not applying bail conditions which prohibit driving is that this period with no driving cannot be offset against any subsequent penalty applied when the case is finally heard in court and there is concern about the fairness of the whole process.

**3.102.** The AA included in its Populus Panel survey<sup>109</sup> a question on administrative licence suspension: ‘Would you be in favour of a policy that would see the immediate suspension of a person’s driving licence where that person fails a breath test?’ 68% of respondents were in favour and 21% against.

**3.103.** NICE concluded that there is sufficiently strong evidence from good and high quality studies to show that administrative licence suspension can help reduce road traffic injuries and deaths. It may well also be the case, however, that administrative licence suspension is a particular disincentive to drink driving in those countries where there are not routine lengthy disqualifications as a penalty for breaching the blood alcohol limit.

<sup>109</sup> Populus interviewed 20,417 AA members online between 16th & 23rd February 2010.

In Great Britain, the minimum 12 month disqualification is clearly seen as the greatest deterrent.

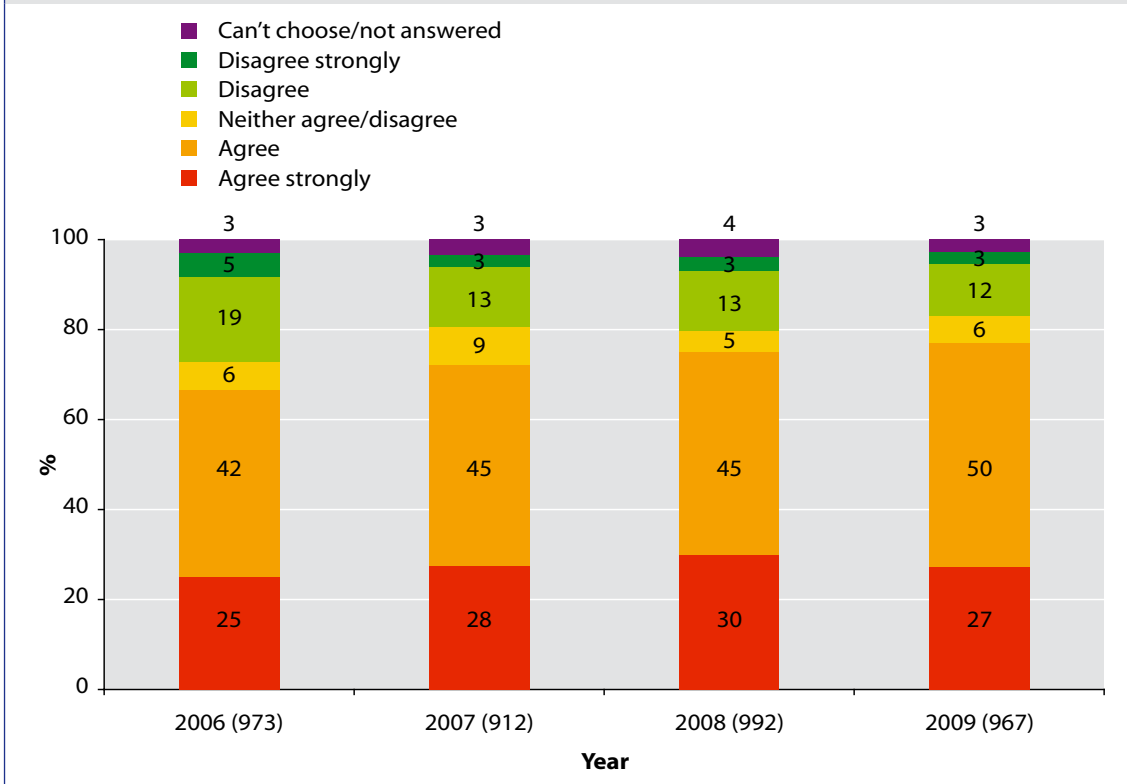
### *Alcohol ignition interlocks*

- 3.104.** There was concern among consultees including the AA that a scheme for offenders might give those who could afford to fund the interlock the benefit of a discounted disqualification, whilst denying the opportunity to those who could not afford it, and without evidence that participation achieves a long-term change in a drink driver's behaviour. Many consultees were also worried about the potential to work around the device, for example, by getting somebody else to provide the breath sample. The RAC Foundation suggested that such devices were prone to abuse.
- 3.105.** The RAC Foundation was, however, among a number of consultees who saw potential benefits for interlock use in fleets. Fleet interlock programmes, such as have been recently introduced by National Express, operate in several countries through conditions of employment for professional drivers. They do not suffer the complications with monitoring offenders and there is little incentive and less potential for others to connive in working around the devices, by providing a sample on behalf of the driver, for example.

### **Information and education**

- 3.106.** There was appreciation among consultees for the efforts which had gone into campaigning against drink driving over many years. The effectiveness and research basis of the *THINK!* campaigns were highly regarded.
- 3.107.** The British Vehicle Rental and Leasing Association, for example, told the Review that "the *THINK!* campaign has been successful in educating people that drink driving is socially unacceptable ... The message now needs to be developed to influence and change the behaviour of the hardened drink driver who has his own limit for how much he can drink and thinks he will not get caught".
- 3.108.** However, there was one aspect of information and campaigning that regularly arose in discussions with interest groups: the level of information which should be provided to the public about how much alcohol could be consumed without infringing the blood alcohol limit.
- 3.109.** The British Social Attitudes Survey has investigated this issue. Seventy-seven per cent of respondents agreed that most people don't know how much alcohol they can drink before being over the legal drink drive limit (see Chart 3.11).

**Chart 3.11: Most people don't know how much alcohol they can drink before being over the legal drink drive limit**



Source: National Centre for Social Research

- 3.110.** The issue arising from these views is whether there should be more education as to the amount of alcohol that could be safely consumed prior to driving. The AA's poll<sup>110</sup> of its Populus Panel included a question on this issue: "The message on alcohol and driving has for many years been 'Don't drink and drive'. Given this, should people be advised on how many drinks they can have without infringing the legal alcohol limit for driving?" Respondents were split on this, with 55% feeling that people should be advised and 42% that they should not.
- 3.111.** There was a common perception among witnesses that part of the success of the drink drive law in this country was that people are confused about how much they can legally drink and therefore frequently underestimate how much alcohol they can consume and still remain legally within the limit. This results in an unexpected benefit; this level of ignorance actually protects the majority of the public on the basis that it provokes a very cautious response from the public to drinking and driving. This approach can be contrasted with the general approach to public health issues of seeking to provide people with a good deal of information on issues such as eating, drinking, smoking and exercise.
- 3.112.** There was some concern that, even if the public could be advised of accurate 'safe' quantities of alcohol, the protective benefit of ignorance would be lost. However, as demonstrated in a recent television programme,<sup>111</sup> individual

<sup>110</sup> Populus interviewed 20,417 AA members online between 16th & 23rd February 2010.

<sup>111</sup> "Police, Camera, Action!": Optomen Productions, aired Feb 2010.

metabolism and other variables make offering general advice about 'safe' alcohol consumption (and the resulting blood alcohol concentrations) very difficult.

- 3.113.** This lack of understanding about alcohol also contributes to the perception of the possibility of a 'morning after trap' – a concern described by various consultation witnesses. There was concern that people who had taken care to avoid driving on a night out where they had been drinking might find themselves over the limit during the next day.

### Breath testing devices

- 3.114.** The Department for Transport recently funded police forces in England and Wales to buy newly-approved memory-equipped roadside screening devices capable of collecting data electronically on the age and gender of drivers; the date, time, day of the week of the test; the reason for testing and the test result. This had hitherto been recorded manually, the new devices thus allowing the collection of better data.
- 3.115.** Since 2005, the police have had the power<sup>112</sup> to require evidential breath specimens elsewhere than at a police station. This allows the possibility of evidential breath testing at hospitals, at the roadside or even, where the circumstances are right, in a person's home. This can help speed up the procedure, remove the need for FPs to attend all hospital cases (in order to take evidential blood samples) and avoid the necessity in appropriate cases of having to take all such drivers to a police station. However, to date, this wider allowance in the law has not been able to be used and police have continued to use the non-evidential roadside breath testing devices.
- 3.116.** The Forensic Science Service (FSS) is currently developing the design specification that mobile evidential testing instruments will be required to satisfy for the scientific and practical demands of 'type approval' and for use under the Traffic Act. The availability of specific devices will nevertheless still be dependent on manufacturers submitting devices for testing and approval in the light of the perceived market. It is hoped that these new devices will be available in 2011. There was criticism of the length of time this type approval process was taking, with Professor Richard Allsop, for example, suggesting that the process had "been incomprehensibly prolonged".

### Levels of enforcement

#### *Police priorities*

- 3.117.** The vast majority of those who gave evidence to the Review in writing or face-to-face were convinced that, regardless of what happened to the blood alcohol limit, the law on drink driving needed to be enforced with more vigour. PACTS were among those who felt that the police would give greater priority to enforcement action against drink driving if it were included in the 'Offences Brought to Justice' which police forces in England and Wales have to report on and which form the basis of the Government's Public Service Agreement. There is no such regime in Scotland.

<sup>112</sup> See section 7 of the Traffic Act, as amended by section 154 of the Serious Organised Crime and Police Act 2005.

*Level of breath testing*

**3.118.** A number of witnesses, including PACTS, drew attention to the relatively low level of breath testing per driver in the UK, as compared with other nations, with less than 2% of drivers being tested in 2008 as against around 50% in Sweden and Norway. Many respondents made the point that such a low expectation of being tested made many drivers feel able to take a chance to drink and drive.

*Random breath testing*

**3.119.** In discussions with ACPO and individual police officers on breath-testing powers, it was clear that they saw current powers as almost sufficient to allow for 'random' breath testing of drivers. The combination of the power to stop any vehicle and the power to require a breath test:

- (a) in the event of an accident;
- (b) in the event of a moving traffic offence;
- (c) on suspicion that a driver is impaired by alcohol;

leaves police officers with very broad powers to test.

**3.120.** Yet two strong arguments were made for the extension of those powers. First, it was suggested that roadside checkpoints for drink driving, in which all drivers were required to provide a breath specimen, were unlawful under this combination of powers and that the ability to conduct such checks would provide a useful deterrent. Secondly, it was suggested that the ability honestly to tell the public that any driver could be breath tested at any time would provide a powerful deterrent and help to overcome the lack of fear of detection of those who drink drive at present. It was notable that 79% of AA members responding to a Populus Poll<sup>113</sup> in 2010 were in favour of the police being able to breathalyse a driver at any time.

**3.121.** However, many questioned whether 'random' was the right word for wider testing policies, since they should be targeted on the problem and led by intelligence. So, for example, targeting times of day, times of year, streets or establishments which might be associated with a problem would be an appropriate and efficient use of police resource. Genuinely random breathalysing was unlikely to be productive or sensible.

**3.122.** Very few of the consultation respondents opposed wider powers of breath testing. Of those who were concerned, the Criminal Bar Association was concerned about the proportionality of the approach. The balance of opinion, both in written representation and among those who gave evidence in person, was heavily weighted in favour of wider police powers. The British Beer and Pub Association was typical, saying "The industry supports the efforts of the authorities to enforce the law regarding drivers over the limit and we fully support the introduction of random breath testing."

<sup>113</sup> Populus interviewed 20,417 AA members online between 16th & 23rd February 2010.



## The statutory option

- 3.123.** The statutory option is explained fully in Chapter 2. It allows for those providing an evidential breath test of between 40 mcg/100 ml and 50 mcg/100 ml the chance to provide an alternative sample in blood or urine. Opinion of consultees on the statutory option was, in the vast majority, opposed to its being retained. Of written respondents, 28 were in favour of it being removed and 5 opposed. Of those who gave oral evidence, there was no outright support for the statutory option, there being a sense that testing equipment had been proved accurate and that the fact that the police would not, in any event, prosecute for a breath reading below 40 mcg/100 ml gave sufficient margin for error.
- 3.124.** In the main, this was because the statutory option was associated with the introduction of evidential breathalyser technology, at a time when there was a good deal less faith in the quality of breathalyser equipment to give accurate readings. The arguments against tended to depend on that lack of trust in the equipment.
- 3.125.** A few respondents, such as the BMA and Professor Richard Allsop, picked up on the fact that the other reason for the introduction of the statutory option was because of a concern about the variability of the relationship between breath alcohol levels and blood alcohol levels in different individuals. Their concern was that, before the option was removed, it was important to be sure that the blood test generally confirmed the breath test reading.
- 3.126.** The Review received evidence from the FSS and LGC (formally the Laboratory of the Government Chemist on drink-drive blood and urine samples tested for the police in their laboratories during 2009. The majority of these would have been submitted to the laboratories because the statutory option had been exercised, though there would also be some cases involving those unable to give a breath test for medical reasons and cases where it was not possible to get an accurate reading from an evidential breath test.
- 3.127.** Various consultees expressed concern that some people who elect to take the statutory option do so in the hope of delaying the process and thus benefiting from any subsequent further metabolism of alcohol from their body. Taking the details of the samples from the two laboratories in combination, just over a quarter of the blood samples and just over 30% of the urine samples tested contained alcohol at levels below the legal limit for driving. It is not clear how much delay was experienced before blood and urine samples were taken and there is no accompanying back-calculation of alcohol concentration to better reflect concentrations at the time of the being stopped by the police. While these figures suggest a not insignificant proportion of people being found to have a BAC below the legal limit, the vast majority of those who have their blood or urine tested have a BAC above the limit.
- 3.128.** The FSS also suggested that an approach to this issue might simply be to specify the legal blood, breath and urine levels for alcohol and decide whether to charge on the basis of the first valid evidential result obtained.

## High Risk Offenders

- 3.129.** There was concern among some of those providing evidence that High Risk Offenders – those who posed the greatest risk – were not as severely punished as they might be. It was suggested, for example, that vehicles of repeat offenders should be seized and RoadPeace welcomed the use in Scotland of powers to seize vehicles of drink drivers. It was also proposed that there should be a lower threshold for the imposition of a lifetime ban; that driving while disqualified should be made an offence triable either way to allow the Crown Court in England and Wales to impose a harsher sentence where appropriate. It was also suggested that it would assist in deterring drink drivers if the significant penalties which are associated with reoffending were publicised more.
- 3.130.** A number of rehabilitative measures were also proposed. For example, it was suggested that the statutory provision requiring medical proof of fitness to drive before a licence was restored should be implemented and the BMA suggested that there should be better systems for dealing with underlying alcohol dependency.

## Relationship with the Government’s wider strategy on alcohol

- 3.131.** Policies on drink driving need to be seen in the context of the Government’s broader policies on alcohol control as set out in 2007 in ‘Safe, sensible, social’.<sup>114</sup> The strategy’s overall goal is to minimise the health harms, violence and antisocial behaviour associated with alcohol, while ensuring that people are able to enjoy alcohol safely and responsibly. Its main focus is on a minority of drinkers, defined as those who cause the most harm to themselves, their communities and their families: young people aged under 18 who drink alcohol; binge drinkers aged 18–24, a minority of whom are responsible for the majority of alcohol-related crime and disorder; and drinkers who are causing harm to their health. ‘Safe, sensible, social’ thus echoes, and places in a wider context, policy proposals on drink driving.

## Wider impacts of any change

- 3.132.** The BMA were among those who pointed out the wider benefits of a reduced alcohol limit for public services and the commercial sector, through reduced road casualties. They drew attention to benefits for healthcare services, the criminal justice system and for productivity and profitability in the commercial sector.
- 3.133.** There were concerns expressed about the impact of a reduced blood alcohol limit on the drinks industry. The British Beer and Pub Association was particularly concerned about the impact on rural pubs, saying that drivers would be reluctant to go out to pubs which involved driving and would be reluctant to go for meals in groups where the driver could not drink. The Association said, “Lowering the BAC limit will therefore have significant impact on footfall in rural food-led pubs resulting in loss of sales across all areas, but especially food”. Their concern was heightened because of the particular reliance of many pubs on food to maintain their profitability. The

<sup>114</sup> Department of Health/Home Office (2007) Safe, sensible, social: The next steps in the national alcohol strategy. London: Department of Health.

Association went on to calculate that if one-third of those currently arriving at pubs by car chose not to go, pubs would lose £624 million a year. This was hugely significant, they said, because pubs were closing at the rate of 39 per week. The consequent loss of duty would also impact upon the Exchequer. This concern for pubs, and rural pubs and their place in rural life, was shared by others in the industry who gave evidence to the Review, with the Federation of Licensed Victuallers Associations, for example, writing in very similar terms. An alternative view came from the Academy of Medical Royal Colleges and Faculties in Scotland suggested that drivers “may be more likely to drink soft drinks” which “would increase profits for pubs as the profit margin is much higher for soft drinks”. Another respondent thought that “Premises serving alcohol should be obliged to serve non-alcoholic drinks at much lower prices than they currently do, and offer a wider range of non-alcoholic drinks”.<sup>115</sup>

- 3.134.** A number of respondents commented on a scheme, part of the Department for Transport’s new driver friendly initiative that aims to reward drivers who refrain from drinking alcohol and driving.<sup>116</sup> The British Institute of Innkeeping noted that some retail chains do offer free soft drinks to designated drivers but that this is less widespread where the establishment is tenant or licensee run. The Federation of Licensed Victuallers Associations pointed out that, currently, the designated driver “can still enjoy, and remain within limits, an enjoyable glass of wine or beer with their meal”. They were concerned that, if the legal limit was lowered, this option would no longer be available and that there would be a knock on effect for the business sector with people deciding to stay at home instead. The charity, UK Youth, noted that young people were aware of the scheme as it had been well-publicised. However they urged caution over it being thought of as the perfect scheme. They noted that young people, on the whole, tend to be spontaneous so, despite their best intentions at the outset, may not always manage to keep to their original plan not to drink and drive. Initially, the designated driver may be content to abstain from drinking but then, feeling left out of the fun, decide to join in and thereby, no longer be able to drive the group home safely.

115 Respondent, C Ward

116 The 2009 Designated Driver Initiative was sponsored and funded by Coca Cola Enterprises Ltd. At participating pubs, customers who were driving and who said they were a Designated Driver could claim a free Coca-Cola or diet Coke.

# Chapter 4: Drink driving – Conclusions and recommendations

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## Introduction

- 4.1. This chapter contains the Review’s conclusions and recommendations in relation to drink driving. The recommendations are based on and take account of the evidence, opinions, written and oral representations and visits that have informed the Review.

## Improving the evidence

- 4.2. As observed in Chapter 3, approximately 70% of coroners and procurators fiscal provide information about blood alcohol concentration in road traffic fatalities which contributes to the annual figures of road deaths due to drink driving. However, this is done on a voluntary basis as there is no statutory requirement to do so.

- 4.3. In England and Wales, the Coroners & Justice Act 2009 and the creation of the new judicial office of Chief Coroner offer an opportunity to reconsider the Coroner role and the purpose of coroner commissioned post-mortem examinations. These could enable mandatory testing of road fatalities for alcohol, whether through requirement by the Lord Chancellor for the Chief Coroner to cover the issue in his annual report or by the Chief Coroner emphasising the need for alcohol testing of road fatalities in the guidance to be issued to coroners. The Review welcomes the ongoing consultation on the Coroners and Justice Act 2009 which will consider these options. At present, there does not appear to be any evidence of an intention to change the responsibilities or powers of procurators fiscal in Scotland.

**Recommendation (1): The Ministry of Justice and the new Chief Coroner should ensure that coroners routinely test for, and provide data on, the presence of alcohol in road fatalities. The Scottish Executive should ensure that similar action is taken by procurators fiscal in Scotland.**

## Interventions

- 4.4. The interventions that have been considered by the Review fall broadly into three categories:
- lowering the legally prescribed alcohol limit;
  - reforming the associated penalty regime; and
  - improving the current process of enforcement of drink driving legislation.

## The prescribed blood alcohol limit

- 4.5. The Review has considered lowering the current drink drive limit of 80 mg of alcohol per 100 ml of blood (80 mg/100 ml). Consideration has been given to lowering the limit to 20 mg of alcohol per 100 ml of blood (20 mg/100 ml) and to 50 mg of alcohol per 100 ml of blood (50 mg/100 ml). These options

raise a number of different issues and the Review has therefore considered them separately.

### Lowering the current blood alcohol limit from 80 mg/100 ml to 20 mg/100 ml

- 4.6. As paragraph 1.23 sets out, a blood alcohol concentration (BAC) limit of 20 mg/100 ml is effectively a zero tolerance level. The NICE Report provides clear evidence that a person's ability to drive is affected after consuming any amount of alcohol. A driver who has a BAC of between 20 mg/100 ml and 50 mg/100 ml is at least 3 times more likely to die in a road traffic accident than a person who has no alcohol in their body.<sup>117</sup>
- 4.7. In consideration of this evidence, there is clearly merit and sense in a general BAC limit, applicable to all, of 20 mg/100 ml. It is also recognised that a limit of 20 mg/100 ml is consistent with the absolutely correct and necessary 'do not drink and drive message'. Indeed, a number of European countries including Sweden, Poland and Belgium have adopted a 20 mg/100 ml, or close to 20 mg/100 ml, BAC limit. The Review also noted with interest the vote in support of a 'zero tolerance' drink drive limit at the Royal College of Nursing's annual conference in April 2010.
- 4.8. Nevertheless, there is a lack of evidence to indicate that drivers with a BAC between 20 mg/100 ml and 50 mg/100 ml are a problem group in terms of the number of drink drive casualties and fatalities. This raises concerns as to whether a reduction in the limit to 20 mg/100 ml would be proportionate.
- 4.9. It is also necessary to acknowledge that a sudden reduction from 80 mg/100 ml to 20 mg/100 ml could have a detrimental effect on the currently high level of public support for and compliance with drink drive legislation in Great Britain, particularly in view of the issues regarding proportionality.
- 4.10. Furthermore, the success of the drink drive strategy and legislation in Great Britain is partially attributable to the tough sanctions for drink drive offences. In those countries, e.g. Sweden and Poland, which have introduced a 20 mg/100 ml limit, a contravention of the limit at that low level is considered to be a minor misdemeanour as reflected by the relatively trivial, and, in some cases, administrative, penalties, which are imposed, compared to the statutory minimum 12 month disqualification that applies in Great Britain. The introduction of a zero tolerance approach in Great Britain would certainly necessitate a graduated penalty scheme under which a contravention at 20 mg/100 ml would justifiably lead to a much less severe penalty. The Review finds concerns that such an approach could dilute the effectiveness of the current regime for little gain in terms of tackling the drink drive problem to be persuasive.
- 4.11. In view of these considerations, the Review has concluded that, whilst this may be a question for the future, such a general reduction is not something that is considered to be proportionate at present.

**Recommendation (2): The current prescribed blood alcohol limit in section 11(2) of the Road Traffic Act 1988 of 80 mg of alcohol per 100 ml of blood should not be reduced to 20 mg of alcohol per 100 ml of blood.**

117 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

## Lowering the current blood alcohol limit from 80 mg/100 ml to 50 mg/100 ml

- 4.12.** The current limit in Great Britain of 80 mg/100 ml has remained unchanged since it was first introduced in 1967. As stated in Chapter 3, studies have shown that impairment of driving related skills starts with any BAC over zero and that, by the time a BAC reaches 50 mg/100 ml, the majority of subjects studied showed significant levels of impairment.<sup>118</sup> Indeed, NICE reports that a driver with a BAC of between 50 mg/100 ml and 80 mg/100 ml is at least 6 times more likely to die in a collision than a driver who had not had consumed alcohol.<sup>119</sup>
- 4.13.** Research evidence of impaired driving was considered at the time that the 80 mg/100 ml limit was set in 1967,<sup>120</sup> but the adoption of that level must be considered against the public attitude towards drinking and driving at that time which, despite the appalling numbers of deaths and serious injuries which were being caused by drink driving, was unrecognisable in contrast to the intolerance towards and social unacceptability of such behaviour today. As such, whilst significant impairment was understood to be present at 50 mg/100 ml and over, the limit of 80 mg/100 ml was considered to be an acceptable and appropriate compromise.
- 4.14.** Great Britain is almost the only European country to continue to have a BAC limit above 50 mg/100 ml. It is, however, unhelpful to draw direct comparisons between Great Britain and other European nations as our penalty regime is considerably tougher than the regimes of many other countries with a lower limit. For example, Great Britain, the Netherlands and Sweden have the lowest numbers of road traffic fatalities per head of population<sup>121,122</sup> yet the BAC limits, enforcement, penalty regimes and cultural and ethical attitudes regarding drink driving practice vary considerably between these countries. That said, it is relevant that the European Commission has called for a harmonised limit of 50 mg/100 ml across Europe and, whilst Britain led the way in introducing drink drive limits, enforcement and legislation in the 1960s, our 80 mg/100 ml limit is now inconsistent with the more recently implemented trend worldwide towards a lower limit. Studies have shown that countries (European and worldwide) that have reduced the BAC limit from 80 mg/100 ml to 50 mg/100 ml have seen an overall reduction in fatalities and injuries attributable to drink driving.<sup>123</sup> In addition, there are also obvious benefits in reducing the difference between drink drive limits between Great Britain and our European neighbours, both for British drivers travelling abroad and for incoming European drivers.
- 4.15.** As was shown in Chart 3.5 and paragraph 3.13, in 2007, approximately 35% of drivers killed had been drinking some alcohol. The number of drivers killed with a BAC over the current limit was approximately 18% of all drivers

118 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

119 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

120 Department of the Environment Report. Drinking and Driving. Blennerhassett F *et al.* HMSO 1976.

121 Department for Transport. Reported Road Casualties Great Britain: 2008 Annual Report. 2009.

122 Department for Transport. A Safer Way: Consultation on Making Britain's Roads the Safest in the World. 2009.

123 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

killed in road traffic accidents.<sup>124</sup> Drivers killed in road traffic accidents who had been drinking but who were under the limit i.e. with a BAC between 10 mg/100 ml and 80 mg/100 ml stood at 17% of the total number of drivers killed and so-called 'border-line' drink drivers killed with a BAC of between 80 mg/100 ml and 100 mg/100 ml made up just over 2% of all drivers killed. Opponents of proposals to reduce the current BAC limit of 80 mg/100 ml argue that a reduction in the limit would only affect those law abiding drivers who currently stay within the limit and who will adjust their drinking accordingly and a few of the 'border-line' drink drivers, rather than the problem group of drivers who drive well in excess of the 80 mg/100 ml limit. The Review accepts that there are people who drive with a BAC in excess of 100 mg/100 ml whose behaviour is unlikely to be influenced simply by a reduction in the limit. These driver deaths represented approximately 16% of all driver deaths. However, there is convincing evidence to indicate that lowering the BAC limit would affect the behaviour of some drivers at all BAC levels, including those drivers who drink heavily and in excess of the current 80 mg/100 ml limit.<sup>125</sup>

- 4.16.** Furthermore, even if the direct effect of a lower limit were to be confined to drivers who currently drive with a BAC between 10 mg/100 ml and 100 mg/100 ml (which may include drivers who intended to keep within the 80 mg/100 ml limit but failed to properly estimate their BAC and who can reasonably be expected to try to keep within a 50 mg/100 ml limit), this group of drivers amounts to 50% of all deaths amongst drink drivers and is far from insignificant.<sup>126</sup> The potential to influence about half of the number of driver fatalities by lowering the current BAC limit to 50 mg/100 ml is very persuasive, more so when one also considers the number of passengers, pedestrians and other road users killed or injured which, it could be reasonably considered, would benefit from the change in driver behaviour.
- 4.17.** The estimates of the potential for a lower limit of 50 mg/100 ml to save lives vary. On the one hand, Professor Richard Allsop estimates, with conservative assumptions, that 43 lives could be saved in Great Britain annually,<sup>127</sup> NICE on the other hand makes more ambitious estimates,<sup>128</sup> based on the experience of research conducted in Europe and in Australia. NICE applies their model to all road traffic casualties in England and Wales rather than just those reported as drink drive-related. Based on the Albalade study of European countries, although without a defined time horizon, 77 – 168 lives could be saved each year in England and Wales whereas, based on the Australian experience, 144 lives could be saved after the first year in England and Wales, progressively increasing by the 6<sup>th</sup> year to a total of up to 303 deaths avoided. These estimates for England and Wales take no account of the possible casualty savings for Scotland. It should be noted that Scotland represented 7% of all drink drive-related casualties in Great Britain in 2008.

124 Department for Transport. Reported Road Casualties Great Britain: 2008 Annual Report. 2008

125 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

126 Professor Richard Allsop, University College London. Written evidence to the North Review. 2010.

127 Professor Richard Allsop, University College London. Written evidence to the North Review. 2010.

128 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

- 4.18.** It is important not to ascribe too great a degree of accuracy to these figures; they are estimates necessarily based on a variety of assumptions. Nevertheless, they provide a helpful indication that the lives to be saved annually from a reduction in the BAC limit to 50 mg/100 ml would be numbered in their tens and possibly in their hundreds. The estimates consistently suggest too that hundreds of serious injuries would be also saved which the Review considers to be very significant.
- 4.19.** Evidence shows that there is a lack of awareness and understanding amongst the public in the whole of the United Kingdom of what the legal BAC limit is, with only 9% knowing what the maximum limit is compared with the European average of 51%, 58% in the Netherlands and 72% in Sweden.<sup>129</sup> However, there is a further problem of understanding what the limit actually means, which is very difficult when one considers that the amounts and measurements in which drinks are served and consumed are not easily converted by the average drinker into units of alcohol, let alone into microgrammes and milligrammes of alcohol in breath or blood. It is also recognised that providing useful and sound public advice on how many drinks the limit equates to is not only difficult to reconcile with the Government's 'do not drink and drive' message but cannot be anything other than anodyne and cautious in view of the fact that a person's ability to absorb alcohol into the bloodstream can be affected by so many different variables such as the physical build of the drinker, the strength of the drink and when it is consumed. However, the marked difference in the understanding of these issues between United Kingdom citizens and our European neighbours is a concern and indicates that greater public awareness and education is needed.
- 4.20.** The Review recognises that the balance between the official message and public advice is difficult, if not impossible, to strike as part of a responsible road safety policy. This dichotomy is illustrated further by the results of investigative journalism<sup>130</sup> in the public domain which, although not hard science, indicate that the current BAC limit of 80 mg/100 ml enables many drivers to consume an amount of alcohol that causes significant impairment whilst remaining under the legal limit. This is also borne out by anecdotal evidence from the police and corresponds to the evidence that the majority of people will show significant levels of impairment at 50 mg/100 ml. Clearly, if the current limit enables some drivers to consume far in excess of what would be considered to be a 'safe' amount of alcohol for road safety purposes, not only is the Government's difficulty in providing helpful and accurate advice further compounded, but, more significantly, it indicates that the current limit is far too high to be safe to drive.
- 4.21.** The Review is aware that there is some concern that a reduction in the BAC limit may have implications for businesses and trades within the hospitality, entertainment and leisure industries. The Review sought the views of the British Beer and Pub Association, the Wine and Spirit Trade Association and the British Institute of Innkeeping. It also considered submissions from

<sup>129</sup> NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

<sup>130</sup> Police Camera Action, ITV documentary, broadcast 2010



the Scottish Whisky Association, the Gin and Vodka Association and the Federation of Licensed Victuallers Association.

- 4.22.** The Review acknowledges that there is solid support for and promotion of the 'do not drink and drive' message throughout the drinks and hospitality sector and welcomed the evidence of good practice and training in relation to drink drive awareness that exists across the sector. The Review also acknowledges the high level of support that was expressed by the industry for increased and specifically targeted police enforcement, including that targeted at their members' venues and premises and for wider education and public awareness campaigns.
- 4.23.** Notwithstanding this support, there was an obvious, but nonetheless valid, concern expressed by many of the representatives from this sector, particularly the pub and innkeeping bodies, that a reduction in the BAC limit from 80 mg/100 ml to 50 mg/100 ml could well have a detrimental impact on a trade that is already under strain. Furthermore, the industry felt that such a change did not target those drivers who are the real cause for concern, i.e. those who drive in excess of the current limit.
- 4.24.** The Review does not consider that reducing the BAC to 50 mg/100 ml will, in itself, have a widespread detrimental impact on the sector. Indeed, in relation to manufacturing, production and retail members of the trade, any increased tendency of people to drink at home would have a positive impact on sales, although the Review has not heard evidence that a change in behaviour amongst significant numbers of drinkers would occur. The Review does acknowledge, however, that such an intervention may affect some individual businesses but considers that this is more likely to be as a result of a combination of other general economic, social or legislative factors or due to issues such a location and facilities that are peculiar to specific premises.
- 4.25.** As indicated at paragraph 4.12, the current BAC limit of 80 mg/100 ml is high enough to allow some drivers to be considerably impaired and yet remain under the drink drive limit. Whilst a limit of 50 mg/100 ml is necessarily considerably lower than 80 mg/100 ml, it is not a zero tolerance approach. Accordingly, the Review does not consider that a change to 50 mg/100 ml would lead to those customers that the trade and industry are most concerned about, namely the responsible driver who wishes to enjoy a drink to accompany their pub meal or have a glass of wine or a pint of beer without being in danger of breaking the law, no longer considering the pub or similar venue as a worthwhile destination.
- 4.26.** Furthermore, the Review considers that there are steps and measures that the industry can continue to implement and promote which would help to encourage situations in which the person who is driving does not drink. The Review welcomed the operation of the Best Bar None award scheme<sup>131</sup> and similar best practice benchmarks and felt that it would be particularly

<sup>131</sup> The Best Bar None website describes The Best Bar None as an awards scheme for licensed premises, currently running in over 80 locations across the UK. Best Bar None schemes provide an incentive for the operators of licensed premises to improve their standards of operation to the level of a commonly agreed national benchmark.

desirable for the measures such as the Designated Driver Scheme<sup>132</sup> and inner city night time safety schemes and the like to be rolled out nationwide and for the cost and range of non-alcoholic drinks to be improved.

- 4.27. The Review has received strong support for a BAC limit of 50 mg/100 ml from the majority of consultees to the Review. There is also evidence to indicate that the public mood is supportive of the current limit being reduced to 50 mg/100 ml. The number of deaths and serious injuries that such a change would avoid is, even on the more conservative estimates, very considerable.

**Recommendation (3): The current prescribed blood alcohol limit in section 11(2) of the Road Traffic Act 1988 of 80 mg of alcohol in 100 ml of blood should be reduced to 50 mg of alcohol in 100 ml of blood and the equivalent amounts in breath and urine.**

**Recommendation (4): The drinks, hospitality and night-time entertainment industry should promote and operate measures and best practice across Great Britain that encourage and facilitate situations where the person who is driving abstains from drinking.**

#### Driver sub-groups: Lowering the current blood alcohol limit from 80 mg/100 ml to 20 mg/100 ml for specific groups of drivers

- 4.28. The Review has considered whether particular interventions are required for two distinct groups of drivers. These groups are (a) drivers of public service vehicles (PSVs), taxis, private hire vehicles and heavy goods vehicles (HGVs) and (b) young or novice drivers.

##### *Taxis and private hire vehicles, PSV and HGV drivers*

- 4.29. The Review and, indeed, many of the consultees, consider PSV and taxi drivers to be a special category of driver because of the element of carriage for hire or reward involved in their use. This factor places a higher level of responsibility and duty of care towards the public, and particularly their passengers, on those drivers. This is already, correctly the Review has concluded, reflected, in England and Wales, by the Magistrates' Court Sentencing Guidelines (the Guidelines) where driving for hire or reward whilst under the influence of alcohol carries a higher level of culpability and can be an aggravating factor in sentencing.
- 4.30. Similarly, the Review considers that HGV drivers can also be distinguished from other road users on account of the size and weight of such vehicles and the high risk that any collision involving an HGV which does occur will have serious consequences. Again, this is also reflected in the Guidelines where driving an HGV can be an aggravating factor in drink drive cases for sentencing purposes and, again, the Review has concluded that this is correct.
- 4.31. The Review is encouraged by the zero tolerance attitude and self-enforcement measures that have been implemented by many employers

<sup>132</sup> The 2009 Designated Driver Initiative was sponsored and funded by Coca Cola Enterprises Ltd. At participating pubs, customers who were driving and who said they were a Designated Driver could claim a free Coca-Cola or Diet Coke.

across much of the passenger transport industry in relation to drink and drug driving. Of specific note was the installation of interlocks by National Express, the random workplace alcohol and drug testing that many employers conduct and the strict approach to relicensing that some private hire licensing authorities have towards drivers who are convicted of a drink driving (or, indeed, drug driving) offence.

- 4.32.** Many of these measures reflect the position across other transport industries which, save for the aviation industry, are also implemented through employment conditions rather than legislation. However, the strong emphasis on safety and the positive steps that are being taken rely on individual licensing authorities, operators or employers and are not applied consistently or universally across the industry.
- 4.33.** Of drivers involved in accidents in 2008, the percentage of taxi and private hire drivers, bus or coach drivers and HGV drivers who failed a breath test following the accident was 0.6%, 0.4% and 0.6% respectively compared to 3.8% of car drivers.<sup>133</sup> Whilst these figures are not themselves indicative of a very serious problem in relation to these types of drivers, neither are they negligible and they must be considered against the background that those drivers that failed a breath test did so notwithstanding the random testing or other employer led interventions that may have been in place and, perhaps more startlingly, the additional risk to the driver of losing their job and occupation.
- 4.34.** The Review's consultation responses indicated that there was a very high level of support for a sub-category for drivers for carriage or reward and HGV drivers, but, given the relative lack of propensity of these drivers to drink and drive compared to the general population and the higher professional and court penalties applied, the Review does not see a convincing case for a lower limit. However, the Review considers it to be highly desirable that interventions such as contractual conditions relating to drink (and drug driving) and testing, the use of interlocks in coaches and the approach of licensing regimes towards drink and drug drive offenders are applied uniformly across the various sectors.
- 4.35.** The Review has also considered the role of traffic commissioners. They are responsible for issuing public passenger vehicle licences and for exercising functions relating to the conduct of applicants for, and holders of, longer goods vehicle driver's licences and passenger carrying vehicle licences. In this role, they may be of significance in implementing such interventions.

**Recommendation (5): There should not be a lower prescribed blood alcohol limit of 20 mg of alcohol per 100 ml of blood for drivers of HGVs, PSVs or taxis and private hire vehicles.**

**Recommendation (6): Drink driving offences in breach of the proposed lower blood alcohol limit of 50 mg of alcohol per 100 ml of blood committed when driving any HGV, PSV or private hire vehicle should continue to be an aggravating factor in the Magistrates' Court Sentencing Guidelines and in any future Scottish sentencing guidelines.**

<sup>133</sup> Reported breath tests and breath test failures, by road user type: 2008 Great Britain, STATS 19

**Recommendation (7): Best practice on drink and drug driving interventions, including interlocks, and employer guidelines should be rolled out throughout the transport industry.**

*Novice or young drivers*

- 4.36.** A separate limit for novice or young drivers has proved to be a more complex issue. Younger drivers, in particular, are hampered by a lack of experience and a propensity to take risks or feel over confident. It appears that youth and inexperience have a multiplying effect in combination with the inherent risk of drinking alcohol and driving. The statistics present a stark picture. The relative risk to drivers between the ages of 17 and 24 of being involved in a fatal collision whilst impaired by alcohol is around six times what might be expected given the mileage that they drive. The risk that this group poses to persons other than drivers is also alarming; drivers in this age group are responsible for 41% of all KSI casualties that are the result of accidents caused by drink drivers.
- 4.37.** However, in considering the practical application of a separate limit, a number of concerns have arisen. First, there is the question of whether to frame any separate provision in relation to age or driving experience. The Road Traffic (New Drivers) Act 1995 already provides a precedent in relation to imposing a stricter regime on inexperienced drivers,<sup>134</sup> (25% of drivers subject to the New Drivers Act 1995 are over the age of 24) banning any driver who collects six penalty points in the first two years of holding a driving licence, and it would be possible to apply a similar approach. Yet, statistics are clear that the elevated risk in driving while impaired by alcohol spans the ages 17–24 and arguably 17–30. Special measures that continue for a period of at least 7 years become difficult to package as aimed at novice drivers. The Review is also aware of no other sphere of life in which the law imposes legal age limits so late in life.
- 4.38.** A further complexity is the relationship between the law and the ‘do not drink and drive’ message. A lower limit for younger drivers has the potential to produce a new generation of drivers, who, having only experienced a zero tolerance level, will continue to comply strictly with the message once that level no longer applies to them. Equally conceivable, however, is the proposition that such drivers feel encouraged or entitled to drink more once they reach the age at which the 50 mg/100 ml limit applies which is not a desirable result. Moreover, the ‘do not drink and drive’ message is arguably diluted by the suggestion that, once a driver reaches a particular age, they are permitted to drink considerably more before driving.
- 4.39.** An age-related limit also presents specific enforcement issues for the police. Whilst drivers in Great Britain are technically obliged to produce their driving licence on demand, the actual position that drivers are permitted to produce it subsequently at a police station results in there being in Great Britain no obligation to carry a driving licence at all times when driving. This gives rise to problems for officers in relation to identifying, at the roadside, whether a young driver is one to whom a 20 mg/100 ml or a 50 mg/100 ml limit applies. A change to the law to require driving licences to be carried

<sup>134</sup> See the explanation of the provisions of the Road Traffic (New Drivers) Act 1995 in Chapter 2.

at all times and to remove the ability for drivers to escape conviction if they subsequently produce their licence, would be an obvious way to address this, but the Review considers that such an intervention is a step too far for these purposes and is well beyond the scope of this Review.

- 4.40.** The Government has recently embarked on an overhaul of the driver training and testing system,<sup>135</sup> marking a shift from a system which emphasises teaching and testing practical skills and knowledge to one which gives greater consideration to attitudes and behaviour. This is a welcome development for tackling drink (and drug) driving among young people.
- 4.41.** The current theory test does not appear to give great consideration to drink and drug driving, but the Review believes that this should change and that the new pre-driver qualification being rolled out to the 14–16 year age group should also give good coverage to these issues.
- 4.42.** In consultation, the proposition in relation to young or novice drivers resulted in a much more mixed response than that for other issues. Whilst the Review can see a case for a lower BAC level for young or novice drivers based on the seriousness of the risks to young people, the Review considers that the difficulties currently outweigh the arguments in support of such a draconian measure at this time. Moreover, the international evidence summarised by NICE suggests that the greatest beneficiaries of introducing a 50 mg/100 ml limit would be young drivers – and more particularly young men – and those who are casualties at the hands of young drivers. It therefore follows that it is worth waiting to see the benefits of the new general limit prior to deciding whether to introduce a lower limit for young or novice drivers.

**Recommendation (8): There should not be a lower prescribed blood alcohol limit of 20 mg of alcohol per 100 ml of blood for either young or novice drivers.**

**Recommendation (9): The Government should, after 5 years, review the impact of the new prescribed limit of 50 mg of alcohol per 100 ml of blood on young and novice drivers and, if the anticipated casualty reductions in that population do not materialise, consideration should then be given to introducing a limit of 20 mg of alcohol per 100 ml of blood for those drivers.**

**Recommendation (10): The reformed driver training and testing regime, including the new pre-driver qualification, should give greater emphasis to the dangers of drink and drug driving.**

### The statutory option and margins of error

- 4.43.** Where the lower of the two breath specimens provided by a suspect contains no more than 50 mcg/100 ml, the statutory option enables that person to opt to have their breath samples replaced by specimens of blood or urine. The Review has considered 3 alternatives in relation to the statutory option:

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<sup>135</sup> Department for Transport/Driving Standards Agency. Learning to Drive. May 2008.

- to retain it;
- remove it completely from the legislation; or
- to remove it but to allow for variations regarding the blood to breath ratio and the accuracy of the testing machinery.

**4.44.** The statutory option is one of three existing allowances built into the process of obtaining evidential specimens of breath, blood and urine to determine the amount of alcohol in the body. The Review's consideration of the case for the retention, or otherwise, of the statutory option, has necessarily also involved consideration of these other allowances.

*(a) The 40 mcg/100 ml threshold*

**4.45.** Since 1983, it has been agreed Association of Chief Police Officers and Home Office policy in England and Wales, and Crown Office policy in Scotland, not to prosecute anyone who has a breath alcohol reading of less than 40 mcg of alcohol per 100 ml of breath (40 mcg/100 ml)<sup>136</sup> despite the law providing that it is an offence to drive with a proportion of alcohol in the breath in excess of the prescribed limit of 35 mcg/100 ml.

**4.46.** The effect of this police and Home Office/Crown Office prosecution threshold has been that the statutory option is available to persons who have a breath alcohol reading between 40 mcg/100 ml and up to and including 50 mcg/100 ml. Such people will, therefore, already have a breath alcohol level of at least 5 mcg over the legal limit of 35 mcg/100 ml and will have benefitted from that prosecution threshold which aimed at ensuring that only persons with a breath alcohol reading clearly in excess of the prescribed limit are prosecuted.

**4.47.** The breath testing equipment used by police forces today is far more sophisticated and reliable than the equipment that was first introduced in the 1980s and which gave rise to the prosecution threshold policy. The Review has been informed that the equipment used now has a precision of 0.1 mcg and, in view of this, the Review has concluded that the current 4mcg/100 ml prosecution threshold is unjustifiably generous.

*(b) Laboratory margin of error*

**4.48.** When a specimen of blood or urine is provided for laboratory analysis, as a result of the statutory option being exercised by a suspect, because the suspect is medically unable to provide a specimen of breath or because the breath testing equipment is not available or functioning, an allowance is subtracted from the analysis of specimens of blood and urine samples by the laboratory of 6 mg/100 ml from specimens containing up to 100 mg/100 ml of alcohol and 6% from specimens containing over 100 mg/100 ml of alcohol. The purpose of this allowance is to safeguard the individual against any inaccuracies in the testing machinery.

**4.49.** The consequence of this subtraction is that a sample containing 83 mg of alcohol/100 ml of blood will be reported as being a blood alcohol

<sup>136</sup> Crown Prosecution Guidance. Road Traffic Offences: Drink Driving. Available at: [http://www.cps.gov.uk/legal/p\\_to\\_r/road\\_traffic\\_offences\\_drink\\_driving/](http://www.cps.gov.uk/legal/p_to_r/road_traffic_offences_drink_driving/) and Home Office Circular 1983/46

concentration of “not less than 77 mg of alcohol per 100 ml of blood” and no prosecution will be brought as the prescribed limit will not be deemed to be exceeded. Therefore, a specimen of blood or urine will in fact need to contain a minimum of 87 mg/100 ml and 114mg/100 ml respectively before a charge will be brought. In discussions with one of the large laboratories and Government scientists, it has been suggested to the Review that a margin of between 2 mg/100 ml (or 2%) and 3 mg/100 ml (or 3%) would provide adequate protection in relation to the accuracy of the testing machinery.

*(c) The statutory option*

- 4.50.** The opportunity afforded by the statutory option for people whose lower breath specimen contains a breath alcohol level of no more than 50 mcg to opt to have it replaced with blood or urine provides persons in that category with a further allowance.
- 4.51.** Chapter 2 refers to the decision by Parliament that, with the introduction of the then new evidential breath testing equipment, the statutory option was considered to be a necessary precaution to address the concerns at that time as to the reliability of the new machines. To ensure public confidence in the new machines, it was considered important to offer people who were marginally over the limit the opportunity to provide a blood or urine sample which they could then have independently analysed.
- 4.52.** Though less discussed than the public confidence objective, the statutory option was also intended to address the scientific issues of individual variability in converting the ratio of alcohol in breath to that in blood. In Great Britain the ratio was, and is, set at 2300:1, i.e. 80 mg/100 ml of blood is assumed to be equivalent to 35 mcg/100 mg of breath.
- 4.53.** In considering the future need for the statutory option, the Review has been interested to find that it appears to be unique to Great Britain and Northern Ireland. The Review has also noted with great interest that the existence of allowances and margins of error in the evidential process (such as those set out in (a) and (b) above) varies considerably between jurisdictions with some, for example Canada, rounding the breath reading down to the nearest 10 – so 89 mg/100 mg becomes 80 mg/100 ml – whilst others, for example, Sweden and Poland, have no allowances in the system at all to compensate for any potential inaccuracies in the machinery.
- 4.54.** The breath to blood ratio and the conversion of the different levels is also an issue which is approached in different ways, with it not being something that is considered at all in Belgium. In Canada, the legislation refers only to the limit in blood and a (non-legislative) formula is applied to convert the reading from breath. The blood to breath ratio formula is also not universally consistent: for example a ratio of 2100:1 is used in Germany, Scandinavian countries, Australia, Canada and the USA. Notwithstanding the more generous ratio used in these countries, the Review is keen to stress, that any difference in approach, and in particular the absence of other further allowances in some countries, cannot be considered without regard to penalties, which in these jurisdictions are considerably more lenient than in Great Britain.

- 4.55.** Since evidential breath testing was introduced in 1983, technology has advanced and public confidence in the accuracy of breathalyser equipment has grown. Accordingly, the scope for legal challenge to the reliability of the equipment has declined, if not totally disappeared. The Review has heard evidence from the Association of Chief Police Officers, the Magistrates' Association, the Justices' Clerks' Society, the Association of District Judges and the Crown Prosecution Service that, whilst the scope for technical defences is limited, elements in the process that involve further steps or complexities, of which the statutory option is the prime example, increase the potential for procedural errors by the police and for technical defences to be raised.
- 4.56.** Of the approximately 16,100 people who qualified for the statutory option in 2009, the Review was advised<sup>137</sup> that approximately one quarter of blood and one-third of urine samples analysed result in a final blood or urine level that is below the prescribed limit. Some of these cases will be due to the laboratory allowance of 6 mg/100 ml (or 6%). Others will be as a result of the alcohol level in the body decreasing through metabolism during the time between the taking of the evidential breath sample and a forensic physician arriving to take the defendant's blood (although the Review acknowledges that where a specimen of urine is taken, there may be less of an issue regarding delay). Accordingly, many people who fall into the 40 mcg/100 ml to 50 mcg/100 ml category may consider that they have 'nothing to lose and everything to gain' by taking the statutory option because it allows for the possibility that they may benefit from the delay in the process that obtaining an evidential specimen of blood (or urine) often causes and which may result in their eventual reading being below the drink drive limit. The Review has heard evidence that the statutory option is not scientifically sound unless an allowance is also made for elimination of alcohol through metabolism between the times of sampling blood and breath.<sup>138</sup> The Review considers this to be neither satisfactory in terms of enforcement of the law nor consistent with the 'do not drink and drive' message.
- 4.57.** Moreover, the Review considers that the combined effect of the statutory option and the prosecution threshold of 40 mcg/100 ml is that the de facto ratio that is applied between 40 mcg/100 ml and 50 mcg/100 ml is in fact a more generous 2000:1 whereas the 2300:1 ratio applies to breath alcohol concentrations beyond 50 mcg/100 ml.
- 4.58.** Whilst the statutory option is partially aimed at addressing the difficulty is converting alcohol levels in breath to blood, the urine to blood ratio is considered to be even more variable,<sup>139</sup> highlighting that neither formula for converting the alcohol concentration in one type of specimen to another is perfect. The Review also considers that the current process that the statutory option creates gives undue primacy to the medium of blood or urine over breath. In fact all three are proxies for impairment of the central nervous system by alcohol which should be given equal weight. Against

137 LGC and FSS in correspondence with the North Review, 2010

138 Jones AW. The relationship between blood alcohol concentration (BAC) and breath alcohol concentration (BrAC) a review of the evidence. Commissioned by Department for Transport. 2010.

139 Jones AW. Urine as a biological specimen for forensic analysis of alcohol and variability in the urine-to-blood relationship. *Toxicol Review* 2006, 25(1);15-35.



that background and given that the law does not give preference to the prescribed limit in breath, blood or urine, the Review considers that there is a good case for referring only to the prescribed limit for the type of specimen in question without any regard for converting the level of one sample to another or the possible discrepancies that such conversion may give rise to between individuals.

- 4.59.** Furthermore, the Review is of the opinion that the effects of the 2300:1 ratio, the statutory option, the 40 mcg/100 ml prosecution threshold and the 6 mg/100 ml (or 6%) laboratory allowance give rise to a regime which is unjustifiably generous towards the offender and, further, that it is undesirable to have the selective application of precautions such as the statutory option; for instance, a person who is medically unable to use a breathalyser does not benefit from the statutory option. Where precautions or safeguards are considered necessary, the Review considers that the correct approach is to apply such measures indiscriminately to everyone and that the statutory option can no longer be justified.
- 4.60.** The Review recognises that provision for some margin of error is nevertheless required to ensure that sound decisions on prosecution are made. It is also the case that the research base relating alcohol to risk is based on blood alcohol concentrations and that there therefore needs to be a conversion of a new BAC limit to limits in breath and urine. Therefore the Review proposes that in determining a new breath alcohol limit, a more generous ratio of 2000:1 is used to counteract the natural variation in the blood/breath ratios and to address issues regarding the accuracy of breath testing machines. In view of the 0.1 mcg/100 ml level of precision in the evidential breath testing equipment, the Review considers that a new ratio of 2000:1 would negate the need for the current 40 mcg/100 ml prosecution threshold. This will result in the single, sizeable and consistent application of the 2000:1 ratio and margin of error to all suspects.
- 4.61.** The Review also agrees with the view of the laboratories and Government scientists that the current 6 mg/100 ml (or 6%) allowance used is unnecessarily high. One view was that an allowance of 2 mg/100 ml would be adequate. Another view was that 3 mg/100 ml would be more appropriate. The Review has concluded that in view of the proposal to apply a more generous 2000:1 blood to breath ratio in setting the prescribed limits, there should now be a lower allowance of 3 mg/100 ml.

**Recommendation (11): The statutory option contained in section 8(2) of the Road Traffic Act 1988 should be removed.**

**Recommendation (12): In establishing a new equivalent in breath to the blood alcohol limit of 50 mg of alcohol per 100 ml of blood, a ratio of 2000:1 should be used, giving an alcohol concentration limit of 25 mcg of alcohol per 100 ml of breath.**

**Recommendation (13): The laboratories should apply a lower allowance to the analysis of blood and urine specimens of 3 mg/100 ml (or 3%).**

**Recommendation (14): There should be no charging threshold applied to the new lower limit of 25 mcg of alcohol per 100 ml of breath. A person who drives or attempts to drive or is in charge of a motor vehicle on a road or other public place after consuming so much alcohol that the proportion of it is that person’s breath exceeds the prescribed limit in breath of 25 mcg of alcohol per 100 ml of breath commits an offence and should be charged, at that level.**

## Penalties for drink driving offences

### Penalties for an offence of driving above the prescribed limit of 50 mg of alcohol in 100 ml of blood

- 4.62. The application of penalties in relation to an offence under section 5(1) of the Traffic Act (the excess alcohol offence) for a reduced BAC limit of 50 mg/100 ml has been considered with close reference to the current framework of penalties rather than as part of a wholesale review of the penalty system. The Review is aware that the penalty toolkit available to the courts includes a large number of different penalty options involving various combinations of existing penalties, including disqualification, fines, community orders and imprisonment. The Review considers that the primary sanction in relation to drink and, indeed, drug driving is disqualification and has concluded that there are three principal penalty options to be considered in relation to a 50 mg/100 ml limit. These are:
- Mandatory endorsement of 6 penalty points for drivers with a BAC of 51 mg/100 ml up to and including 80 mg/100 ml for the first offence and mandatory disqualification for a period of between 6 and 12 months for a second offence and no change to the current penalty for drivers with a BAC of 81 mg/100 ml and above.
  - Not less than six months’ mandatory disqualification for drivers with a BAC of 51 mg/100 ml up to and including 80 mg/100 ml and no change to the current penalty for drivers with a BAC of 81 mg and above.
  - Not less than 12 months’ mandatory disqualification for drivers with a BAC of 51 mg/100 ml and above.
- 4.63. Consultees to the Review overwhelmingly advocated retaining a period of mandatory disqualification for exceeding a lower BAC limit of 50 mg/100 ml. This support for mandatory disqualification derives from the effectiveness that this sanction has had in changing driver behaviour in Great Britain, thus reducing the number of drink drive offences.
- 4.64. The Review notes that there is further public support for lengthy periods of disqualification for drink driving offences. Indeed, the British Survey of Social Attitudes cites 71% of people polled favouring a period of 5 years disqualification for drink-drive offences.
- 4.65. Many consultees expressed considerable concern that a less robust penalty that did not impose a period of disqualification, or which imposed a much shorter period of disqualification, for example 6 months, would dilute the ‘do not drink and drive message’, damage the effectiveness of the current regime and diminish the significant progress that has been made in Great

Britain in tackling drink driving. Many of the consultees stressed that the mandatory 12 month disqualification was the major deterring factor rather than the accompanying fine or other sanctions because of the serious implications of being unable to drive for at least 12 months. At best a driving ban is extremely inconvenient and costly for a person who only uses their vehicle for social or family purposes. At worst, the repercussions are disastrous for a person who drives for a living or has no alternative means of reaching their place of employment. Factors such as the impact of subsequent insurance premiums and, indeed, the element of social stigma are also significant consequences of disqualification that contribute to its deterring effect. The current 12 month minimum mandatory disqualification provides both an appropriate penalty and an effective deterrent to drink driving.

- 4.66.** Whilst acknowledging the effectiveness of the minimum 12 month disqualification period, there was some concern expressed to the Review by Dr Beirness that imposing such a penalty at a 50 mg/100 ml limit would increase the number of instances of driving whilst disqualified which itself is a problem. Similarly, the CPS were concerned that imposing too lengthy disqualification periods risked creating punishments that offenders felt they could never comply with.
- 4.67.** There was some very limited opinion that a minimum 12 month period of disqualification for offenders with a BAC between 50 mg/100 ml and 80 mg/100 ml would be considered too severe and might not gain public acceptance. It was suggested that it might even result in a backlash against the drink drive legislation. There was also some concern expressed that to impose even a 6 month ban for driving with a BAC in excess of 50 mg/100 ml would be particularly harsh and unfair on those drivers who, whilst having responsibly avoided driving during an evening's drinking, are subsequently caught with excess alcohol the following morning, as their level of culpability was arguably lower. In response to this, the Review takes the view that, given the amount of alcohol involved at the 50 mg/100 ml limit, this is very unlikely and someone who finds themselves to be still over the 50 mg/100 ml limit the morning after an evening's drinking will not be fit to drive. There seems to be a misconception amongst many drivers in Great Britain that a period of sleep speeds up the process of eliminating alcohol from the body and renders one fit to drive only a few hours after drinking. The Review is of the opinion that drivers must take a responsible approach and not drive in situations where they are likely to still be unfit, so soon after a drinking session that has continued until the early hours. The Review also considers that the rate at which alcohol is eliminated from the body and the ineffectiveness of factors such as sleep or caffeine in speeding up this process is a subject that could benefit from a public education and awareness campaign.
- 4.68.** In considering whether a shorter period of mandatory disqualification for a lower limit of 50 mg/100 ml is appropriate and workable, many consultees opined that the success of the current regime was attributable in part to the clear and straightforward mandatory penalty regime. Many consultees felt that to introduce a shorter penalty for particular offenders would result in a

more complex graduated penalty structure which might dilute the strength of the overall message.

- 4.69. The Review finds that it is not insignificant that the success of Great Britain's drink driving policy has been largely attributable to the deterrent effect of severe criminal sanctions, most particularly the 12 month minimum disqualification period that is applicable to all. This has contributed to Great Britain's comparatively good record for drink-drive deaths and on road safety more generally, despite the comparatively high BAC limit and low level of police enforcement<sup>140</sup> compared to many other countries.
- 4.70. The Review is conscious that there is presently considerable public support for a change to the limit and that it can be assumed that this will generate acceptance of a lower limit amongst the majority of the general population who have regard to and seek to stay within the current limit.
- 4.71. The Review finds the arguments for retaining a 12 month mandatory period of disqualification for a BAC level in excess of 50 mg/100 ml to be very persuasive. The risk of undermining the overriding message by suggesting, through a more lenient penalty, that drink driving in excess of 50 mg/100 ml is less serious and reprehensible is far greater than the potential, but not convincing, risk of currently law abiding people choosing to disregard the new limit.

**Recommendation (15): The excess alcohol offence under section 5(1)(a) of the Road Traffic Act 1988 of driving or attempting to drive a motor vehicle on a road or other public place after consuming so much alcohol that the proportion of it in a person's blood exceeds the prescribed limit of 50 mg of alcohol per 100 ml of blood should carry a period of disqualification of not less than 12 months and a band C fine.**

- 4.72. The Review is mindful that the variable circumstances that can be involved in a drink (or drug) driving case may require that the courts continue to have discretion when sentencing offenders, not only in relation to periods of disqualification above the statutory minimum, but equally, in relation to the other penalties that are available.
- 4.73. The Review therefore considers that it is appropriate that the graduation of all penalties above the statutory minimum of 12 months for levels of alcohol above 50 mg/100 ml in blood is a matter for the Sentencing Council in England and Wales (and for any future Scottish Sentencing Council) to consider. This is equally the stance the Review takes in relation to the periods of disqualification over the statutory minimum and the other penalties in relation to offenders convicted under section 4(1) (driving or attempting to drive while unfit), section 7(6) (failing to provide a specimen) and section 7A(6) (failing to allow a specimen to be subjected to a laboratory test).
- 4.74. Similarly, the Review is also conscious that the Magistrates' Court Sentencing Guidelines will need to be amended to reflect a new lower prescribed limit in relation to the offence of being in charge of a motor vehicle with an alcohol concentration above the prescribed limit (section 5(1)(b) of the Traffic Act) for which disqualification is discretionary. The starting point for the penalties

140 SARTRE. European drivers and road risk. SARTRE 3 Reports. Part I Report on principal report and analyses. INRETS. Arcueil. 2004

applicable to the excess alcohol in charge offence under the current limit is a band B fine and 10 penalty points. The Review considers that it is matter for the Sentencing Council (and any future Scottish Sentencing Council) to consider in what way the starting point for the range of penalties available for this offence needs to be altered in relation to a 50 mg/100 ml limit.

- 4.75. In addition, the Review considers that the current level of fine applied in England and Wales under the Magistrates' Court Sentencing Guidelines (band C) should apply to excess alcohol offences where the prescribed limit is 50 mg/100 ml as it does under the current prescribed limit of 80 mg/100 ml.

**Recommendation (16): The Sentencing Council (and any future Scottish Sentencing Council) should determine the applicable bands of penalties in the Magistrates' Court Sentencing Guidelines for drink driving offences involving alcohol concentrations in excess of a new limit of 50 mg of alcohol per 100 ml of blood.**

## Repeat offenders, offenders with high levels of alcohol and those who fail to provide

### *The High Risk Offender Scheme*

- 4.76. Under the High Risk Offender Scheme, where an High Risk Offender (HRO) is disqualified for certain drink driving offences, their driving licence is not automatically returned at the end of the period of disqualification. An HRO is required to be first assessed by a Department for Transport approved doctor for the purpose of determining whether or not they are physically or psychologically dependent on alcohol and are therefore safe to be allowed to drive before their licence is returned. The HRO Scheme applies to offenders in the following categories:
- (a) those disqualified twice, within a ten-year period, for drink drive offences involving mandatory disqualification;
  - (b) those disqualified for driving or attempting to drive with a proportion of alcohol in the body at least two and a half times the legal limit;
  - (c) those disqualified for failing, without reasonable cause, to provide a specimen of breath, blood or urine for analysis.
- 4.77. The HRO Scheme relies in part on statute, in part (in England and Wales) on the Magistrates' Court Sentencing Guidelines and in part on regulations relating to the driver licensing regime. People in category (a), that is repeat offenders, are subject to longer minimum periods of mandatory disqualification by virtue of section 34(2) and (4) the Road Traffic Offenders Act 1988 (RTOA). Additionally, the Guidelines provide (in England and Wales) for periods of disqualification above the statutory minimum in relation to persons in categories (a) and (b).
- 4.78. Whilst the law, the Guidelines and the HRO Scheme treat these types of drink drive offender together, they are clearly different and it is right that the Review considers them separately as the different categories of offenders raise different issues.

*Failure to provide*

- 4.79.** For those who fail to provide a specimen, it is of particular concern that those drivers whose BAC may be far in excess of the limit and who refuse to provide a specimen should not benefit from the refusal to provide by avoiding the lengthy ban they would otherwise receive on the basis of their high BAC. In England and Wales, the Magistrates' Court Sentencing Guidelines provide, correctly in the view of the Review, for significant penalties in respect of cases where there is a refusal to provide a specimen and evidence of serious impairment: consideration of custody and a 29-36 month disqualification from driving. Similarly the Review also considers it to be right that such offenders are caught by the HRO Scheme, to allow for the effective operation of the HRO Scheme.

**Recommendation (17): The High Risk Offenders scheme should continue to operate in respect of offenders who fail to provide a specimen.**

**Recommendation (18): The provisions of the Magistrates' Court Sentencing Guidelines in respect of those who fail to provide a specimen should be maintained and followed to guard against offenders benefiting from failure to provide. Any future Scottish sentencing guidelines should include equivalent provisions.**

*High levels of alcohol*

- 4.80.** We know that drink-drive offenders who have a BAC in excess of 200 mg/100 ml, that is two and a half times the prescribed limit, or more, are more than 500 times as likely to be involved in a fatal accident as those who have no alcohol in the body.<sup>141</sup> It is therefore concerning that there are as many as 10,000 such offenders of this type and very important that those who are guilty of drink driving at very high levels should be included in the HRO Scheme. It is also important that those who are convicted of drink driving at very high levels should be appropriately punished with lengthy periods of disqualification.
- 4.81.** The current sanctions applicable to offenders who are two-and-a-half times, or more, over the prescribed limit appear to the Review to be reasonable given the seriousness of the offence and the disregard shown by such offenders for public safety. However, there is clearly an issue as to whether, at a lower limit of 50 mg/100 ml, this threshold for HROs should remain at 200 mg (2 ½ times the 80 mg limit) or be reduced. A lower HRO threshold of 2 ½ times a new limit of 50 mg/100 ml would encompass a much larger group of offenders than at present, some of whom may not have an alcohol dependency problem which the HRO Scheme is aimed at addressing. The consequence of this is that a larger group of people would be required to be assessed by an approved doctor to ensure that they do not have an alcohol dependency or misuse problem before having their licence reinstated. However, 2 ½ times a lower limit of 50 mg/100 ml is still a very high level of alcohol and is associated with an almost 50 fold increase in the risk of dying from a road traffic accident and the Review therefore considers that it would be desirable to apply the current HRO threshold to a limit of 50 ml/100 ml.

**Recommendation (19): The High Risk Offenders scheme should continue to operate in respect of offenders with high levels of alcohol concentration.**

**Recommendation (20): The application of the High Risk Offender threshold of two-and-a-half times the prescribed limit should be applied to a lower prescribed blood alcohol limit of 50 mg of alcohol per 100 ml of blood.**

#### *Repeat offenders*

**4.82.** Repeat offenders are the third group included in the HRO Scheme and are also subject to longer minimum periods of disqualification by virtue of the RTOA and (in England and Wales) the Magistrates' Court Sentencing Guidelines.

**4.83.** It is, again, concerning that 10% of drink driving offenders are apparently repeat offenders. The 3 year minimum period of disqualification (rising to 5 years depending on the severity of the offence) is both a reasonable punishment and an important safeguard in the event of a second offence and it is appropriate that the courts should have the discretion to impose such a severe sentence where appropriate.

**4.84.** It is also appropriate that persons who have a propensity to commit drink driving offences are assessed by a doctor under the HRO Scheme to determine where they have an alcohol problem that makes them unfit to hold a driving licence.

**Recommendation (21): The High Risk Offenders scheme should continue to operate in respect of repeat offenders.**

**4.85.** Paragraph 2.117 explains that section 88(1) of the Traffic Act allows HROs to drive when they have applied for their licence back at the end of the period of disqualification, regardless of whether they have, by then, been cleared by the doctor. The Government moved to close this loophole, obtaining powers to do so under the Road Safety Act 2006, but the relevant provisions have not yet been brought into force.

**Recommendation (22): The Government should move swiftly to bring into force those provisions of the Road Safety Act 2006 which will ensure that High Risk Offenders do not regain their licence without first being assessed by a Department for Transport-approved doctor.**

#### *Vehicle forfeiture in relation to repeat offenders*

**4.86.** The issue of appropriate penalties for offences beyond the second offence has exercised the Review. The Review has considered the use of forfeiture powers in relation to the vehicle used in the repeat offence. Whilst, in England and Wales, there exists a general power to confiscate property used in the commission of an offence, it appears, on the basis of the evidence provided by witnesses, including the police, the Crown Prosecution Service and the Magistrates' Association, that this power is seldom used for seizure of vehicles in drink (or indeed drug) driving cases. The fact that the prosecution has to conduct a full examination into the consequences of

seizure, for example in terms of others' use of the vehicle or of its ownership, and the regularity with which problems will arise, has tended to be a deterrent to use of this power.

- 4.87.** The Review was particularly interested in the use of the specific power, under section 33A of the RTOA, to seize and forfeit vehicles in Scotland which has been used in relation to repeat drink drive (section 5(1) excess alcohol) offenders as part of the Scottish police's 2009 Christmas Drink Drive Enforcement Campaign. The Review was informed that there were 47 cases of repeat offenders out of the 490 total festive season drink drivers tested in Scotland (in line with the national profile of around 10%). Of these, 7 had their vehicles forfeited and a further 12 cases were, at the time of the report to the Review from the Scottish police,<sup>142</sup> pending the consideration of forfeiture by the procurators fiscal.
- 4.88.** Seizure and forfeiture of vehicles is clearly not always going to be appropriate. There will be issues of ownership of the vehicle and of use by others which mean it will not be appropriate in all cases. There will also be practical problems to consider, not least in terms of the capacity of the system to locate and seize and accommodate vehicles. Nevertheless, the Scottish experience seems to suggest that there is a sustainable model available to courts in Great Britain and that, through the offsetting of the proceeds of auctions against the costs of the process, it should not involve net expenditure of resource.
- 4.89.** The Review has concluded that, in the case of serious repeat drink driving offences (disqualification twice within a 5 year period as in the Scottish model), seizure of the vehicle should be routinely considered as part of the judicial toolkit, given the threat to public safety posed by the repeat offender and the clear likelihood of reoffending. Clearly other factors will continue to play a part in the judgment as to whether it is an appropriate sanction in any given case.

**Recommendation (23): Provision should be made in England and Wales, as in section 33A of the Road Traffic Offenders Act 1988 in relation to Scotland, for seizure and forfeiture of vehicles used by repeat offenders in drink (and drug) driving offences involving mandatory disqualification.**

#### *Bail conditions for repeat offenders*

- 4.90.** The Review has considered the rare use by the courts in England and Wales, of bail conditions to prevent a person accused of a drink driving offence who pleads not guilty from driving prior to trial. The Review recognises the concerns and difficulties involved in imposing such a condition on a person who has not been found guilty of an offence. However, the Review has concluded that magistrates should be reminded that bail conditions do form part of their judicial toolkit and, where appropriate, should be utilised.

<sup>142</sup> Evaluation by Association of Chief Police Officers (Scotland), February 2010



### *Permanent disqualification*

- 4.91.** The second penalty the Review has considered at length in relation to repeat offenders has been the period of disqualification. Again, the period of disqualification set out, for England and Wales, in the Magistrates' Court Sentencing Guidelines of 36 to 60 months for a repeat offence involving serious impairment or high levels of alcohol appears to the Review to be appropriate. However, there is a question about the appropriate penalty for repeat offences beyond the second offence and for offences committed while disqualified.
- 4.92.** The Review has noted the way in which the current regime, with the scrutiny by DVLA doctors of the HROs' fitness to regain their licences, allows offenders back onto the roads when they prove themselves to be fit. Put simply, this system rightly gives serious offenders another chance. The Review also recognises that imposing very lengthy periods of disqualification can lead to more offenders driving whilst disqualified.
- 4.93.** However, driving is not an inalienable right; it is a considerable responsibility. The Review therefore considers that there must come a point in the cycle of drink driving reoffending, and particularly of drink driving whilst disqualified, where society is entitled to take a view that drivers have proved themselves unworthy of the responsibility of driving a vehicle safely on the public roads and that the chances provided have been exhausted.<sup>143</sup>
- 4.94.** The Review therefore takes the view that the sanction of permanent disqualification from driving should be one of the sanctions available to the magistrates' court and sheriffs' court in the case of repeat offenders convicted of offences involving mandatory disqualification beyond a second offence. Clearly, this penalty will need to be considered in the context of all the factors in the particular case. The Review considers that section 42 of the RTOA, discussed in paragraph 2.91, which enables convicted drivers to apply to the court to have the disqualification period reduced or removed, provides adequate protection for convicted drivers who are permanently disqualified and would address any concerns regarding proportionality and fairness.

**Recommendation (24): The Magistrates' Court Sentencing Guidelines should be amended so that, in cases of repeat drink drive convictions for offences involving mandatory disqualification and particularly of those convicted of such offences whilst disqualified, permanent disqualification from driving is routinely considered by the magistrates. Similarly, sheriff courts should also routinely consider permanent disqualification in such circumstances.**

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<sup>143</sup> The European Court of Human Rights has held that those who choose to own and drive a car have an implied responsibility to accept certain requirements under UK law. *O'Halloran and Francis v. United Kingdom* (nos. 15809/02 and 25624/02)

## Alcohol ignition interlocks

- 4.95.** As noted in paragraph 2.116, there is power, albeit, not yet in force, to provide for offenders to be referred to an alcohol ignition interlock programme as part of their penalty. The Review is aware that trials have shown that there are merits in such initiatives in that when in use, they prevent people from drink driving but they are not effective in preventing people re-offending once they have been removed.
- 4.96.** However, the Review is also aware that interlocks also give rise to a number of problems, in particular the ease with which they can be circumvented (by getting someone else to blow into the device) the expense of implementing such a scheme and the unfairness stemming from the fact that they enable those offenders, that can afford to pay, an opportunity to continue driving which offenders without the financial means to pay do not have.
- 4.97.** Accordingly, the Review finds that, on balance, the disadvantages and problems associated with such a scheme seem to outweigh the potential benefits.
- 4.98.** It is important to add, however, that in the context of employment and industry, where it is possible to have tighter controls on the driver, such problems do not arise and interlocks can be particularly beneficial and effective. This was addressed in Recommendation 7 above.

## Police enforcement of drink drive law

- 4.99.** The Review's recommendations regarding the reduction of the limit to 50 mg/100 ml and the penalties for breach cannot be implemented in isolation. The deterrent effect of a penalty depends on the level of police enforcement and the related public perception of the risk of detection. The finding of the 2004 SARTRE study that only 3% of drivers in the UK had been stopped and tested for alcohol in the previous 3 years against the European average of 16% provides cause for concern. Notwithstanding that many of the comparator countries in the SARTRE study, such as Sweden and Slovenia, permit random breath testing, the figure for the UK is suggestive of unacceptably low enforcement and undermines the deterrent effect of the law and associated penalties by providing a low risk of detection, tempting some people to drink and drive at whatever BAC level.

## Police priorities

- 4.100.** The precise cause of the low level of testing in Great Britain compared to other European countries is difficult to determine. However, the Review makes the following observations.
- 4.101.** The level of enforcement between police forces across the country is inconsistent, with some forces taking a much more active approach than others. There are undoubtedly resource related reasons for this discrepancy that are outside of the scope of the Review and which are an internal matter for the police. However, the Review considers it to be highly pertinent that, in England and Wales, the impairment and excess alcohol offences under sections 4(1) and 5(1)a of the Traffic Act are not included in the Ministry of Justice list of Offences Brought to Justice.

- 4.102.** This omission stems from the Offences Brought to Justice crime categories which categorise offences under the headings of 'serious violent offences', 'serious sexual offences' and 'serious acquisitive crime'. Consequently, offences such as causing death by dangerous driving, causing death by careless driving when under the influence of drink or drugs, causing death by careless and inconsiderate driving are included, as are the offences of aggravated vehicle taking and theft from a vehicle, but drink and drug driving offences are excluded as they do not fall into any of these three categories.
- 4.103.** The omission of drink (and drug) driving offences from the list of Offences Brought to Justice has implications for the priority afforded to the enforcement of these offences by the police which needs to be addressed and which seems wholly inappropriate, given the potentially serious consequences for members of the public of the behaviour of a section 4(1) and 5(1)(a) offender. It appears wholly irrational to include the section 1 (death by dangerous driving), section 2B (causing death by careless or inconsiderate and section 3A (death by careless driving when under the influence of drink or drugs) offences under the Traffic Act in the list of Offences Brought to Justice, but not the section 4(1) and 5(1)(a) offences, when it is often pure chance that separates the section 4(1) and 5(1)(a) offenders from the section 1, 2B and 3A offenders.

**Recommendation (25): The offences involving mandatory disqualification in sections 4(1), 5(1)(a), 7(6) and 7A(6) of the Road Traffic Act 1988 should be added to the list of 'Offences Brought to Justice' determined by the Ministry of Justice, on which the police in England and Wales are required to report.**

### Public awareness

- 4.104.** For the law to be an effective deterrent, the actual and perceived risk of detection and punishment must be high. This requires drivers to have a greater awareness of the limit, the penalties and enforcement measures. This comes from information and publicity but, more vitally, as a result of direct personal experience, or indirect experience (friends, relatives, acquaintances etc), of being stopped and tested. Apart from those drivers who, either because they are naturally strictly law abiding or have addiction or lifestyle issues, are not affected by such deterrents, visible, well-publicised and frequently used enforcement measures all contribute to a real and perceived increase amongst drivers in the likelihood of being caught which will have the effect of countering the inclination of some drivers to disregard the limit.

### Powers to stop and test

- 4.105.** Whilst the police have the power to stop a vehicle with no reason pursuant to section 163 of the Traffic Act, there is currently no power in Great Britain for the police to conduct unrestricted breath testing. The police may only require a person to cooperate with a preliminary breath test where they reasonably suspect that the person is or has been driving (attempting to drive or in charge of a vehicle) and has alcohol in their body, has been involved in an accident or has committed a traffic offence while the vehicle is in motion.

- 4.106.** The police have indicated to the Review that in the majority of cases, a person driving will be tested because the police have observed the driver concerned committing a traffic offence, for example speeding, driving with a broken light or without a seat belt or because the police are alerted to the manner of a person's driving which has suggested that the driver may be impaired.
- 4.107.** These powers are wide enough to enable a driver to be stopped for no prior reason and tested where the officer subsequently forms a suspicion that the driver may have been drinking alcohol. The existing powers also allow the police to carry out intelligence-led or targeted breath testing, where vehicles are stopped, randomly or otherwise, in particular locations or at selected venues and drivers are then required to be breathalysed where, having stopped the vehicle, the constable suspects the driver of consuming alcohol. In short, random or arbitrary stopping of vehicles by the police is lawful, but random breath testing is not. The Association of Chief Police Officers submitted to the Review that they do not consider that their ability to carry out drink drive enforcement is hampered or limited by the current legislation.
- 4.108.** Across Europe, there is a more or less even split between countries that have unrestricted powers to conduct so-called 'random' breath screening and those, such as Great Britain, which require the police to have specific grounds for demanding a breath test. The NICE Report examines the results of studies carried out in 1999 and 2001 which looked at the impact of random and targeted breath testing schemes. Random studies involved vehicles being stopped at a road block and breathalyser tests required, in some cases on a random basis, regardless of suspicion of alcohol consumption, and in other cases for every driver stopped. The targeted interventions involved vehicles being stopped on a random basis and tests being required where alcohol use was suspected.
- 4.109.** The findings of these studies indicate that both random breath testing checkpoints and selective breath testing checkpoints are interventions that are effective in reducing alcohol impaired driving, alcohol related crashes and associated fatal and non-fatal injuries,<sup>144</sup> particularly, in the case of random screening interventions, when implemented as part of a concentrated effort over a relatively short period of time.<sup>145</sup>
- 4.110.** The Review considers that the distinction between targeted, intelligence-led or inclusive screening and purely 'random' screening is important. The Review recognises that a strictly random approach may in practice be excessively resource and time intensive for the police and detrimental to the effectiveness of such operations. It may also invite concern or criticism regarding the proportionality of the use of such a wide and arbitrary power and real, or perceived, issues of abuse or unfairness. What is clear, however, is that enforcement of drink drive law in Great Britain must be much more visible, frequent, routine, sustained and well-publicised. In the opinion of the Review, targeted or evidence led screening operations are an effective means of achieving these aims.

144 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

145 NICE. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. 2010.

- 4.111. In order to strengthen the effectiveness of drink drive law enforcement, increase public understanding and awareness, the Review considers that it is highly desirable to amend the law in Great Britain to allow for an unrestricted power to breathalyse drivers, in addition to the current conditions for testing contained in section 6(2) of the Traffic Act. The Review considers that this may be achieved by replacing the current conditions for requiring and administering preliminary breath tests with a general, unrestricted power to require such tests or by inserting an additional power to enable preliminary breath tests to be required and administered in the course of a designated drink drive enforcement operation.
- 4.112. The police use of such a power would be determined by resources and local intelligence and the Review expects that it would be used in a targeted rather than purely random manner. The Review considers that enabling the police to stop and test drivers without the need to rely on some direct or indirect reason to do so sends a clear public message to drivers that they can be stopped and tested at any time and that such an intervention will contribute greatly to improving enforcement and awareness of the law.
- 4.113. The current power in section 6 of the Traffic Act to require and administer preliminary tests applies not only to persons who a constable suspects are driving but also to persons the police reasonably suspect to be attempting to drive or in charge of a motor vehicle, as well as persons who it is reasonably suspected have been driving, attempting to drive or in charge of a motor vehicle.
- 4.114. The current breath testing power therefore encompasses a very wide number of people and situations. The Review does not consider that an unrestricted power to require and administer breath tests would be proportionate in relation to all such people. Accordingly, the Review proposes that the unrestricted power should be limited to persons who are in fact driving at the time they are required to stop.
- 4.115. Accordingly, the Review considers that the existing conditions in section 6(2) for requiring and administering a breath test should be retained in relation to a person who, it is suspected, has been driving, is or has been attempting to drive or who is or has been in charge of a motor vehicle on a public road or other public place.

**Recommendation (26): Section 6 of the Road Traffic Act 1988 should be amended to provide a general and unrestricted power to require anyone who is driving a motor vehicle to cooperate with a preliminary breath test. This power should not be extended to a person who had been driving, was or had been attempting to drive or who is or has been simply in charge of a motor vehicle.**

#### Portable evidential breath testing equipment

- 4.116. In relation to the use of portable evidential breath testing equipment, the law is ahead of technology. Section 7(1) of the Traffic Act provides a power to require two specimens of breath for evidential analysis at a police station, a hospital or, importantly, at or near a place where a preliminary breath test

has been administered or would have been but for the person's failure to cooperate with it, such as at the roadside.

- 4.117. The development of portable evidential breath testing equipment is, it is understood, at an advanced stage. Type-approval of such equipment would provide the police with a flexible tool and an alternative to the fixed police station testing equipment used at present. This would be of particular assistance to the police in rural locations that are often some distance from the nearest police station. Portable equipment would also enable officers to administer the evidential test without the need to first take the accused into custody at a police station, a process which can slow down the process, particularly at busy custody suites, because of the requirements under the Police and Criminal Evidence Act 1984 (PACE) to open a custody record for the suspect upon arrival. Further, it is in the interests of both the accused and the police that the evidential test provides a reflection of the level of alcohol in the suspect's system close to the time of driving (or attempting to drive etc) and this equipment would facilitate this. It is, therefore, highly desirable, that portable evidential breath testing equipment is introduced as a matter of urgency.

**Recommendation (27): Type approval and deployment of portable evidential breath testing equipment should be completed no later than the end of 2011.**

- 4.118. The Review is aware that, once type-approved portable evidential breath testing equipment is available, its use in police stations would be subject to the requirements in relation to custody under PACE. The Review considers it to be important that the use of such equipment should not be made more difficult at a police station than in any other location or situation and that further consideration of these difficulties may be required.
- 4.119. The Review notes that, as currently drafted, section 7(1)(c) of the Traffic Act requires a preliminary breath test to be administered prior to the use of evidential breath testing equipment, where such evidential testing is administered at or near a place where a preliminary breath test had been administered (or would have been administered but for the person's failure to cooperate). This requirement to first administer a preliminary breath test does not apply where the evidential test is administered at a police station or in a hospital.
- 4.120. Once portable evidential testing equipment is type approved and available for use, the Review considers that it would be desirable to amend section 7(1)(c) of the Traffic Act to enable the police to avoid this two-step approach and proceed directly to the evidential testing device without the need to first require and administer a preliminary breath test.

**Recommendation (28): Section 7(1)(c) of the Road Traffic Act 1988 should be amended to dispense with the requirement for the police to administer a preliminary breath test before an evidential breath test.**



## **Part III – Drug driving**

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# Chapter 5: Drug driving – Law and procedure

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## Introduction

- 5.1. This chapter sets out the current law and procedure in relation to drug driving. It explains the current legislation, including the drug driving offences, the testing regimes and the associated penalty regime. It contains definitions and descriptions of the processes and terms that are referred to in the remainder of Part III.
- 5.2. The chapter is divided into the following five headings:
- Introduction;
  - Legislative history;
  - The current law;
  - Other procedural issues;
  - The current penalty regime for drug driving offences.

## Legislative history

- 5.3. The offence of driving, attempting to drive or being in charge of a motor vehicle while under the influence of drugs first appeared on the statute book in the Road Traffic Act 1930. Under the Road Traffic Act 1930, a conviction required proof that the driver was under the influence of a drug to such an extent that the driver was not in proper control of the vehicle.
- 5.4. The modern wording of driving while unfit to drive through drugs was introduced by section 6 of the Road Traffic Act 1960, although it was not until the Road Traffic Act 1962 that the definition of unfit to drive was amended from meaning 'under the influence of drink or a drug to such an extent as to be incapable of having proper control of a motor vehicle', as in the Road Traffic Act 1930, to meaning that the person's 'ability to drive properly is for the time being impaired', which remains the position today.
- 5.5. The Road Traffic Act 1962 also introduced for the first time the power to obtain and use evidence of the proportion or quantity of alcohol or of any drug which was contained in the blood or present in the body of the accused. The legislation provided that a specimen of breath, blood or urine could be obtained by a medical practitioner for such purposes, with the consent of the accused. It also made provision for a refusal to give consent without reasonable cause to be used against the accused. This was re-enacted in the Road Traffic Act 1972.
- 5.6. The modern offence of driving or attempting to drive while under the influence of drugs is now to be found in section 4(1) of the Road Traffic Act 1988 (the Traffic Act) and has remained largely unchanged since the 1960 and 1962 Road Traffic Acts. The provisions regarding the requirement of evidential specimens for analysis that are contained in the Traffic Act are derived from the Road Traffic Act 1972, as amended, as the Traffic Act was mostly an exercise in consolidation and did not include any significant amendments to the process.

- 5.7. The Railways and Transport Safety Act 2003 amended the Traffic Act by amending section 6 of the Traffic Act (breath tests) and adding five new sections, section 6A to 6E. Section 6B introduced for the first time the power for the police to administer a preliminary impairment test to test for the presence of drugs (or alcohol) in a person's body and, by virtue of section 6C, a preliminary drug test to test for the presence of drugs in a person's body using a specimen of sweat or saliva. Sections 6D and 6E made provision for powers of arrest and powers of entry respectively in connection with the administration of the preliminary tests.

## The current law

- 5.8. The current statutory provisions concerning drug driving are contained in sections 4–11 of the Traffic Act. The principal offences relevant to drug driving can be summarised as:
- driving, attempting to drive or being in charge of a mechanically propelled vehicle whilst unfit to drive through drink or drugs (sections 4(1) and (2)); and
  - failing to provide a specimen for analysis or failing to permit a specimen to be tested in a laboratory (sections 7(6) and 7A(6)).
- 5.9. The full text of the relevant sections of the Traffic Act is reproduced in Annex G.

## A note about alcohol

- 5.10. The offence under section 4(1) (and 4(2)) involves the consumption of drink or drugs. Accordingly, some of the provisions concerning the testing regime, related offences (for example, refusing to provide a sample) and penalties apply equally in cases involving either type of substance. This chapter considers the relevant provisions of the Traffic Act in the context of drugs and it has been seen that Chapter 2 does so in relation to alcohol. There is, however, some unavoidable overlap in the discussion of the legislative framework concerning drink- and drug driving and there is consequently some cross-referencing between chapters to avoid unnecessary duplication.

## Definition of drugs

- 5.11. The meaning of the word 'drug' is defined in section 11 of the Traffic Act as including '*any intoxicant other than alcohol*'. This definition is very wide and clearly extends to illegal substances which are recognised as drugs, such as cocaine or cannabis, but also includes prescribed medicines and over the counter remedies. The Traffic Act does not distinguish between illegal drug use and the prescribed use of legal medicines.

## Motor vehicles

- 5.12. The Traffic Act distinguishes between motor vehicles and mechanically propelled vehicles. Section 4 of the Traffic Act applies to driving, attempting to drive or being in charge of a *mechanically propelled vehicle* whilst section 5(1) only applies to *motor vehicles*.
- 5.13. A motor vehicle is defined in section 185 of the Traffic Act as a mechanically propelled vehicle intended or adapted for use on a road. Vehicles such

as golf buggies are not intended or adapted for use on the road and are therefore considered to be mechanically propelled vehicles within the meaning of the Traffic Act rather than motor vehicles. Consequently, the offence under section 4 applies to the use of all such types of mechanically propelled vehicle.

### Unfit to drive

- 5.14.** It is an offence under section 4(1) of the Traffic Act to drive or attempt to drive a mechanically propelled vehicle on a road or other public place while unfit to drive through drink or drugs. This is referred to in the Report as 'the impairment offence'. Similarly, it is an offence under section 4(2) to be in charge of a mechanically propelled vehicle while unfit to drive through drink or drugs.
- 5.15.** These are behaviour based provisions which require evidence of impairment. Under section 4(5), a person is considered unfit to drive if that person's ability to drive is for the time being impaired. In relation to drug driving, a successful prosecution for the impairment offence will require evidence of impairment at the time of driving (or attempting to drive etc) and that that impairment was caused by drugs and not by something else (e.g. fatigue or illness).
- 5.16.** The evidence required will consist first of scientific or expert evidence that a drug or drugs were found to be present following a blood or urine test. Secondly, there needs to be evidence of a more subjective nature, whether from the FIT test or otherwise, such as that the person appeared to be under the influence of drugs from the way that the person was behaving, their demeanour, appearance, the manner of their driving or other relevant indicators.
- 5.17.** Whilst not required by the Traffic Act, it may also be desirable to have evidence of impaired driving, depending on the strength and nature of the evidence of the person's impairment and condition.
- 5.18.** The application of this provision in relation to persons who are driving while unfit through drink is dealt with in Chapter 2 of the Report.

### Preliminary testing

- 5.19.** The police have a general power under section 163 of the Traffic Act to stop any vehicle at any time. Although in practice the manner of a person's driving or a road traffic contravention may alert the police and cause them to stop a particular driver, no grounds are, in law, required.
- 5.20.** There is no similar general power to require a person to cooperate with a preliminary test for the presence of drugs (or alcohol). Section 6 of the Traffic Act provides the police with a power to administer one or more of three types of preliminary test in the following circumstances:
- (a) Where a constable reasonably suspects that the person –
    - (i) is driving, attempting to drive or in charge of a motor vehicle on a road or other public place, and
    - (ii) has alcohol or a drug in his body or is under the influence of a drug.

- (b) Where a constable reasonably suspects that the person –
  - (i) has been driving, attempting to drive or in charge of a motor vehicle on a road or other public place while having alcohol or a drug in his body or while unfit to drive because of a drug, and
  - (ii) still has alcohol or a drug in his body or is still under the influence of a drug.
- (c) Where a constable reasonably suspects that the person –
  - (i) has been driving, attempting to drive or in charge of a motor vehicle on a road or other public place, and
  - (ii) has committed a traffic offence while the vehicle was in motion.
- (d) Where an accident occurs owing to the presence of a motor vehicle on a road or other public place, and a constable reasonably believes that the person was driving, attempting to drive or in charge of the vehicle at the time of the accident.

**5.21.** Where one or more of the circumstances described in paragraph 5.20 arises, a constable has the power to require a person to cooperate with a preliminary breath test under section 6A (this is considered in full in Chapter 2) and/or a preliminary impairment test under section 6B. The third available test under section 6C is a preliminary drug test. The requirement to cooperate with a preliminary test may be made by a constable in any place.

**5.22.** Given the simplicity of the preliminary breath test (the breathalyser), the immediate results it produces and the propensity for drug use to be combined with the consumption of alcohol, in practice, where a constable suspects that a person may have a drug in their body or may be under the influence of a drug, the first step in the investigation may nevertheless be for the constable to administer the breathalyser test in order to ascertain quickly whether the person has consumed any alcohol and, particularly, an amount of alcohol in excess of the prescribed limit.

### **Preliminary Impairment Test**

**5.23.** Section 6B of the Traffic Act provides for a preliminary impairment test. This is a screening test which must be designed to indicate whether a person is unfit to drive and whether the unfitness is likely to be due to drugs (or drink).

**5.24.** The test, known as a Field Impairment Test (FIT test), may be administered at or near the place where the requirement to cooperate with the test is imposed (for example, at the roadside) or, where the constable thinks it expedient, at a police station.

**5.25.** Section 6B(2) of the Traffic Act provides that the Secretary of State must issue a Code of Practice setting out the kinds of tasks and observations that may form part of the FIT test, the manner in which the test should be carried out and the inferences that may be drawn from the observations made in the course of the test.

**5.26.** In accordance with this sub-section, the Code of Practice for Preliminary Impairment Tests (the Code) was issued by the Secretary of State for Transport in 2004. As required under section 6B(3), the test set out in the

Code is designed to indicate whether a person is unfit to drive and, if so, whether that person's unfitness is likely to be due to drugs (or drink).

- 5.27.** The FIT test consists of a pupillary examination and a series of separate physical tasks set by the constable in accordance with the Code of Practice. By observing the person's ability to perform these tasks and making such other observations as to the person's physical and cognitive state as the constable thinks expedient, the constable can obtain an indication as to whether the person is unfit to drive and, if so, whether that person's unfitness is likely to be due to drink or drugs.
- 5.28.** There is no requirement to administer the FIT test in order to assess impairment but, where it is used, it may only be conducted by a constable who has been approved to carry out such tests (section 6B(6)).
- 5.29.** A detailed description of the components of the FIT test is to be found in paragraph 5.51.

### **Preliminary drug test**

- 5.30.** Section 6C of the Traffic Act makes provision for the use of a preliminary drug test. This test is a procedure by which a specimen of sweat or saliva<sup>146</sup> is obtained and used for the purpose of obtaining, by means of a device type approved by the Secretary of State, an indication whether the person to whom the test is administered has a drug in their body. A preliminary drug test may be administered at or near a place where the requirement to cooperate with the test is imposed or, if the constable thinks it expedient, at a police station.
- 5.31.** Whilst the legislation provides a power for such testing to take place, a testing device has yet to be approved by the Secretary of State for use in Great Britain. This is a process known as type approval and is considered in paragraph 6.81. Accordingly, the police are not able to administer such a test at the present time.

### **Failure to cooperate with a preliminary test**

- 5.32.** By virtue of section 6(6) of the Traffic Act, a person commits an offence if they fail, without reasonable excuse, to co-operate with any preliminary test in pursuance of a requirement imposed under section 6 of that Act. A reasonable excuse must generally arise from a physical, mental or medical condition which prevents the person from taking the preliminary test together with evidence to support any such claim.
- 5.33.** Failure to cooperate with a preliminary breath test under section 6(6) of the Traffic Act is considered in Chapter 2 in relation to alcohol.
- 5.34.** As has been said, there is no requirement for the police to conduct the FIT test in order to assess impairment. The purpose of the FIT test is simply to gather further evidence of impairment. Consequently, where a person

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<sup>146</sup> Section 6C refers specifically to saliva (or sweat). The Review understands that in practice, oral fluid (which may contain other substances found in the mouth besides saliva e.g. cells and remnants of food) is collected and that it may therefore be desirable to amend section 6C to reflect this. For the purposes of this Report, however, reference is made only to saliva.

refuses or fails to cooperate with a FIT test, the opportunity to gain evidence from the person's performance of the FIT test is lost. It is true to say that the opportunity for the suspect to also provide evidence that they are *not* impaired is also lost.

- 5.35.** In the absence of an unambiguous refusal to cooperate, it may be difficult for a constable to determine whether a person's failure to cooperate is in fact a symptom of that person's intoxicated or drugged state, rather than a deliberate failure to cooperate. This may be particularly challenging when the person concerned is intoxicated and the constable will need to form a view as to whether there is sufficient other evidence to arrest the person concerned under the impairment offence and to continue with the investigation or whether to arrest the person for failing to cooperate with a preliminary test. Sufficient evidence may consist of the constable's observations of the person's driving or the person's general demeanour, including the person's lack of cooperation with the FIT test. In practice, it is unlikely that a person will be charged with an offence under section 6(6) where that person subsequently complies with either a further request to do the FIT test or a request at the police station to provide a specimen for analysis.

### **Arrest on suspicion of driving, attempting to drive or being in charge of a mechanically propelled vehicle when unfit due to drugs**

- 5.36.** Section 24 of the Police and Criminal Evidence Act 1984 (PACE) provides a police constable with a general power of arrest without warrant where a constable has reasonable grounds for believing that the person is, has, or is about to, commit an offence and that it is necessary to arrest the person, *inter alia*, to allow the prompt and effective investigation of the offence or conduct of the person.
- 5.37.** Where a constable suspects that a person has committed the impairment offence involving drugs, the constable may arrest that person under section 24 of PACE in order to continue with the investigation by way of obtaining a specimen of blood or urine to submit for analysis.
- 5.38.** The requirement, in section 24 of PACE, for reasonable grounds for believing that an offence has been committed may be satisfied by the observations and inferences the constable makes from the person's performance of the FIT test, their general demeanour, manner of driving or other relevant factors.
- 5.39.** In Scotland, there is an explicit power of arrest in relation to an offence under section 4 of the Traffic Act in section 4(6) of that Act. This sub-section was repealed in relation to England and Wales by the Serious Organised Crime and Police Act 2005 but remains in force in relation to Scotland.

### **Provision of specimens for analysis**

- 5.40.** In the course of an investigation into whether a person has committed the impairment offence involving drugs, an officer has the power under section 7(1) of the Traffic Act to require a specimen of blood or urine for a laboratory test.

- 5.41.** This part of the investigative process will take place where a constable suspects that a person has committed the impairment offence as a result of the observations and inferences made from the person's performance of the FIT test, or, where the FIT test was not or could not be administered, from the suspect's general demeanour, driving or other relevant factors which give rise to a suspicion that the person concerned is unfit to drive, or both.
- 5.42.** The requirement to provide a specimen of blood or urine can only be made at a police station or hospital (section 7(2)). Where the investigation relates to the impairment offence involving impairment due to drugs, the requirement to provide a specimen of blood or urine cannot be made at a police station unless –
- (a) the constable has been advised by a medical practitioner that the person has a condition which might be due to some drug (section 7(3)(c)), or
  - (b) where, as a result of a preliminary drug test, the constable making the requirement has reasonable cause to believe that the person required to provide a specimen of blood of urine has a drug in their body (section 7(3)(bc)).
- 5.43.** Until a preliminary drug testing device is type approved for use in Great Britain, section 7(3)(bc) is redundant.
- 5.44.** Where the circumstances permit a specimen of blood or urine to be taken, the decision which specimen it is to be lies with the constable making the request (section 7(4)). However, where the constable opts for a blood sample, the constable's discretion can be overridden where a medical practitioner or registered healthcare professional<sup>147</sup> is of the opinion that blood cannot or should not be taken for medical reasons (section 7(4)).
- 5.45.** Except for urine (and dental impressions), intimate samples, including blood, may only be taken in a police station by a registered medical practitioner or a registered health care professional (section 62(9A) of PACE) or taken elsewhere, such as at a hospital, by a medical practitioner (section 15(4) of the Road Traffic Offenders Act 1988 (RTOA)).
- 5.46.** Where a specimen of blood or urine is taken, in order for it to be admissible as evidence of the proportion of any drug (or alcohol) found in the specimen on behalf of the prosecution, the specimen must be divided into two parts at the time it is provided by the accused and one part must be supplied to the accused (section 15(5) of the RTOA).
- 5.47.** Where the accused opts to take a part of the specimen, they may have it independently analysed at their own expense and are provided with information from the Royal Society of Chemistry with details of laboratories to contact.

<sup>147</sup> A registered healthcare professional is defined in section 11 of the Traffic Act as a person (other than a medical practitioner) who is a registered nurse or a registered member of a health care profession who is designated for the purposes of section 11(2) of the Traffic Act by an order made by the Secretary of State. The Health Care Profession (Designation No 2) Order 2003 (S.I. 2003/2462) designated the profession of paramedics.

## Failure to provide an evidential specimen

- 5.48.** A specimen of blood or urine taken in accordance with section 7(1) may only be taken with the consent of the person concerned. However, it is an offence under section 7(6) of the Traffic Act for a person to fail, without reasonable excuse, to provide the required specimen for analysis under section 7(1).
- 5.49.** A reasonable excuse must generally arise from a physical or mental condition which prevents the person from taking the test or providing a specimen together with medical evidence to support any such claim. This could include a phobia of needles, provided that medical evidence can support such a claim. Where a person objects to providing blood, a constable has discretion to require urine instead, should that constable be minded to do so.

## Specimens of blood taken from a person incapable of consenting and from hospital patients

- 5.50.** Sections 7A and 9 of the Traffic Act make provision in relation to specimens of blood being taken from a person incapable of consenting and from hospital patients. The procedures set out in sections 7A and 9, in addition to the related offence, under section 7A(6), of failing, without reasonable excuse, to give permission for a specimen of blood taken under section 7A to be tested in a laboratory, apply equally in relation to both the drink and drug driving offences and more detailed commentary on these sections is contained in Chapter 2.

## Other procedural issues

### The Field Impairment Test

- 5.51.** A full description of the tests which constitute the FIT test is as described in the Code of Practice for Preliminary Impairment Tests at Annex M. In summary, the FIT test comprises a pupillary examination and the following physical tasks –
- (a) The Modified Romberg Balance Test  
This is an indicator of a person's internal clock and ability to balance.
  - (b) The Walk and Turn Test  
This is an exercise that enables the assessment of whether a person is able to divide attention between walking, balancing and processing instructions.
  - (c) One Leg Stand  
This is a task that includes balance and counting out loud.
  - (d) The Finger to Nose Test  
This is a test of depth perception and balance.
- 5.52.** The constable administering the FIT test should record any additional notes about a subject's behaviour, physical or mental state or other relevant observations.
- 5.53.** The Code of Practice for the administration of the FIT test in accordance with sections 6 and 6B of the Traffic Act provides that the tests that



are administered and the observations made must be recorded on the appropriate form. This is the MGDD/F form which is reproduced in Annex N.

- 5.54.** The FIT test can only be carried out at or near a place where the requirement to cooperate with the test is imposed or, if the constable thinks it is expedient, at a police station. The Code provides that, in selecting the location for the test, the constable must consider the safety of the person concerned, particularly in view of the fact that the person concerned is suspected to be under the influence of drugs (or drink). The Code provides that the location for the test should, therefore, wherever possible have a hard, level, non-slippery surface, be in a well-lit, unobstructed area, away from the public gaze and in appropriate weather conditions. Where a safe and appropriate environment or location is not possible to achieve, the constable should consider whether to require that the test be conducted at a more appropriate location nearby or at a police station or to make appropriate allowances in interpreting the observation of the tests.
- 5.55.** It may be appropriate to advise the person to remove their footwear if they are wearing footwear which may affect their performance of the tests.
- 5.56.** Certain physical, mental or medical conditions may affect a person's ability to undertake the FIT test. Constables administering the FIT test must therefore be aware of and make a record of any disability, injury or illness, whether physical or mental, which may affect the performance of a test and be mindful of such matters when interpreting the results of the tests or, when considering whether the administration of the tests is appropriate or practical.
- 5.57.** It is not possible to 'pass' or 'fail' any of the tests that comprise the FIT test. The constable must record the observations of the pupillary examination and of the person's performance of each individual test. The constable should then form a view based on the collective observations made, together with any other relevant evidence, such as the person's driving and general demeanour, as to whether the person is unfit to drive through drugs (or drink) and whether there is sufficient evidence to arrest a person for the impairment offence.

### Forensic physician

- 5.58.** The role of forensic physicians (FPs) is explained in full in Chapter 2. In relation to drug driving investigations, and in the absence of type approved drug screening devices, a blood or urine specimen may only be required by a constable where a FP has advised the constable that the person concerned 'has a condition that might be due to a drug', in accordance with section 7(3) (c) of the Traffic Act. The legislation does not require the FP to form a view as to whether the person is impaired or to say categorically that the condition is due to a drug.
- 5.59.** In some cases, however, it may assist the FP, in advising whether the person concerned has a condition that might be due to a drug, to discuss with the arresting constable the behaviour and other factors which led to the constable's decision to arrest the person concerned under the impairment offence. The apparent 'recovery' of a person who, when seen by the FP, no

longer displays the signs of unfitness that caused that person to be arrested, may in fact be an indication of a condition that may be due to a drug. Without the information as to the person's condition at the roadside, it might be difficult for such a judgment to be made.

- 5.60.** Similarly, where a suspect is being uncooperative with the FP, the observations made by the police, coupled with any general observations made by the FP (such as the smell of cannabis on the person concerned), may assist the FP in providing advice under section 7(3)(c). There is no requirement for the suspect to cooperate with the FP.
- 5.61.** The FP has a further role under section 7A of the Traffic Act, in relation to taking a blood specimen from a person incapable of consenting. Section 7A(2) provides that such a requirement must be carried out by the FP, unless it is not practicable for the FP to do so. In such a case another medical practitioner may do so instead, provided that that medical practitioner is not responsible for the clinical care of the person from whom the sample is required.

## The current penalty regime for drug driving offences

### Obligatory disqualification

- 5.62.** The current penalty regime for drug drive related offences is set out in Schedule 2 to the RTOA. A table showing the offences and their corresponding penalty ranges is in Annex H.
- 5.63.** Section 34(1) of the RTOA provides that where a person is convicted of an offence involving obligatory disqualification, which in the case of drugs means the impairment offence and those under sections 7(6) and 7A(6) of the Traffic Act, the court must order that the person be disqualified for not less than 12 months. In England and Wales, the Magistrates' Court Sentencing Guidelines (the Guidelines), described more fully in Chapter 2, provide the court with the discretion to set a shorter, or no, disqualification period. The Guidelines cite driving a very short distance, genuine emergency as examples of where that discretion may be exercised. However, the court will only consider such factors in exceptional circumstances and a disqualification period less than the statutory minimum is very rarely imposed by the court.
- 5.64.** In relation to a person who has been sentenced to more than one period of disqualification for a fixed period of 56 days or more within a 3 year period, section 34(4)(b) of the RTOA provides that the minimum disqualification period must be 2 years.

### Discretionary disqualification

- 5.65.** In the case of the, usually, less serious offences of being in charge whilst unfit (section 4(2) of the Traffic Act) and failing to cooperate with a preliminary test (section 6(6)), disqualification is at the discretion of the court. Schedule 2 of the RTOA provides that endorsement is obligatory for such offences and the court must therefore endorse the offender's licence with penalty points

within the range provided in the Act. Where the offender is not disqualified, the maximum available number of penalty points must be imposed.

## Magistrates' Court Sentencing Guidelines

- 5.66.** Chapter 2 provides a comprehensive overview of the role, in England and Wales, of the Guidelines in the sentencing process, with particular reference to offenders convicted under section 5(1) of the Traffic Act (driving with an alcohol concentration above the prescribed limit) and the offences under section 7(6) and 7A(6) of that Act of failing or refusing to provide a sample or a specimen for analysis, which apply equally to drink and drugs offences. As has also been seen in Chapter 2, there is currently no system of Guidelines for the courts in Scotland where sentencing is currently done on a case by case basis exercising judicial discretion. However, there are current proposals for the establishment of a Scottish Sentencing Council which would be tasked with creating sentencing guidelines.
- 5.67.** The approach to sentencing applied by the Guidelines in England and Wales in relation to drink-drive offences applies equally to drug-drive cases. A conviction for the impairment offence will involve a statutory disqualification period of not less than the 12 months and, usually, a fine. Aggravating levels of impairment correspond to a range of penalties which graduate upwards, with evidence of high levels of impairment resulting in longer periods of disqualification and higher fines. In the most serious cases, a conviction may also result in a community order or custody. A table indicating the applicable penalty ranges is at Annex H.
- 5.68.** In addition to aggravating levels of impairment, further aggravating factors which may affect the sentence available within the applicable range for the level of impairment in question, include:
- the defendant was driving a larger goods vehicle, heavy goods vehicle or public service vehicle;
  - driving for hire or reward;
  - poor road or weather conditions;
  - carrying passengers;
  - evidence of an unacceptable standard of driving;
  - involvement in an accident;
  - location (e.g. near to a school);
  - high level of traffic or pedestrians in the vicinity.

## Fines

- 5.69.** Fines are based on one of 3 bands, with bands A, B or C being relevant to offences under section 4–11 of the Traffic Act. A full explanation of the application of fines is provided in Chapter 2 in relation to drink-drive offences.

### Ancillary orders – confiscation of vehicles

- 5.70.** Chapter 2 has considered in some detail the use of ancillary orders in England and Wales to confiscate vehicles for drink driving offences and the explicit power in section 33A of the RTOA to confiscate vehicles in Scotland for offences under the Traffic Act which are punishable with imprisonment and which involve –
- (a) driving, attempting to drive, or being in charge of a vehicle; or
  - (b) failing to comply with a requirement to provide a specimen for analysis (section 7(6) of the Traffic Act) in the course of an investigation into whether an the offender has committed an offence while driving, attempting to drive or being in charge of a vehicle.
- 5.71.** In Scotland, during the Christmas 2009 Drink Drive Enforcement Campaign the power in the RTOA was used in relation to repeat drink drive offenders, but notably, not in relation to repeat drug-drive offenders.

### Bail conditions

- 5.72.** In England and Wales, the Magistrates' Court and Crown Court are able to impose bail conditions under section 3 of the Bail Act 1976. The normal conditions of bail that may be imposed include, inter alia, such conditions as the court considers necessary to secure that the defendant does not commit an offence while on bail. In the context of drug driving cases, it is possible to impose a bail condition that the defendant must not drive. In practice, because there is a presumption of innocence unless and until a person is convicted, magistrates will impose such a condition extremely cautiously and only where there is evidence that the defendant was continuing to drive under the influence of drugs whilst awaiting trial on one or more drink or drug driving charges. Similarly in Scotland, sheriffs will generally only apply interim bail conditions of not driving if the defendant had pleaded guilty initially and background reports are being completed prior to sentencing.

### High Risk Offender Scheme

- 5.73.** The High Risk Offender Scheme (HRO Scheme) has existed since 1983. The HRO Scheme is aimed at dealing with drivers whose dependence on alcohol presents a serious road safety risk. As such, it is considered in full in Chapter 2. The HRO Scheme only applies to drink drivers but a drug driver may find themselves subject to the HRO Scheme where the offender refuses to provide a specimen and is convicted under section 7(6) of the Traffic Act. It is clearly not possible to determine how many of such offenders are, in fact, drug drivers by virtue of their refusal to provide a specimen. The exclusion of drug driving offences from the HRO Scheme is considered further in Chapter 7.

### Administrative licence suspension

- 5.74.** Administrative licence suspension has been considered in Chapter 2. Where such sanctions are used, they normally apply only in relation to drink driving.

## Drink driver rehabilitation scheme

- 5.75.** The procedure for the operation of the drink driver rehabilitation scheme (the rehabilitation scheme) is set out in sections 34A to 34C of the RTOA and is considered in detail in Chapter 2. Where an offender is referred by the court to the rehabilitation scheme and the offender successfully completes a course approved by the Secretary of State, the period of disqualification will be reduced. Although the legislation permits referrals to be made for offences involving drug driving, there are currently no approved drug driving rehabilitation courses and the courts are not permitted to refer people convicted of drug driving offences to any of the approved drink drive courses.
- 5.76.** The absence of any approved rehabilitation courses aimed at drug drivers is not unique to Great Britain. Indeed, other countries which operate driver rehabilitation schemes have also not managed to develop any suitable scheme to deal specifically with drug drivers. This is indicative of the low level of understanding of drug drive issues and the diversity of drug drivers.

## Coroners and procurators fiscal

- 5.77.** Chapter 2 refers to the coroners and procurators fiscal in greater detail. In relation to coroners, the Coroners and Justice Act 2009 provides for the appointment of a Chief Coroner. Under section 36, the Chief Coroner must give the Lord Chancellor a report for each calendar year covering both matters that the Chief Coroner wishes to bring to the attention of the Lord Chancellor and matters that the Lord Chancellor has asked the Chief Coroner to cover in the report. The Chief Coroner has not yet been appointed by the Lord Chancellor and section 36 has therefore yet to be brought into force. Section 36 may be of future assistance in the procuring of data from coroners on the presence of drugs in drivers killed in road traffic accidents. This is discussed further in Chapters 6 and 7. There is no equivalent of the Coroners and Justice Act 2009 in Scotland.

## Current law in relation to drink and drugs and operating other modes of transport

- 5.78.** Chapter 2 sets out the legislative framework concerning drink and drug consumption in relation to the operation of other modes of transport, namely railways, shipping and aviation. The legislation applicable to persons working on ships or trains either mirrors the provisions of the Traffic Act or applies the relevant sections of the Traffic Act directly. In relation to the aviation industry, the Railways and Transport Safety Act 2003 makes specific provision for the regulation of alcohol and drug consumption by aircraft flight and cabin crew, air traffic controllers, licensed aircraft maintenance engineers in the United Kingdom as well as by the crew of an aircraft registered in the United Kingdom wherever it may be in the world. In the case of drugs, it is an offence to perform an aviation function or ancillary activity when impaired by drugs.

# Chapter 6: Drug driving – Evidence, issues and opinions

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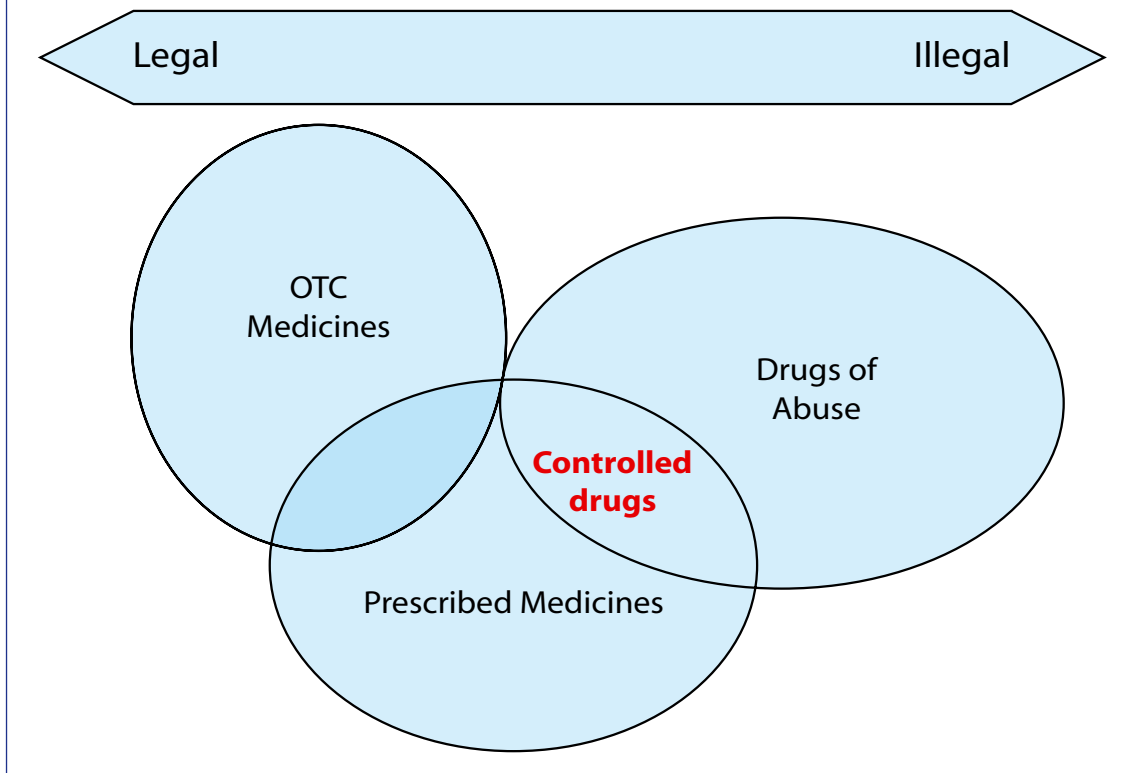
## Introduction

- 6.1. This chapter considers the key issues identified from examination of the evidence and stakeholder opinions in relation to drugs and driving. The issues relate to establishing the size of the problem, the risk of harm and whether it is possible to establish impairing levels of certain drugs within a driver's system. It considers what drugs could be included in any new offence and the practical and procedural issues of enforcement. It includes outlining the supporting statistics, research and stakeholder opinion underpinning each issue.

## Categorising drugs

- 6.2. The Misuse of Drugs Act 1971 is the main piece of legislation covering drugs and categorises illegal drugs into three classes (Class A, B and C) according to the harm that they cause, with Class A drugs considered to be the most harmful. These three classes of drugs are termed as controlled substances. For this reason it controls not just illegal drugs but also medicinal drugs (which are also covered in the Medicines Act 1968 – see below).
- 6.3. Class A drugs include ecstasy (MDMA), LSD, heroin, cocaine, crack, magic mushrooms (whether prepared or fresh), methylamphetamine (crystal meth) and other amphetamines if prepared for injection. Class B drugs include cannabis and amphetamines. Class C drugs include minor tranquilisers such as Valium (diazepam), GHB (gamma hydroxybutyrate) and ketamine.
- 6.4. Many of these controlled drugs have medical uses while others may be of scientific interest, therefore the Misuse of Drugs Act 1971 allows the government to authorise possession, supply, production and import or export of drugs to meet medical or scientific needs. These exemptions to the general prohibitions are in the form of a number of regulations made under the Misuse of Drugs Act 1971. The regulations define the further categorisation of these drugs.
- 6.5. The Medicines Act 1968 affects the manufacture and supply of certain drugs used as medicines. There are three categories:
- Prescription Only Medicines can be supplied by a pharmacist if prescribed by a doctor or by an appropriate practitioner;
  - Pharmacy medicines may be sold by a pharmacist without prescription;
  - General sales list medicines may be sold without a prescription in any shop.

Figure 6.1: Schematic representation of the relationship between medicines and drugs of abuse with respect to their legality



- 6.6. Figure 6.1 is a simplistic schematic representation of the approximate inter-relationships between medicines and drugs of abuse in terms of a spectrum of legality. It should be noted that drugs within each category are not necessarily fixed within that category but may move due to changes in classifications as prescribed by the Misuse of Drugs Act 1971.
- 6.7. In terms of driver impairment, it is probably not, in practice, helpful to distinguish between illicit and licit drugs. Any substance that can interfere with the cognitive or physical abilities required to operate a vehicle can produce qualitatively the same effect on subjects irrespective of whether the substance was obtained legitimately by prescription or not. Adverse drug effects experienced by patients taking a drug for the first time, after a change in dose, or through drug interactions can be just as impairing as illicit drug use or abuse.

## Sources of information

- 6.8. While there has been a considerable amount of research into the prevalence and impact of drink driving in this country, little research has focused on driving under the influence of drugs other than alcohol.
- 6.9. However, considerable information has been synthesised from a review of the literature available both within the UK and internationally including work commissioned by the Organisation for Economic Cooperation and

Development (OECD)<sup>148</sup> and the EU.<sup>149</sup> The Review has drawn heavily on research commissioned specifically for this task in *A Review of Evidence Related to Drug Driving in the UK*.<sup>150</sup>

- 6.10.** Although there is little ongoing research on the topic in the UK at present, there has been increased activity internationally. Notably, there is the DRUID study (Driving under the Influence of Drugs, Alcohol and Medicines) which is due to report by early 2012. The aim of this extensive EU project is to gain new insights into the real degree of impairment caused by psychoactive drugs and their actual impact on road safety in order to provide a solid base to improve regulation of drug driving.

### Current casualty statistics

- 6.11.** Driver impairment related to drugs is reported as a contributory factor<sup>151</sup> in reported road accidents resulting in 60 deaths (approximately 3% of all fatal road deaths), 280 serious injuries and 745 slight injuries – a total of 1085 casualties.<sup>152</sup> However this is likely to be an under-estimate. There are various reasons for this which includes the lack of routine testing for drugs by coroners and procurators fiscal, the low frequency of use of the Field Impairment Test (FIT) by police and the dominant effect that alcohol plays in the consideration of the cause of impairment when someone is suspected of driving while unfit. These reasons are considered in more detail in the course of this chapter.

### Prevalence of illicit drug use among the general population

- 6.12.** In light of the relative paucity of information regarding driving and drugs, it is helpful to understand better what is happening with drug use in Great Britain amongst the general population.
- 6.13.** The British Crime Survey (BCS)<sup>153</sup> is a robust source of data regarding the current prevalence of illegal drug<sup>154</sup> use in the general population of England and Wales, albeit with some methodological caveats. The Scottish Crime and Justice Survey (SCJS)<sup>155</sup> is the equivalent survey of the Scottish population. (The main difference is that the SCJS surveys everyone under 60 unlike the BCS which only surveys those aged 16–59. Findings from the BCS 2008-09 among 16–59 year olds have been compared with results from the SCJS 2008–09 following adjustment for this difference.) Across England and Wales, patterns of reported drug use were similar to those found in Scotland, with similar proportions of 16-59 year olds having used cannabis in the last year (7.9% England and Wales; 8.4% Scotland), as well as a number of other drugs, including cocaine (3.0% England and Wales; 3.7% Scotland), ecstasy (1.8%

148 Beirness D *et al.* ITF/OECD Report on Drugs in Traffic. 2010. In press.

149 EMCDDA (2008) EMCDDA Insights 8 – Drug use, impaired driving and traffic accidents. Luxembourg: Office for Official Publications of the European Communities.

150 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

151 Includes only accidents where a police constable attended the scene and in which a contributory factor was reported.

152 RRCGB 2008. Department for Transport. Reported Road Casualties Great Britain: 2008.

153 Hoare J. British Crime Survey, 2008-2009: Special Licence Access, Drug Use Module (BCS). Home Office. 2010.

154 The survey covers drugs classified under the Misuse of Drugs Act 1971.

155 MacLeod P *et al.* Results from the Drug Use module of the 2008-09 Scottish Crime and Justice Survey. National Statistics Publication for Scotland. 2010.



England and Wales; 2.5% Scotland) and amphetamines (1.2% and 1.4% respectively).

- 6.14.** In England and Wales, since 1996, overall, there has been a reduction in illicit drug use (from 11.1% to 10.1% of the population) but a significant increase in the use of Class A drugs (from 2.7% to 3.7%). Much of this increase stems from a long term increase in 'last year use' of cocaine (from 0.6% to 3%), partially offset by a decrease in use of LSD over the same period (from 1.0% to 0.2%). Between 1996 and 2008/9 there has also been a significant increase in the use of tranquilisers. In Scotland, there has been an overall decrease in illicit drug use since 2006 with decreases in the use of all drugs except cocaine and temazepam (a type of benzodiazepine) where use has remained static.
- 6.15.** The distribution of drug type prevalence indicated by the BCS and SCJS broadly mirrors patterns of drug use across other European member states, as indicated by statistics from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The EMCDDA annual report for 2009 revealed that cannabis and cocaine were the two most commonly used drug types, followed by amphetamines and ecstasy.<sup>156</sup> This similarity in prevalence of drug use to that in Europe may be useful to Great Britain in terms of relying on European drug driving research in the absence of Great Britain's own up to date research.

### Prevalence of illicit drug use among drivers in Great Britain

- 6.16.** The evidence regarding the prevalence of drug driving is far less robust. The most relevant and recent research has been conducted in Scotland which has sought to address a number of gaps in the evidence. For example, in a Scottish Executive Social Research survey of drivers between the ages of 17–39, 6% claimed to have driven at some time whilst under the influence of drugs and 3.5% in the last year.<sup>157</sup> It was suspected that there was likely to be under-reporting of this finding. In contrast to other surveys, there were no significant differences between men and women and across age groups. In the EU project, IMMORTAL, random roadside drug testing of drivers who were not involved in accidents resulted in an estimated 10.8% of drivers being found to be drug users.<sup>158</sup>
- 6.17.** By contrast, in a UK study of drivers actually suspected of driving while being impaired, the percentage of drug users was far higher. This study<sup>159</sup> which was looking at the effectiveness of the FIT test found that, of those drivers tested, 75% were positive for drugs.

<sup>156</sup> EMCDDA (2009a) Annual report 2009: State of the drugs problem in Europe. Luxembourg: Publications Office of the European Union.

<sup>157</sup> Myant K, Hope S, McIntosh J, O'Brien T, McKeganey N and Stradling S (2006) Illicit drugs and driving. Transport Research Series. Edinburgh: Scottish Executive Social Research.

<sup>158</sup> Assum T, Mathijssen MPM, Houwing S, Buttress SC, Sexton B, Tunbridge RJ and Oliver J (2005) The prevalence of drug driving and relative risk estimations. A study conducted in The Netherlands, Norway and United Kingdom. IMMORTAL EU research project, Deliverable D-R4.2.

<sup>159</sup> Oliver JS, Seymour A, Wylie FM, Torrance H and Anderson RA (2006) Monitoring the Effectiveness of UK Field Impairment Tests, Road Safety Research Report No. 63. London: Department for Transport.

- 6.18.** Analysis of the various data sources that are available shows a number of common findings:<sup>160</sup>
- Cannabis remains the most prevalent illicit drug amongst drivers across all surveys and data sources. However, there has been a significant increase since the mid-1990s in the prevalence of cocaine use: in the general population; in drug drive submissions to forensic toxicology laboratories; and amongst drivers and other road users fatally injured in road traffic accidents.
  - Regional variations are also apparent; in Scotland, benzodiazepines are the most prevalent drug group, with over 80% of these drivers suspected of being impaired due to drugs testing positive for a benzodiazepine.
  - There appears to have been a considerable increase in polydrug use by drivers since the 1990s. 16% of submissions to the Forensic Science Service (FSS) in 2008 tested positive for more than one drug,<sup>161</sup> while analysis of Scottish data<sup>162</sup> showed that 75% of drivers suspected of being impaired due to drugs tested positive for 2 or more drugs, and in 25% of cases, drivers tested positive for 4 or more drugs.
  - Recent surveys as well as media reports and anecdotal evidence suggest there has been a surge in the use of so-called 'legal highs'.<sup>163</sup> (These are described in more detail later in the chapter.) However, to date, 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, either alone or in combination with illicit drugs and/or alcohol.

### Prevalence of drug use among road collision-involved drivers

- 6.19.** There is a general lack of recent data from Great Britain on the impact that drug driving has on casualty rates, partly due to inadequate recognition of drug driving as a problem and the dominant role that alcohol plays in assessment of vehicle accidents (as described below in paragraph 6.20).
- 6.20.** According to the Reported Road Casualties of Great Britain (RRCGB) 2008<sup>164</sup> there were 131,582 accidents (resulting in 184,215 casualties) where the police attended and recorded a contributory factor. Of these, driver impairment by drugs was recorded as a contributory factor by police in 687 (0.5%) of all reported road accidents in which injury was sustained. In contrast, driver impairment due to alcohol was cited as a contributory factor in 6,758 (5%) of all accidents. Accidents involving drug impaired pedestrians account for a further 242 (0.2%) accidents (and pedestrian impairment due to alcohol was a contributory factor in 2,494 (1.9%) accidents).

160 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

161 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

162 Oliver JS, Seymour A, Wylie FM, Torrance H and Anderson RA (2006) Monitoring the Effectiveness of UK Field Impairment Tests, Road Safety Research Report No. 63. London: Department for Transport.

163 'Legal highs' are legal substances that create a feeling of intoxication and are popularly used as recreational substances.

164 RRCGB 2008. Department for Transport. Reported Road Casualties Great Britain: 2008

## What is the prevalence of drug use among road accident fatalities?

- 6.21.** In 2008, driver impairment due to drugs was listed as a contributory factor in 56 fatal road accidents in Great Britain. This accounted for 3% of all fatal road accidents that year.<sup>165</sup>
- 6.22.** Tunbridge *et al*,<sup>166</sup> analysed the results of blood and urine samples taken from 1184 road accident fatalities between 1996 and 2000. The study reported a six-fold increase in the incidence of illicit drugs detected in samples taken from victims (both driver and non-driver) of fatal road accidents since a previous, similar study<sup>167</sup> in 1989, rising from 3% in 1989 to 18% in 2000. Overall, there was a three-fold increase in drug use (medicinal and illicit combined): from 7.4% to 24.1%. Cannabis was by far the most prevalent drug detected in fatalities. In Everest *et al*'s study in 1989 of 141 participants, it was detected in 47% of all single drug use casualties and present in 11.9% of all samples analysed.<sup>168</sup> Opiates were the second most prevalent drug group (5.6% of samples) followed by benzodiazepines (4.8%) and amphetamines (4.5%). Trends in polydrug use of those fatalities who tested positive for drugs increased significantly between the two studies just described, from 6.3% of fatalities testing positive for multiple drugs in 1989, to 26% in 2000. The most common drug combination was amphetamines and cannabis (17% of multiple drug samples). The studies concerned detected the presence of drugs but there was no assessment of actual impairment at the time of driving.

## The changing landscape of drug driving

- 6.23.** The data that are available now and from approximately 10 years ago, suggest that there have been significant changes in the patterns of drug use in the past decade. This makes the reliance on historic data even more problematic. While research suggests that cannabis is still the illicit drug most commonly used in the general population (and most frequently detected in drivers), the continuing rise in the use of cocaine, particularly among younger adults, coupled with the move away from ecstasy and drugs such as LSD is worthy of note. Moreover, the recent surge in interest in drugs known as 'legal highs' is also of particular concern.<sup>169</sup>

## Lack of systematic drug driving data collection in Great Britain

- 6.24.** The review of the literature has identified a number of potential sources of data on drug driving, for example that collected by coroners and the results of drug drive submissions sent to toxicology labs for analysis. However, whilst data on drug driving do exist, a lack of coordination between all stakeholders (e.g. Home Office, Ministry of Justice, Department for Transport, coroners, forensic toxicology laboratories) and a lack of resources means

165 RRCGB 2008. Department for Transport. Reported Road Casualties Great Britain: 2008

166 Tunbridge RJ, Keigan M and James F (2001) The incidence of drugs and alcohol in road accident fatalities. TRL Report 495. Crowthorne: TRL.

167 Everest JT, Tunbridge RJ and Widdop B (1989) The incidence of drugs in road accident fatalities. TRL Report RR202. Crowthorne: TRL.

168 Everest JT, Tunbridge RJ and Widdop B (1989) The incidence of drugs in road accident fatalities. TRL Report RR202. Crowthorne: TRL.

169 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

that these data have neither been collected on a routine basis or in a standardised manner, nor extracted and analysed to determine the true extent and nature of the drug-drive problem.<sup>170</sup>

- 6.25. Procurators fiscal are not required in law to report the levels of drug and alcohol for fatalities involved in road traffic accidents although they may report this to the Registrar in cases where it can be proved that this has contributed to the cause of death. There are no plans to change procurators fiscal's responsibilities on this issue.<sup>171</sup>

## Understanding the basis of drug effects on safe driving performance<sup>172</sup>

- 6.26. Driving is often described as a complex task that requires the coordination of a variety of motor, perceptual and cognitive tasks. The skill and attention required for safe driving are acquired through years of practising the necessary actions and operations to guide a vehicle safely through traffic.
- 6.27. Some drug effects are obvious in terms of their adverse effects on driving. Depressant drugs, which can cause slowed response time, slower neural processing, slower recall, greater error rates in complex tasks, balance and orientation changes, lowered alertness and sedation, can obviously be related to impairment. Likewise hallucinogens, and drugs with sedation as their main effect or side effect, have an obvious adverse effect on overall driving performance. Stimulants, often thought of as performance-enhancing drugs, might improve reaction time but can also affect critical judgment, increase impulsiveness, increase error rate, and interrupt normal sleep patterns.
- 6.28. The interrelation of skills involved in safe driving, and the inevitable occurrence of side effects, means that any centrally-acting drug has at least the potential negatively to affect driving skill or to displace driving performance from its baseline level – that is, they can interfere with the ability to operate a vehicle safely.

### Effects of different drugs on driving

- 6.29. Information about the effects of drugs in driving populations has been studied through a combination of laboratory based behavioural studies, on-road driving studies, and epidemiological study. However, there are ethical constraints which limit such studies. Review of the literature<sup>173</sup> allows a summary of the main illicit drugs which cause impaired driving most commonly.

170 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

171 Scottish Executive. Road Safety Policy. Correspondence Apr 2010.

172 Beirness D *et al.* ITF/OECD Report on Drugs in Traffic. 2010. In press.

173 Beirness D *et al.* ITF/OECD Report on Drugs in Traffic. 2010. In press.

## *Cannabis*

**6.30.** Cannabis (marijuana) is a unique drug, having both hallucinogenic and central nervous system depressant properties. In on-road driving experiments, difficulty in maintaining lane position (weaving) and headway were noted with a trend towards increasing impairment with increasing dose.<sup>174</sup> Other reported effects of marijuana on driving ability include inattention, poor coordination, slowed reaction time and increased error rates in complex tasks. When combined with alcohol, the effects appear to be considerably greater than would be expected by each substance's effect working alone. This includes a decrease in visual search activity, changes in reaction time, and increased driving out of lane.<sup>175,176</sup>

## *Stimulants*

**6.31.** Stimulants, which include amphetamines, metamphetamine and cocaine, produce a range of effects on drivers that differ in the acute phase (shortly after drug consumption) from the post-acute phase, when drug withdrawal or abstinence syndrome can be an issue.<sup>177</sup> The immediate effects of stimulant use produce intense excitement and euphoria, which can be distracting and disorienting, affecting the degree of attention and concentration on driving. The drugs also produce changes in reaction time, often resulting in faster but less reasoned and more impulsive responses, and increased risk taking. At low doses, stimulants can offset fatigue and delay the need for sleep (which may be of some short-term benefit for a driver),<sup>178</sup> but when abused the chronic sleep loss resulting from binge use creates a rebound or withdrawal effect when drug use stops.

## *Central nervous system depressants*

**6.32.** This category includes drugs such as benzodiazepines (for example, diazepam and temazepam), sedative hypnotics used as 'sleeping tablets', some antidepressants, muscle relaxants and some antihistamines. This category is the most challenging to discuss, because most of these compounds have legitimate therapeutic uses, and in many cases a driver treated with an impairing drug, for example, a driver successfully treated for depression with an antidepressant, is often a better driver than an untreated driver.<sup>179</sup> Benzodiazepines, while a legitimate medicine, are frequently either misused as such or are used as a drug of abuse. In terms of impairment, the central nervous system depressant-impaired driver has difficulty maintaining lane position, drives too fast or too slowly for conditions, fails to obey traffic signals, and is involved in crashes through lack of sustained attention and

174 Ramaekers JG, Robbe HW, O'Hanlon JF. (2000) Marijuana, alcohol and actual driving performance. *Hum Psychopharmacol.* 15(7):551-558.

175 Lamers CT, Ramaekers JG. (2001) Visual search and urban driving under the influence of marijuana and alcohol. *Hum Psychopharmacol.* 16(5):393-401.

176 Ramaekers JG, Robbe HW, O'Hanlon JF. (2000) Marijuana, alcohol and actual driving performance. *Hum Psychopharmacol.* 15(7):551-558.

177 Logan BK and FJ Couper (2001) 3,4-Methylenedioxyamphetamine (MDMA, ecstasy) and driving impairment. *J Forensic Sci.*, 46(6): 1426-33.

178 Caldwell JA *et al.* Efficacy of Dexedrine for maintaining aviator performance during 64 hours of sustained wakefulness: a simulator study. *Aviat Space Environ Med.* 2000 Jan;71(1):7-18.

179 Wingen M, Bothmer J, Langer S, Ramaekers JG. (2005) Actual driving performance and psychomotor function in healthy subjects after acute and subchronic treatment with escitalopram, mirtazapine, and placebo: a crossover trial. *J Clin Psychiatry* 66(4):436-43.

slow reactions. Recent research has concluded that benzodiazepine users are at a significantly increased risk of crashes compared to nonusers, and these differences may be accounted for by a difficulty in maintaining road position.<sup>180</sup> This increased risk of crash appears to be highest during the first few weeks of use.<sup>181</sup>

### *Narcotic analgesics*

**6.33.** The narcotic analgesics include the drugs heroin and morphine (used commonly for relief of severe pain). Tolerance to the effects of opioids is well documented, and there is some evidence that people who become stabilized on moderate doses of opioids have tolerance to some of the impairing effects of these drugs. However, recreational use or abuse of opiates generally involves the use of doses which defeat any offset for tolerance. The euphoric intoxicating effect of opioid abuse is inherently inconsistent with safe driving. There is a specific marker (6-monacetylmorphine) which can differentiate between use of morphine, and heroin abuse.<sup>182</sup>

### *Hallucinogens, dissociatives and inhalants*

**6.34.** Hallucinogens, dissociatives and ‘inhalants’ are drugs which create associations in the mind resulting in an altered perception of reality. ‘Inhalants’ are a broad range of substances whose volatile vapours are taken in via the nose and windpipe. Common ‘inhalants’ of abuse include glue and acetone (nail varnish remover). Hallucinogens, dissociatives and ‘inhalants’ are highly debilitating, and interfere with a person’s normal daily activities to the extent that driving is not just impaired, but is impossible; consequently, they are less frequently encountered in arrested or deceased drivers.

### *Priority drug classes identified as being detected in driving populations*

**6.35.** As described, there is a wide variety of substances (both licit and illicit) that can negatively affect the skills and abilities necessary to operate a vehicle safely which makes their listing a challenge. It appears, on the basis of the synthesised research evidence, that the drugs or classes of drugs of most concern which are associated with impairment of driving and more commonly abused (rather than used under medical supervision) are:<sup>183,184,185</sup>

- opiates;
- amphetamines;
- methamphetamine;
- ecstasy (MDMA);
- cocaine;

180 Rapoport M *et al.* Benzodiazepine use and driving: a meta-analysis. *J Clin Psychiatry*. 200V Dec;70(12):1727-9.

181 Van Laar M, Volkerts E. Driving and benzodiazepine use: Evidence that they do not mix. *CND Drugs*. Vol 10, (5), Nov 1998, pp383-396(14).

182 Beirness D *et al.* ITF/OECD Report on Drugs in Traffic. 2010. In press.

183 Beirness D *et al.* ITF/OECD Report on Drugs in Traffic. 2010. In press.

184 EMCDDA (2009a) Annual report 2009: State of the drugs problem in Europe. Luxembourg: Publications Office of the European Union.

185 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

- benzodiazepines;
- cannabinoids (including cannabis); and
- methadone.

**6.36.** Other depressants, which are mostly medicines, such as sedative hypnotics, first-generation antidepressants, antihistamines and muscle relaxants have also been found to be impairing.

### Legal highs<sup>186</sup>

**6.37.** 'Legal highs', also known as new psychoactive substances, refers to a group of relatively new drugs which have increased in popularity over the past 2 years throughout the UK and across Europe. Until December 2009, this group included mephedrone, GBL, BZP and synthetic cannabinoids. However, as a result of being newly classified under the Misuse of Drugs Act 1971, of these named drugs, only mephedrone remained legal until March 2010 when it was also banned and made a Class B drug. However, one of the challenges of the 'legal highs' is that they are a dynamic group reflecting both rapidly changing synthesis and manufacture patterns and their customers' drug-taking 'fads'.

**6.38.** At present, very few data are available to establish the true prevalence of legal highs in Great Britain. However, media reports, largely based on anecdotal interviews, suggest use is widespread throughout the country. A recent survey<sup>187</sup> on drug use amongst clubbers revealed that, of 2,200 respondents, 59% had tried a legal high of some kind and 38% had tried some form of legal high 'party pill'. 42% of respondents reported having used mephedrone at some time (34% in the last month) and one in four respondents (26%) had used BZP at some time. The same survey found that the percentage of the group who had used cannabis, ecstasy and cocaine in the last month was 54%, 48% and 47% respectively. Despite their increased prevalence, particularly within certain demographic groups, at present, few if any of these drugs are included in standard screening panels in toxicology laboratories.

**6.39.** Research has yet to consider the effect of these drugs on driving or road safety generally. From what is known of the chemical structures of the drugs and user reports, the effects of legal highs on road safety may be inferred by reference to research on similar, established drugs. The true scope of effects, however, is unknown and so these comparisons should be treated with caution as the legal high effects may be less predictable, more intense or may interact with other drugs and alcohol in different ways.

**6.40.** Synthetic cannabinoids present particular challenges to forensic laboratories, as by the time their chemical structure has been identified, still more will have been developed, with ever changing brand names and active components, as those producing them change the drugs' composition to circumvent the law.

<sup>186</sup> Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

<sup>187</sup> Mixmag (2010) "Drugs Survey". Issue 225, February 2010.

## Polydrug use including alcohol and drugs

### *Prevalence of polydrug use*

- 6.41.** A European Monitoring Council for Drugs and Drug Addiction (EMCDDA) review<sup>188</sup> of the literature relating to drug use and driving concluded that drivers stopped on suspicion of alcohol use are frequently also under the influence of drugs. Cannabis is the most frequently detected drug in these samples.
- 6.42.** In Great Britain, Tunbridge *et al*<sup>189</sup> found that, of all road fatality cases in which at least one drug was detected, multiple drugs were detected in 26% of (75) study subjects. Another study of GB road fatalities found that 26% of (87) drivers testing positive for either drugs and/or alcohol were found to have taken both.<sup>190</sup> Oliver *et al*<sup>191</sup> reported that 63% of cases where drivers were suspected of driving under the influence of drugs were found to be positive for multiple drugs. The most common drugs found in combination were benzodiazepines and opioids (90% of polydrug cases). As noted in paragraph 6.18, polydrug use is on the increase in Great Britain.

### *Risks of polydrug use*

- 6.43.** The OECD review<sup>192</sup> of several studies concluded that drivers who combine the use of alcohol with cannabis, benzodiazepines or any other psychoactive substance are at significantly increased risk of crash involvement. Importantly, the risks associated with the use of more than one substance are higher than those associated with the use of a single substance alone. The review concluded that drivers who combine more than one psychoactive substance and/or alcohol pose a serious threat to themselves and other road users.

## Medicines

- 6.44.** While cannabis remains the most commonly used drug associated with driving impairment, there are various medicines which have been detected in suspected driver impairment (although not necessarily associated with increased crash risk). The medicines most frequently implicated<sup>193</sup> are benzodiazepines (e.g. 'Valium', temazepam), sedative hypnotics (e.g. zopiclone, zolpidem), first generation antidepressants (e.g. amitriptyline), antihistamines (e.g. chlorpheniramine), muscle relaxants (e.g. carisoprodol) and narcotic analgesics (e.g. codeine, morphine, tramadol and methadone).
- 6.45.** It should be noted that abuse or misuse of therapeutic drugs or 'medicines' can produce significant impairment and adverse effects. The Medicines and Healthcare Products Regulatory Agency (MHRA) highlighted in its evidence

188 EMCDDA (2008) EMCDDA Insights 8 – Drug use, impaired driving and traffic accidents. Luxembourg: Office for Official Publications of the European Communities.

189 Tunbridge RJ, Keigan M and James F (2001) The incidence of drugs and alcohol in road accident fatalities. TRL Report 495. Crowthorne: TRL.

190 Elliott S, Woolacott H and Braithwaite R (2009) The prevalence of drugs and alcohol found in road traffic fatalities: A comparative study of victims, Science and Justice 49 pp. 19-23.

191 Oliver JS, Seymour A, Wylie FM, Torrance H and Anderson RA (2006) Monitoring the Effectiveness of UK Field Impairment Tests, Road Safety Research Report No. 63. London: Department for Transport.

192 Beirness D *et al.* ITF/OECD Report on Drugs in Traffic. 2010. In press.

193 Beirness D *et al.* ITF/OECD Report on Drugs in Traffic. 2010. In press.



to the Review that there is an increasing trend of buying prescription only medicines over the Internet. It is likely that a proportion of medicines bought in this way may be misused.

- 6.46.** Recent studies show very poor rates of compliance with prescription directions in some patient populations such as those with chronic pain. Patients frequently take more analgesia than originally prescribed or recommended.<sup>194</sup> Although tolerance to some sedative effects may occur in some patients, narcotic analgesic toxicity, whether caused by heroin injection or double dosing with oxycodone (a prescription only opiate medicine), may still, for a proportion of patients, result in the same symptoms of sedation and sleepiness, slowed reactions and pinpoint pupils leading to driver impairment.
- 6.47.** However, despite evidence of impaired driving, the evidence regarding the role of medicines in road crashes remains unclear, mainly due to the lack of adequately large and robust research studies. A recent OECD review of the international literature on the effect of psychoactive substances used as medicines (including anticonvulsants, antidepressants, antipsychotics and sedatives) has concluded that there is currently insufficient evidence to determine the extent to which these psychoactive substances are associated with an increased crash risk.<sup>195</sup>

### The role of health care professionals

- 6.48.** While the impairing effects of drugs – both illicit and medicines – may be similar, the significant differences between them lie in the potential role of others to intervene and manage the risks of medicines. Health care professionals, more sophisticated medicines information and the pharmaceutical industry each play a significant role in managing the risks associated with medicine-related driver impairment.

#### *Health care professionals' advice*

- 6.49.** A recent study<sup>196</sup> explored the knowledge and attitudes of healthcare professionals towards advising patients about their fitness to drive as set out by the DVLA (Driver Vehicle Licensing Agency) medical standards. Overall, general knowledge of these standards was poor even though most health care professionals believed they have a 'duty of care' to discuss and to advise on fitness to drive with their patients. And from the patient's perspective, most patient interviewees (91%) believed that health care professionals should advise patients on how medical conditions may affect fitness to drive. Although the focus of this study was on medical conditions, it is not unreasonable to infer that health care professionals might also not be advising patients sufficiently on the possible impairing effect of medicines.

194 Couto J E *et al.* High Rates of Inappropriate Drug Use in the Chronic Pain Population. *Population Health Management*. August 2009, 12(4): 185-190.

195 Beirness D *et al.* ITF/OECD Report on Drugs in Traffic. 2010. In press.

196 Hawley D *et al.* The Attitudes of Health Professionals to Giving Advice on Fitness to Drive. DfT 2010.

- 6.50.** The General Medical Council<sup>197</sup> advises the following to all practising doctors: *'You should seek the advice of an experienced colleague or the DVLA or DVLA's medical adviser if you are not sure whether a patient may be unfit to drive. You should keep under review any decision that they are fit, particularly if the patient's condition or treatments change. The DVLA's publication For Medical Practitioners – At a Glance Guide to the Current Medical Standards of Fitness to Drive includes information about a variety of disorders and conditions that can impair a patient's fitness to drive.'*
- 6.51.** The DVLA's *At a Glance Guide*<sup>198</sup> offers some advice regarding care with medication and driving although much of the advice on medication in this document refers to drugs taken for psychiatric conditions. A more comprehensive review of the effects of medicines on driving can be found in *Fitness to drive: A guide for health professionals*.<sup>199</sup>
- 6.52.** There is an opportunity for health care professionals and the person taking the medicine to consider various questions. For a prescribed medicine, the health care professional may wish to consider the following questions:
- Could this medicine at this dose cause impairment to a driver and could this therefore affect my patient?
  - Could I prescribe a therapeutically-equivalent medicine that will be less impairing?
  - Have I warned this patient about the impairing effects of this medicine?
- 6.53.** At the point of dispensing or sale of a potentially driver-impairing medicine, there is also an opportunity for a pharmacist or pharmacy assistant to highlight the risk of impaired driving to the customer.

#### *Medical categorisation*

- 6.54.** Over the last 20 years, following the initial development in the Netherlands,<sup>200</sup> several countries have tried to compile a list of medicinal drugs categorized according to their impairing properties. The general aim of these guidelines is to allow the prescribing doctor and dispensing pharmacist to look for the least impairing alternatives within one specific therapeutic class. In Great Britain, a current Department for Transport *THINK!* campaign<sup>201</sup> is aiming to increase awareness of driving under the influence of medicines.
- 6.55.** The International Council on Alcohol, Drugs and Traffic Safety (ICADTS) proposed a pragmatic consensus-based categorisation,<sup>202</sup> based on previous European work but also highlighted the future work of DRUID.<sup>203</sup> One of the DRUID work packages is to review the available evidence regarding

197 GMC. Confidentiality: reporting concerns about patients to the DVLA or the DVA. Supplementary Guidance. Sep 09.

198 DVLA. At a glance guide to the current medical standards of fitness to drive. Sep 09.

199 Carter T. Fitness to drive: A guide for health professionals. DfT. 2006.

200 Wolschrijn H, De Gier JJ and De Smet PAGM. Drugs and driving: a new categorization system for drugs affecting psychomotor performance. Institute for Drugs, Safety and Behaviour, University of Limburg, The Netherlands, 1991. Tech Report.

201 THINK! campaign on legal drugs (medicines). Launched in Jan 2010. Available at: <http://www.dft.gov.uk/think/drugdrive/legaldrugs.shtml>

202 ICADTS. Categorisation system for medicinal drugs affecting driving performance. 2007.

203 DRUID. <http://www.druid-project.eu/>

medicines categorisation and to propose the definitive categorisation system according to the level of impairment they cause. DRUID is expected to report on its findings by early 2012.

### Labelling of medicines

- 6.56.** For prescribed medicines, the British National Formulary<sup>204</sup> (BNF) provides a list of recommended wording for cautionary and advisory labels. For certain medicines, pharmacists are recommended to use one of three labels which warn of drowsiness. For medicines for adults, the labels also advise against driving or operating machinery if the person is affected by drowsiness. Over the counter (OTC) medicines are generally labelled by the manufacturer. There is provision for warnings in patient information with medicines in the current national and European regulatory framework.
- 6.57.** There is a statutory requirement for a warning for antihistamines of drowsiness and the need for caution if driving or operating machinery since 1994.<sup>205</sup> Despite this, a UK review<sup>206</sup> of over one hundred OTC medicines with the unwanted potential to cause drowsiness highlighted the inconsistency of accuracy of information regarding drowsiness and dosage provided by some manufacturers. Few products had clear and well presented labelling. The authors recommended that the introduction of a standard symbol, warning of drowsiness, should be considered in Great Britain. It would provide more uniformity and reduce the possibility of people driving drowsy after taking medication they believed to be safe. However, drowsiness is not the only adverse effect that can impair driving. Other impairing effects include, for example, severe nausea or impaired concentration.
- 6.58.** Different countries have tried to address the issue of the impact of various medicines on driving ability. A scheme of medicines labelling has been adopted in France. Medicines are labelled with one of three 'traffic light' warnings as demonstrated in Figure 6.2.

Figure 6.2: Showing the traffic light' warnings for medicines labelling in France<sup>208</sup>



Translation:

- Yellow (Level 1): Be careful. Don't drive without reading the leaflet.
- Amber (Level 2): Be very careful. Don't drive without advice from a healthcare professional.
- Red (Level 3): Warning – Danger: Don't drive. Take advice from a doctor before driving again

204 British National Formulary (BNF) 58, September 2009. (2009). 58th Ed., Derby, Great Britain, British Medical Association and the Royal Pharmaceutical Society of Great Britain.

205 Regulation 14B schedule 6 of the Medicines for Human Use Regulations 1994. SI 1994/3144.

206 Paragraph 6(2)(c) of Schedule 5 to the Medicines for Human Use (Marketing Authorisation Etc.) Regulations 1994 (S.I. 1994/3144).

207 Source: AFSSAPS. Mise au point. Médicaments et conduite automobile. Actualisation – Mars 2009.

## Other procedural issues

### The field impairment test

- 6.59.** As described in Chapter 5, the FIT test may be used by police constables at the roadside in the assessment of a driver suspected of being unfit to drive due to either drink or drugs.
- 6.60.** The origins of the FIT test used in Great Britain lie in the Drug Recognition Expert program originated by the Los Angeles Police Department in the 1970s. Subsequently, through collaboration with other agencies and following interest internationally, adaptations of the resulting Drug Evaluation and Classification (DEC) programme have been implemented in many countries including Great Britain.
- 6.61.** As described in Chapter 5, the FIT test consists of a battery of 5 tests of psychomotor ability and divided attention that are based on the Standardised Field Sobriety Tests (SFST)<sup>208</sup> that form part of the DEC programme.

### *Uptake of FIT test*

- 6.62.** The research conducted on behalf of the Review<sup>209</sup> has highlighted the lack of data on the current practical implementation of FIT testing across police forces. The researchers found that, although Department for Transport records showed that since 2005 there were approximately 200 police constables approved as FIT test Instructor Trainers, there were no records of whether instructors had received refresher training or were up-to-date in their training. There is no requirement for data (and therefore no routine data available) on the number of police constables who are trained to administer FIT tests and of those who are actively doing so, nor on the number of FIT tests performed by either the individual police constable or for each police force as a whole. However, there was some limited evidence of the use of FIT tests in comparison to the use of alcohol breath tests collected as a one-off review of the 2009 Christmas drink-drive campaign.
- 6.63.** Although data on preliminary testing for drink-drive campaigns is not collected routinely, ACPO statistics on the Christmas 2009 drink-drive campaign are informative.<sup>210</sup> The data showed that, between 1st December 2009 and 1st January 2010, the 43 police forces in England and Wales administered 223,423 breath tests. This was a 22% increase on the number administered during the Christmas 2008 campaign. Over 7600 (4%) of these tests were positive, failed or refused, resulting in the arrest of the driver. (The proportion of breath tests which are positive during the rest of the year, are usually in the order of 16–17%.)<sup>211</sup> In contrast, during the same campaign (Christmas 2009) a total of just 489 FIT tests were conducted (up from 481 in 2008) of which 87 (18%) resulted in an arrest on suspicion of

208 The SFST was originally designed to detect alcohol intoxication and usually consists of the walk-and-turn test, the one-leg-stand test and horizontal gaze nystagmus (HGN) – a test particularly sensitive to alcohol impairment.

209 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

210 ACPO submission to North review. Feb 2010. (Unpublished.)

211 Department for Transport. Correspondence May 2010.

drug driving. These data are clearly not representative of normal policing activities throughout the whole of the year. However, it is informative to see how few FIT tests were conducted, and how many of these resulted in arrest, compared to the number of breath tests administered and the small proportion found to be positive.<sup>212</sup>

- 6.64.** In the absence of data regarding the use of the FIT test across police forces, it is not easy to draw any clear statistical conclusions regarding the effectiveness of the FIT test in helping the police constable to make a judgment as to a driver's impairment. However, qualitative research has been completed which offers insights into reasons why so few FIT tests are conducted. Officer<sup>213</sup> compared drug drive cases submitted for analysis to the Scottish Police Services Authority in three time periods (1996-2000, 2003 and 2008). Although the focus of the report was the differences in drug driving prevalence across the 12 years of the study, the author comments that, following the original introduction of the FIT test in Scotland, there was an increase in the number of cases of suspected drug driving under section 4 of the Traffic Act being submitted for analysis, but *"the number of FIT tests being carried out has dropped and arrests have tailed off. Discussions with the Police revealed that many Police Constables lack the confidence to carry out the tests and a lack of regular training may be partly to blame."*

#### *FIT test as a screening tool*

- 6.65.** Previous research has established that FIT tests are a useful screening tool for police constables to use when faced with a driver that they suspect of being impaired due to drugs.<sup>214</sup> The tests enable police constables to interact with the driver at close quarters, as a result of which they are able to observe the driver's manner and demeanour, their speech and appearance. Together with the constable's prior observations of the individual's driving (and other behaviour), the tests provide additional evidence which helps the constable to make a decision as to whether the driver may be impaired due to drugs. While it is clear that certain aspects of the FIT test procedures could be improved, in the absence of a type-approved roadside screening device the tests are a valuable addition to the evidence gathering process.
- 6.66.** Hampshire Police, who have considerable experience of using the FIT test and its associated processes widely, reported that, in 2009, 475 FIT tests were performed of which 63 were found to be positive for impairment. Of these 63 cases, 38 cases led to a prosecution in which 33 (52%) were found guilty in court which was considerably higher than in 2008, when only 25% of cases prosecuted actually led to conviction. The improved result was considered to be a result of better quality case file evidence (which included the quality of the FIT test assessment). The results are summarised in Table 6.1.

212 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

213 Officer J (2009) Trends in drug use of Scottish drivers arrested under Section 4 of the Road Traffic Act – A 10 year review, Science and Justice 49 pp.237–241.

214 Oliver JS, Seymour A, Wylie FM, Torrance H and Anderson RA (2006) Monitoring the Effectiveness of UK Field Impairment Tests, Road Safety Research Report No. 63. London: Department for Transport.

	2008	2009
<b>Number of FIT tests conducted</b>	871	475
<b>Positive FIT tests</b>	118	63
<b>% of positive FIT tests in relation to tests conducted</b>	14%	13%
<b>Number of prosecutions</b>	66	38
<b>% of prosecutions in relation to positive tests</b>	56%	60%
<b>Number found guilty at court</b>	30	33
<b>% of guilty findings in relation to positive tests</b>	25%	52%

### *Potential of the FIT test to detect impairment due to specific drugs*

- 6.67.** Research<sup>215</sup> has also considered whether the FIT test (or more typically the US version – the SFST) is effective in detecting impairment due to specific drugs. This research suggests that the FIT test is not a sensitive measure for detecting amphetamines; however, positive results were found for cannabis (alone and in combination with alcohol) and also for ketamine. Evaluation of the more sophisticated DEC programme suggests that, in general, police officers trained in the DEC programme are able to identify those under the influence of drugs and to specify the drug class responsible with a degree of accuracy that not only exceeds chance, but in some cases reaches a very high level.<sup>216</sup>
- 6.68.** These findings highlight an important benefit of the FIT test that should not be overlooked: the dynamic nature of drug culture is such that, until a screening device is available that is capable of detecting all drugs, drug screening devices are likely to be at least one step behind current trends. It is likely that there will always be drugs which are not easily and practically detected. In these cases, a well conducted FIT test could help the constable to identify impairment and pinpoint the broad group of drugs that might account for that impairment, thus helping to direct any subsequent toxicological analysis in the laboratory.

### *Other benefits of the FIT test*

- 6.69.** The process of the FIT test also allows a police constable to search the driver's car for any other evidence of drug use, such as needles and syringes, which may be useful for drug identification purposes

### **Supporting the forensic physician**

- 6.70.** Forensic physicians, as described in Chapter 5, are supported by the Faculty of Forensic and Legal Medicine (FFLM). This is the academic body that facilitates the development and training of forensic physicians (FP). They

215 Oliver JS, Seymour A, Wylie FM, Torrance H and Anderson RA (2006) Monitoring the Effectiveness of UK Field Impairment Tests, Road Safety Research Report No. 63. London: Department for Transport.

216 Beirness D *et al.* Evaluation of the Drug Evaluation and Classification Program: A Critical Review of the Evidence Traffic Injury Prevention. Vol 8, Issue 4 Dec 2007, pp 368 – 376.

produce a range of publications and proforma which FPs can use as part of their assessment of a detainee.<sup>217</sup>

- 6.71.** FFLM have produced a comprehensive proforma<sup>218</sup> intended to “assist FPs in determining whether a person has a condition, which might be due to drink or drugs and not necessarily due to ‘impairment.’” On the form, the FFLM advise that the form is to be regarded as an aide-memoire and that “it is important to stress that the primary question police require to be answered is ‘Has the person a condition which might be due to some drug?’”. It is highlighted to any FP who uses the form that “it is not necessary [for them] to determine impairment or unfitness to drive.” It is also suggested that the contents of the form may be useful in the general assessment of a person’s fitness to be detained as the proforma allows a broader assessment of a person’s physical and mental state. It is not known how many FPs are likely to use this proforma in practice and how carefully they would read the caveats about its use in suspected drug driving cases.

### Laboratory blood drug tests

- 6.72.** Police forces in England and Wales submit blood samples for drug analysis to a laboratory approved under the police’s National Procurement Framework. These laboratories participate in strict quality control processes as part of the national assurance process, the United Kingdom Accreditation Service (UKAS). In 2008, approximately 5100<sup>219</sup> samples were processed by the two main laboratories used under the National Procurement Framework, LGC and the Forensic Science Service (FSS). The aim of the processes is to minimise the possibility of error, both human and from the instruments, in order to produce a result that is as accurate as possible. Scottish police forces use the Scottish Police Services Authority Forensic Services.
- 6.73.** If a FIT test is performed, police procedure specifies that any sample which is then taken and sent to the laboratory should be accompanied by police form MG DD/F which details the observations of the FIT test. However, the Review was told that, in practice, this is infrequently adhered to. Police form MG DD/E which allows the police constable to inform the laboratory of which drugs are suspected (for example, from local intelligence of drug use patterns) is also infrequently used and this prevents the laboratory from targeting the most likely drug(s). Both forms are presented in Annex N.
- 6.74.** In the absence of additional information, the laboratory must apply a standard panel of drug tests in the hope of identifying one of the more common drugs of misuse. Should no drug be identified in the initial panel of testing, it is at the discretion of the laboratories whether other drugs will be tested for.

217 Faculty of Forensic and Legal Medicine website. Available at: <http://fflm.ac.uk/>

218 Faculty of Forensic and Legal Medicine. Proforma. Section 4 RTA assessment.

219 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

## Prosecution of drivers with positive blood tests: Drug driving offences and outcomes

6.75. The Ministry of Justice releases annual statistics on the number of proceedings and convictions for driving-related offences in Magistrates' Courts in England and Wales.<sup>220</sup> Table 6.2 summarises drug and drink driving related offences for 2007 and 2008. The table highlights the change in the number of proceedings and proportion of cases resulting in a conviction across the two years. It is interesting to see just how few drugs-related proceedings compared to drink-related proceedings are carried out. Drug-related proceedings represent less than 1% of drink-related proceedings and this figure has fallen substantially over the 2 years. Furthermore, drink-related proceedings were more likely to have resulted in a finding of guilt compared to drug-related proceedings.

Driving offence type		2007	2008	Change
Drink <sup>222</sup>	Proceedings	81,578	73,223	-10%
	Findings of guilt	76,693	69,493	-9%
	% found guilty	94.0%	94.9%	1%
Drugs <sup>223</sup>	Proceedings	646	253	-61%
	Findings of guilt	412	168	-59%
	% found guilty	63.8%	66.4%	4%
Drink or drugs <sup>224</sup>	Proceedings	1,939	2,599	34%
	Findings of guilt	1,014	1,426	41%
	% found guilty	52.3%	54.9%	5%
Failing to provide a specimen <sup>225</sup>	Proceedings	12,873	10,981	-15%
	Findings of guilt	10,438	9,134	-12%
	% found guilty	81.1%	83.2%	3%

Source: [collated from] MoJ, 2008

220 Ministry of Justice. 2008.

221 Drink driving offences include: Unfit to drive through drink (impairment), Driving with alcohol in the blood above the prescribed limit, In charge of stolen vehicle while unfit through drink (impairment), In charge of motor vehicle with alcohol in the blood above the prescribed limit.

222 Drug driving offences include: Unfit to drive through drugs (impairment), In charge of stolen vehicle while unfit through drugs (impairment)

223 Drink or drugs offences include: Causing death by careless driving under influence of drink or drugs, Unfit to drive through drink or drugs (impairment), In charge of motor vehicle while unfit through drink or drugs (impairment).

224 Failing to provide a specimen offences include: Driving and failing to provide specimen for analysis (breath, blood or urine), In charge of motor vehicle and failing to provide specimen for analysis (breath, blood or urine), Failing to provide specimen for initial breath test, Failing to allow specimens of blood to be subjected to laboratory test



Table 6.3: Persons proceeded against for drink and drug driving offences in Scottish summary courts, 2007–08 and 2008–09 <sup>226</sup>				
Driving offence type		2007-08	2008-09	% Change
Drink <sup>222</sup>	Proceedings	6926	6418	-7.9%
	Findings of guilt	6349	6194	-2.5%
	% found guilty	91.7%	96.5%	5.0%
Drink or drugs <sup>224</sup>	Proceedings	325	345	5.8%
	Findings of guilt	300	321	6.5%
	% found guilty	92.3%	93.0%	0.8%
Failure to provide a specimen <sup>225</sup>	Proceedings	7,251	6,763	-7.2%
	Findings of guilt	6,649	6,515	-2.1%
	% found guilty	91.7%	96.3%	0.0%
* No available data for drug driving offences				

Source: [collated from] Scottish Executive, 2010

**6.76.** These figures might point to a number of issues which are related to the priority that police attach to drug driving in comparison to drink driving, the competence and confidence they feel to charge suspects in such cases and the general ability of the system (including the Crown Prosecution Service and Magistrates Courts) to manage these cases.

### Role of custody nurses

**6.77.** Custody nurses already play a role in assessing people held in police custody as described in Chapter 2. The Royal College of Nursing (2008)<sup>226</sup> describes a custody nurse as providing:

*"...health care services within police custody suites. Their work is focused on conducting clinical assessments, identifying and implementing appropriate interventions, collecting forensic samples, providing advice and guidance, and maintaining detailed and accurate records to ensure the health, safety and welfare of people held in police custody."*

**6.78.** Over the last 5–8 years, there has been a trend for police authorities in Great Britain to replace or supplement the provision of FPs with custody nurses. Much of the case work handled by nurses is to determine if the person is fit to be detained or interviewed although other issues include medication requests, illegal drug use assessments, Mental Health Act assessment and the assessment of injuries, suicide risks and alcohol related issues. However, custody nurses are not involved in the evaluation of whether a driver's "condition might be due to drugs" nor any subsequent blood testing. The changes in healthcare provision in police custody suites to that of a

<sup>225</sup> Where main offence.

<sup>226</sup> Royal College of Nursing. Health and Nursing Care in the Criminal Justice System: RCN Guidance for nursing staff. 2008.

multidisciplinary team approach has been reported as being “a practical response to the challenges faced by an overburdened service”.<sup>227</sup>

- 6.79.** A study<sup>228</sup> to examine the operational impact of a police custody nursing service on healthcare delivery in one police service analysed just under 9,000 calls for medical assistance from five police stations and interviewed 31 custody nurses, custody officers and FPs over a year. The research showed that nurses, who were specifically employed to provide on-call custody support, demonstrated faster response times and similar consultation times to the doctors. Police custody staff also found them extremely approachable when it came to providing information. The study reported that FPs had mixed views about custody nurses although they agreed that they were more approachable and helpful in determining detainees’ clinical needs but they felt they were slower when it came to examinations and had less experience of custody situations.
- 6.80.** This broader and more autonomous role of nurses, working either as part of a multidisciplinary team or alone using clinical protocols, is increasingly common-place within the NHS in areas such as minor treatment centres, NHS Direct and in Accident and Emergency. However, crucial to fulfilling a more autonomous role in each of these instances is the need for appropriate and ongoing training. Whatever the healthcare discipline of the person making an assessment in drug driving cases, they need to be trained for the specific task: understanding the drugs which might be involved and their effects. Where there is less evidence of a clearly drug-related condition, it is also important that the suspect can be assessed appropriately to exclude significant medical conditions which might also be present. In addition, suspects under the influence of drugs or alcohol may have medical needs relating to this intoxication.

### The status of drug testing devices

- 6.81.** As described in Chapter 5, there is a power for a police constable to administer a preliminary impairment test “by means of a device of a type approved by the Secretary of State”.
- 6.82.** Such a preliminary test screens for drugs in a sample of either oral fluid or sweat (which are considered to be non-invasive samples, in comparison to blood which is an invasive sample) collected from the driver. If type-approved drug screening devices were available, a positive result from a preliminary test would allow the police to collect an evidential sample of blood or urine from the driver without the driver being examined by the FP. However, if the preliminary test result was negative, the suspected drug driver could still be examined by the FP, who would consider the possibility of the presence of other drugs. Utilising a drug screening device would remove the requirement for all suspected drug drivers to be assessed by the FP.

227 Bond P, Kingston P & Nevill A. Operational efficiency of healthcare in police custody suites: comparison of nursing and medical provision. *Journal of Advanced Nursing* 60 (2) 127-134. 2007.

228 Bond P, Kingston P & Nevill A. Operational efficiency of healthcare in police custody suites: comparison of nursing and medical provision. *Journal of Advanced Nursing* 60 (2) 127-134. 2007.

- 6.83.** Of the two non-invasive samples that the legislation allows for preliminary testing, oral fluid is generally considered to be the preferred option. Oral fluid is much less susceptible to environmental contamination than sweat and the relationship between blood drug concentration and oral fluid drug concentration is much better understood. Commercial manufacturers have tended to focus their devices on oral fluid sampling for this reason and the discussions below focus upon oral fluid drug screening devices.
- 6.84.** The current legislation covers impaired driving due to all drugs – illegal drugs, prescription or over-the-counter medications and herbal remedies. The majority of commercial-off-the-shelf (COTS) drug screening devices are based upon immunoassay technology.<sup>229</sup> Utilising immunoassay technology, it is not possible to fulfil demanding drug detection requirements without creating a separate assay for every compound of interest. The COTS devices are currently able to screen for at most six different drug classes in a single test.
- 6.85.** According to the Home Office Scientific Development Branch (HOSDB),<sup>230</sup> who are assisting the FSS, to date a completed type-approval specification for such a device has not been produced (although it exists in near-final draft form). The current draft type approval document consists of a full description of the technical requirement to be met for new drug testing devices for police use in Great Britain – with reference to both portable and fixed drug testing devices. (To date, no distinction has been made, in terms of specification, between either portable (roadside) and fixed (indoor) screening devices.) The document is intended as a reference for manufacturers wishing to develop new devices and covers, amongst other things, safety considerations, calibration records, storage and operating temperatures, environmental testing procedures, target drug concentrations and repeatability and specificity requirements. Without a completed type-approval document, while a range of commercial drug screening devices is available, none can be approved for enforcement purposes in Great Britain.
- 6.86.** Outside of drug testing within the remit of the Traffic Act, there are examples of drug screening within the Justice system which use commercial devices that are type-approved by the Home Office. An example is the Drug Interventions Programme (DIP) which is a Home Office initiative that involves identifying Class A drug misusing offenders as they go through the criminal justice system. Once identified, offenders are offered a range of interventions, such as drug rehabilitation treatment, to deal with their behaviour. DIP covers offences which tend to be related to acquisitive crime such as burglary, so-called ‘trigger offences’. Drug screening testing is used to identify one or both of the two Class A drugs (heroin and cocaine/crack) most commonly associated with acquisitive crime. In 2009, 232,361 drug screening tests were reported in England and Wales, of which 214,941 (93%) resulted from suspected ‘trigger’ offences.<sup>231</sup>

229 Immunoassays are chemical tests used to detect or quantify a specific substance in a blood or body fluid sample, using an immunological reaction.

230 HOSDB briefing (unpublished). Overview of drug driving technological challenges. 25 February 2010.

231 Home Office (Offender-based Interventions Unit) correspondence. Apr 2010.

## Road side drug screening devices

- 6.87.** HOSDB has been working for at least ten years on the in-house development of a roadside screening device based on surface-enhanced Raman spectroscopy (SERS). Such a device would be a considerable advance over existing commercially available devices in that it would be capable of identifying any drug present in an oral fluid sample. However, following an expert peer review in 2008, the in-house development of the SERS-based device by HOSDB was halted and contracts have since been set up with two external providers in the USA with the aim of developing prototypes within the next 3 years. Whilst one of these contracts utilises SERS technology, the other is focused on an immunoassay technique that offers far greater sensitivity than is currently available in commercial products, within a robust, portable device.<sup>232</sup>
- 6.88.** The early trials of roadside drug screening devices based on oral fluid (ROadSide Testing Assessment studies ROSITA, ROSITA II<sup>233</sup>) concluded that none of the devices tested at that time was suitable for use in enforcement at the roadside. However, recent evaluations of drug screening devices have highlighted continued improvements in sensitivity and in the general performance of oral fluid drug testing devices; but it appears that the reliable detection of benzodiazepines still remains problematic.
- 6.89.** The DRUID study includes an analytical evaluation of several road-side oral fluid screeners. The final report is still in production but early results suggest that:
- police evaluations of the devices tested were broadly positive;
  - 8 out of the 13 evaluated devices were rated as “promising” and were subsequently included in a scientific evaluation focusing on sensitivity and specificity.
- 6.90.** Research papers in press have reported on the evaluations of four of these devices. While one device was considered unsuitable, three devices demonstrated excellent sensitivity for amphetamine/MDMA (ecstasy) and moderate sensitivity for the detection of cocaine and cannabis. A newer version of one of the devices using ‘new generation’ oral fluid screening tests demonstrated improved sensitivity (93%) for the main psycho-active ingredient of cannabis, tetrahydrocannabinol (THC).<sup>234</sup>
- 6.91.** HOSDB has been promoting research to develop technologies with the required polydrug detection capabilities for use by the police at the roadside. Roadside devices are required to cope with a wide range of storage and usage temperatures, must be rugged and robust, small and portable, weather resistant and easy to operate. COTS devices based upon immunoassay technology may not function properly if exposed to high temperatures and some devices are not weather resistant or readable in low lighting conditions. Given the extremely low target drug concentrations,

232 Based on Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

233 Verstraete A, Raes E. Rosita-2 project Final Report. 2006. Available at: <http://www.rosita.org/>

234 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

the wide array of compounds to be detected and, at the roadside, the harsh operational environments, FSS working with HOSDB concluded that this had proved to be an extremely challenging research project. They considered that though there are technologies with the potential to meet these demands, it would be unlikely that any current COTS device would pass Great Britain's standard of type-approval in relation to these harsh roadside environmental testing conditions.

### Police station drug screening devices

**6.92.** According to HOSDB, one of the main reasons for the delay in developing the type-approval specification for a roadside screening device has been the requirement to be able to store and operate the devices within a limited temperature range. By carrying out the preliminary testing at the police station rather than at the roadside, the environmental conditions in which the drug screening devices must operate become less harsh. Weather and lighting are no longer a factor; temperature is maintained within a much more narrow range, electromagnetic interference is reduced and size and weight constraints of the device are significantly reduced. Current COTS devices are much more likely to pass type-approval in relation to these police station based environmental testing conditions.

### Per se drug offence: Impairing levels vs. zero tolerance

- 6.93.** The current 'impairment-based' approach to drug driving offences (as described in Chapter 5) has been criticised for a variety of reasons, particularly because of the time delays between a police constable's initial observations and the driver being examined by an FP, which can cause conflicting opinions on impairment.
- 6.94.** Jurisdictions elsewhere have tackled these and associated problems by removing the need to demonstrate impairment. In theory, an alternative would be to establish legal *per se*<sup>235</sup> limits for specific drugs, akin to the drink drive limit that exists for alcohol. However, in practice, some jurisdictions have established either a zero-tolerance approach, or a two-tiered approach combining elements of both zero-tolerance for some drugs and the need to demonstrate impairment for others.

### Establishment of per se drug levels

**6.95.** The complex nature of drug pharmacodynamics and pharmacokinetics<sup>236</sup> make it difficult to establish values which would represent impairment in the general population. The main challenges in determining suitable cut-offs include: individual variations, drug tolerance, interactions with other drugs, and the variable effects of the same blood concentrations of drugs depending on whether the concentration is rising or falling.<sup>237</sup> A robust review of the evidence for levels of cannabis related to impairment has

235 Per se (Latin) meaning by or of itself, or intrinsically. With regard to drink drive legislation, a per se law defines legal limits for blood/urine alcohol concentrations above which it is illegal to drive. This is of itself an offence: there is no need to demonstrate impairment or (within reason) any other facts.

236 Put simply, pharmacodynamics explores what a drug does to the body; whereas pharmacokinetics explores what the body does to a drug.

237 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

suggested a cut-off for THC in whole blood of between 3.5 and 5 nanograms per millilitre.<sup>238</sup>

- 6.96.** To date, there has been no research which has found it possible to identify a suitable cut-off limit for cocaine.<sup>239</sup> Similarly, attempts to develop comparable levels for amphetamines, metamphetamine and ecstasy (MDMA) have found wide variation in the association between blood concentrations and tests of impairment and therefore *per se* cut-offs are suggested to be inappropriate for these drugs.<sup>240</sup> For drugs such as opiates, methadone and benzodiazepines, tolerance issues and interactions with other drugs suggest that identifying suitable cut-off values may also be inappropriate.<sup>241</sup>
- 6.97.** In addition, the exaggerated effects observed when alcohol is consumed in combination with many psychoactive drugs, or other polydrug use, increases the complexity of setting *per se* limits. The specific interactions between these drugs may serve to promote (or, less commonly, to inhibit) the effects of a certain drug in isolation, rendering correlations between drug blood concentrations and impairment open to interpretation.<sup>242</sup>
- 6.98.** Further research into the correlations between blood concentrations of certain drugs and impairment may help to move toward developing suitable cut-offs (like those developed over time for alcohol). The DRUID study may offer some useful conclusions on this when it reports by early 2012. An alternative to specific *per se* toxicological studies may be to review before and after studies of newly introduced laws to evaluate the performance of these various approaches in practice.

#### *Evaluating the success of different regimes to tackle drug driving*

- 6.99.** Within Europe, a variety of drug driving policies has been adopted by different countries, ranging from zero-tolerance *per se* limits (e.g. Sweden) to proof of impairment (e.g. current Great Britain laws), each with subtle variations.
- 6.100.** Recent evaluations of the zero-tolerance approach adopted in parts of Australia and Sweden are informative. A report on the first 12 months of the new zero tolerance law in Western Australia<sup>243</sup> suggests that such a policy utilising roadside screening devices has distinct advantages over Great Britain's impairment-based approach. Specifically, the process was found to be simple, straightforward, relatively quick to administer, and unambiguous. In contrast, studies of the effectiveness of Sweden's zero-tolerance laws found them to have been unsuccessful in deterring 'driving under the

238 EMCDDA (2007) EMCDDA selected issue – Drugs and driving. Luxembourg: Office for Official Publications of the European Communities.

239 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

240 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

241 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

242 Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.

243 Woolley JE and Baldock MRJ (2009) Review of Western Australian Drug Driving Laws, Centre for Automotive Safety Research Report.

influence' re-offenders.<sup>244</sup> The study concluded that this lack of success in Sweden might be related to the high rate of re-offending amongst typical offenders. The study also concluded that there had been no change in the pattern of drug use amongst those tested.

- 6.101. The Australian experience also suggests that, were Great Britain to move to a *per se* system, one effect would be that police constables would be less likely to pursue a case for driving whilst unfit due to drugs and would become de-skilled in the use of the FIT test which would still be needed to assess drivers who are using drugs, including medicines, that are not easily detectable by routine drug testing.
- 6.102. A zero-tolerance approach overcomes the difficulties associated with: a) proving impairment; and b) deciding on scientifically valid cut-offs from conflicting sources of data. However, zero limit *per se* laws also have the potential to penalise drivers who are not impaired and pose no risk to safety.

## Issues and opinions

### The state of knowledge of drug driving

- 6.103. Many witnesses to the Review were concerned about how little we understood of the drug driving problem: its extent, the drugs involved and the contribution of drug driving to road casualties. The AA, for example, pointed to the lack of evidence from coroners and procurators fiscal on the presence of drugs in road fatalities and to the lack of roadside screening for drugs and suggested that both needed to be addressed. The Department for Transport and the Coroners' Society of England and Wales confirmed that they were working together to try to address this but highlighted that there were likely to be resource implications for local authorities, which fund the coroner service, as testing for drugs is more expensive than testing for alcohol. The Coroners' Society of England and Wales acknowledged that, while the reporting of the levels of drugs (and alcohol) in road traffic fatalities was voluntary, it might be harder to bring about significant change when there were so many other competing demands for resources.
- 6.104. PACTS were concerned at the lack of UK participation in international research on the extent of drug driving, the nature of the problem and possible measures to address it. By example, they cited the lack of involvement in the EU's DRUID project.
- 6.105. In the event that a driver is stopped on suspicion of driving whilst unfit due to drink or drugs, before any further steps the driver will be tested for alcohol by means of a breath test. In practice, in the event that the driver is over the alcohol limit, there will be no routine investigation into the possibility of drugs also contributing to the state of impairment. It can be argued that this is a pragmatic solution and, in view of limited police resources, the best use of time and money. The current minimum penalty is the same for the offence of driving whilst unfit whether it is due to drugs or alcohol.

<sup>244</sup> Jones AW. Driving under the influence of drugs in Sweden with zero concentration limits in blood for controlled substances. *Traffic Injury Prevention*, 6:317-322, 2005.

- 6.106.** The BMA and others drew attention, however, to the shortcomings of this approach: that the true impact of drug-impaired driving cannot be known and, arguably, that the driver is not punished 'sufficiently' for the hidden impairment (due to drugs) that is not reflected by the breath test reading. There is sufficient evidence that most illicit drugs exaggerate the impairing effects of alcohol and it was argued that this worsened impairment would be sufficient to justify a more stringent penalty.
- 6.107.** The Medicines and Healthcare Products Regulatory Agency (MHRA) pointed out that there was "a dearth of evidence that medicinal drugs contribute significantly to road accident statistics".

### Priority given to drug driving

- 6.108.** In written contributions and evidence sessions, a number of respondents raised the issue of the police priority given to drug driving, with a general sense that the law was inadequately enforced. The charity Roadsafe felt that there should be higher levels of roads policing in this area. Another respondent noted that a number of police forces had reduced or abolished their dedicated Roads Policing Units.
- 6.109.** On drug testing, many respondents, including RoSPA, the AA, the Criminal Bar Association (CBA) and the Scottish Occupational Road Safety Alliance, drew attention to the significant difference in the number of tests for drink driving as opposed to drug driving. They referred to the 2009 annual Christmas drink and drug driving campaign during which the police conducted over 223, 000 alcohol breath tests compared to fewer than 500 Field Impairment Tests (FIT tests) for suspicion of drug driving.<sup>245</sup>
- 6.110.** The CBA noted that, of those alcohol breath tested, 3% were positive, failed or refused and that for drugs, 18% were arrested. They commented that, even though there was a wide difference in the number of tests conducted for drink compared to drug driving, proportionally more drivers were found to be positive for drugs. Unite, the union, questioned whether the 18% arrest figure based on a smaller sample was statistically robust compared to the number of alcohol breath tests taken. In addition it asked how many of the 18% arrested for drug driving were convicted.
- 6.111.** Respondents, including the AA, pointed to the need to establish the extent of the problem of drug driving. Greater Manchester Joint Road Safety Team suggested that STATS 19 should capture data on the number of FIT tests undertaken (both pass and fail) and that there should be a nationally agreed system for recording information and for the data to be available to researchers and road safety officers. Another respondent, Stephen Collier, a former Road Policing Training Officer who developed the National Drug Drive Instructor Training for FIT testing on behalf of ACPO and the Department for Transport, noted that there was no requirement for police forces to record officially the number of FIT tests that are carried out.

<sup>245</sup> Association of Chief Police Officers (ACPO) Press Release 006/10, 21 January 2010.



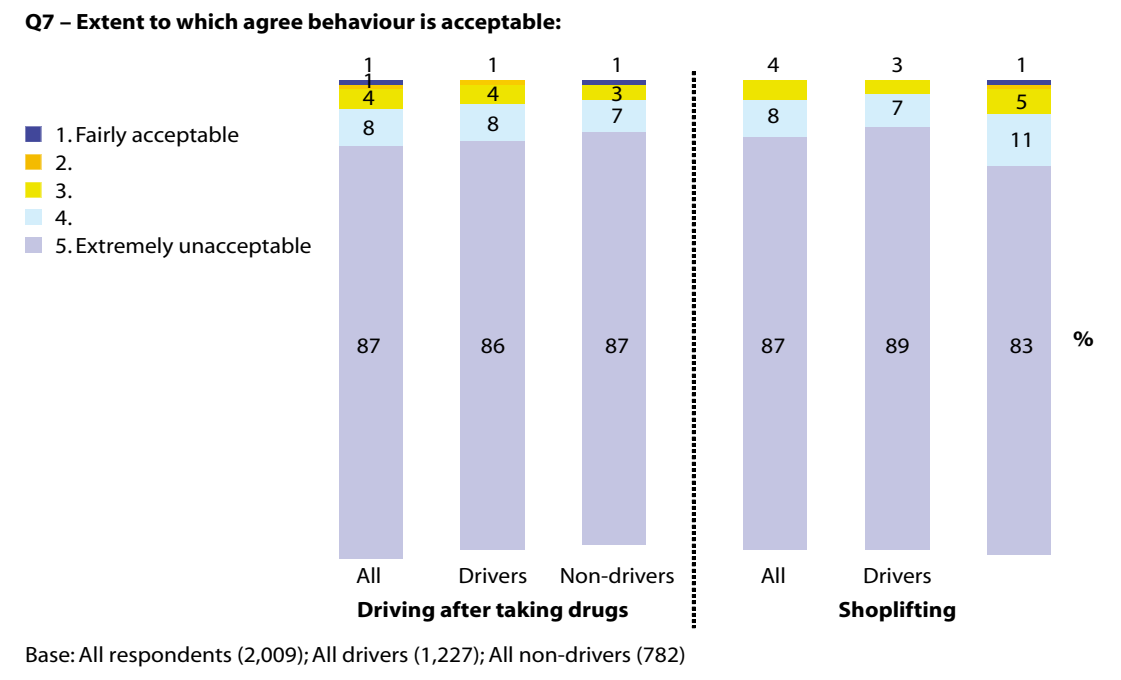
### The case for, and the nature of, any new offence

6.112. There is no doubt that the public find drug driving objectionable. The RAC Report on Motoring, in 2007, found that drug driving was top of a list of issues that motorists were ‘very concerned’ about, ranking them as follows:

1. other motorists driving under the influence of illegal drugs: 76%
2. other motorists driving over the legal alcohol limit: 74%
3. other motorists driving too fast or speeding: 71%
4. other road users not paying attention: 62%
5. other motorists’ aggressive driving: 61%
6. car crime: joy-riding, vandalism, theft, etc.: 60%
7. other motorists’ ability to drive in bad weather/ poor visibility: 54%

6.113. The annual *THINK!* Road Safety survey in 2008<sup>246</sup> found that 95% of respondents found driving after taking drugs unacceptable (see Chart 6.1) – comparable to results on the unacceptability of shoplifting.

Chart 6.1: **BMRB *THINK!* Survey, acceptability of drug driving**



6.114. The AA’s response to the Review’s consultation pointed out that 100% of its Populus Panel of 20,000 respondents said that a driver should be prosecuted for drug driving if there are traces of illegal drugs in his/her body *and* he/she is practically impaired by the drug. The AA also drew attention to the fact that 72% said that a driver should be prosecuted for drug driving if there are traces of illegal drugs in his/her body, even though there was no visible or practical impairment of driving.

6.115. Brake and Direct Line collaborated on a survey<sup>247</sup> on impaired driving which included a question on a new possible offence: ‘Do you think the

246 THINK! Road Safety Annual Survey 2008, BMRB for DfT.

247 Brake/Direct Line Report on Safe Driving, 2009-2011 Part Two, Fit to Drive?, February 2010.

Government should introduce a specific law against driving on illegal drugs?' Those responding 'yes' were 92% of the sample of 800 drivers and motorcyclists.

- 6.116.** There was an appetite among a number of witnesses to the Review for a new drug driving offence. The Scottish Occupational Road Safety Alliance (ScORSA) said that, "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".
- 6.117.** The Association of British Insurers said that "it would be difficult and seemingly illogical to set limits on the levels of certain drugs individually". Instead they would support "a complete ban on driving with any illegal drug in the bloodstream".
- 6.118.** The police saw the case for a new offence as a strong one. ACPO felt "the drug using community are confident that they are able to drive with virtual impunity" and that "consideration should be given to the creation of a new offence specifically targeting those drugs that are both illegal and which research has proved cause impairment to such an extent as to impact upon driving". Thames Valley Police supported this view.
- 6.119.** There was a very broad consensus that the existing impairment offence needed to be retained as a 'catch-all', even if a new offence were created. It would continue to be needed to deal with medicines and illegal drugs which were not on a specified list.
- 6.120.** There was a concern expressed by many, but perhaps most succinctly put by Liberty, that a strict liability offence (driving with any level of a specified drug in the body) "conflates the Government's drug policy with road safety objectives". Many felt that road traffic law should maintain road safety and not be used as an intervention to enforce other aspects of social policy; and the AA expressed a concern that to "remove the link between being unfit to drive and committing an offence ... could cause some public concern and create the argument that the law change is more about fighting drugs than it is about road safety".
- 6.121.** Others suggested that an impairment based approach was still the right way to address the issue. The Parliamentary Advisory Council for Transport Safety (PACTS), for example, said that "enforcement of Drug Driving Offences should focus on identification of impairment, rather than identifying the presence of drugs in the body". The Faculty of Forensic and Legal Medicine suggested that "There is no need for a new offence – there is need for better application of current legislation".
- 6.122.** The BMA were concerned to distinguish between legal medicines and illegal drugs. They said, "Consideration would need to be given to the fact that many currently prescribed medicines could become unusable for drivers, and the impact this may have on prescribing patterns and compliance with treatment regimes". The Medicines and Healthcare products Regulatory Agency (MHRA) also pointed out that "medicinal drugs are used to treat a medical condition and are authorised on the basis that benefits outweigh risks".

## Capacity for drug testing

- 6.123.** The capacity to test for drugs in blood was not disputed by witnesses to the Review (though the Forensic Science Service (FSS) were doubtful as to whether measurement of drug metabolites in urine was appropriate). However, there was a great deal of discussion as to the capacity for preliminary drug testing of oral fluid as a screening measure analogous to the breath test for drink.
- 6.124.** A number of manufacturers gave evidence of the potential of their devices to be used at the roadside for drug screening. These included Dräger, Dtec, and Concateno. The companies referred to the use of their devices in enforcing drug driving laws in other countries and their worldwide use, including Great Britain, in other parts of the criminal justice system and in the workplace.
- 6.125.** Other stakeholders stressed the benefits that screening devices could offer, both in terms of their ability to assist the enforcement process and the deterrent effect they would have on drug drivers.
- 6.126.** However, as referred to above, the Home Office Scientific Development Branch (HOSDB) and the FSS have been at the heart of efforts to develop a roadside drug screening device and gave evidence to different effect. They explained that type approval of such a device had so far been thwarted by fundamental environmental factors such as variations in temperature and precipitation, which could prevent an accurate read-out from the device.
- 6.127.** In discussions with colleagues concerned with Home Office policing policy and Department for Transport road safety policy colleagues, HOSDB and FSS had therefore concluded that shorter-term efforts should be focussed on type-approval of screening devices for use in the more stable environment of the police station.
- 6.128.** Evidence of police frustration in respect of progress on drug screening equipment came from PC Ian Rees, on behalf of the Police Federation's Roads Policing Group. PC Rees said:
- "On the streets at operational level, we need a simple process by which if a constable suspects a driver to have in their body (NOT impaired) a controlled substance, the constable should have available to him a simple device which detects whether a limited number of controlled substances are present in the driver's body. Such devices are already available commercially but there appears a reluctance to take advantage of their use. The standards for screening would not need to be the same standards required for evidential analysis. However, this does not appear to be what Government Departments are looking at and the standards are being set too high for any realistic progress to be made in the near future. This is not acceptable to front line constables who have waited years for the opportunity to deal slickly and professionally with drug driver offenders."*

## Establishment of impairing levels for drugs

- 6.129.** Many respondents were convinced of the desirability of setting levels at which drugs were deemed to be impairing, so that findings of guilt could be based on detection of drugs in drivers above those levels, without the

need for evidence of impairment. The Association of Chief Police Officers in Scotland (ACPOS) for example felt that “to introduce a zero limit policy would be unrealistic” but felt that “research needs to be undertaken to establish what the safe minimal defined levels are”.

- 6.130. The FSS felt that, alternatively, “threshold values” for drugs should be established which precluded false positives, but which provided certainty as to the presence of a drug, which could not be present, for example, through passive inhalation. However, these threshold levels “would not in any way equate to the effects that a drug could produce on a person”.
- 6.131. Dr W Morrison, a consultant physician in emergency medicine, was very keen to see progress in tackling drug driving, but suggested that it “would be incredibly complex having a certain, specified level of a drug that is permissible”. He was further concerned about extending such a regime to the huge variety of drugs which were inappropriately used by drivers.
- 6.132. Francis Meylan, a serving police officer questioned whether it would be “possible to ascertain what a safe level would be”. He went on, “With some drugs it is almost impossible to quantify a ‘level’”, citing LSD.
- 6.133. The AA favoured couching a new offence in terms of impairing levels, but said, “it is not clear, however, that this is technically possible at the moment”.
- 6.134. Napp Pharmaceuticals were concerned about removing the link to impairment, saying in their response that “it would be unjust and disproportionate to apply sanctions where impairment could not be demonstrated”.

## Procedures

### The Field Impairment Test

- 6.135. A number of respondents commented on the validity of the FIT test, its subjectivity and the need for better training of police constables to conduct the FIT test.
- 6.136. Stephen Collier pointed out that the FIT test has been scientifically validated, referring to studies from the USA and the UK.<sup>248,249</sup> He recommended the retention of the FIT test as an operational tool for police constables and thought that there should be further evaluation of how the test might be improved.
- 6.137. The Faculty of Forensic and Legal Medicine, by contrast, raised concerns as to the validity of the FIT test as performed by the police. It believes that correct interpretation of the FIT test results relies on experience and that few police constables are sufficiently experienced in drug recognition to do the FIT test well. The Parliamentary Advisory Council for Transport Safety (PACTS) recommended that different police forces should be trained to similar standards in areas relating to drug driving law enforcement, thus reducing drug drive risk to society as well as allowing for more consistent data on the

248 Burns M, Dioquino T. A Florida Validation study of SFSTs, US Department of Transportation Report No AL-97-05-14-01. 1997.

249 Oliver JS, Seymour A, Wylie FM, Torrance H and RA Anderson. Monitoring the Effectiveness of UK Field Impairment Tests, Road Safety Research Report No. 63. London: Department for Transport. 2006.

FIT test and an improved evidence base. The RAC Foundation also sought better training in, and consistency of use of, the impairment test.

- 6.138.** ACPO noted that the FIT test was a lengthy and subjective process, which relied on adequate police constable training. ACPO considered tackling drug driving to be a major issue in improving road safety and it acknowledged that there should be more investment made in the training of police constables.
- 6.139.** The Police Federation noted that the FIT test was a subjective method of determining impairment and commented that it was impractical (if the driver is not cooperative) and time consuming. For example on a busy Saturday night in towns and cities, there can be problems with onlookers and the driver 'playing to the crowd'. The Intelligent Transport Society for the United Kingdom thought that, whilst the FIT test was effective, it was a subjective test and was subject to legal challenge. The Justices' Clerks' Society also raised this point.
- 6.140.** Transport for London was concerned that constables needed to be trained in conducting the FIT test to enforce drug driving law. Whilst this is not technically the case, and indeed some forces, such as Northumbria Police who focus on obtaining other evidence of impairment rather than using evidence obtained from observation made during a FIT test, enforce the law without use of the FIT test, TfL were concerned that the FIT test did not provide an effective deterrent to driving with any drugs in the body.

## The forensic physician

### *Time delay issues*

- 6.141.** In the course of the Review, concern was widely expressed that the limited availability of FPs adds considerable delay to the processing of detainees arrested on suspicion of drug driving. Delays in arrival appear to be due to the fact that doctors often have to come long distances to the station and there are often too few on call to meet all the police needs quickly. In Cheshire and Hampshire, for example, it was said by their respective police forces that there is often only a single doctor on call to cover the whole county at night. Quite rightly, that doctor will attend any case involving the medical needs of somebody in custody rather than cases of evidential requirement like those for drug driving. Unfortunately, although the maximum time for an FP to attend a custody suite may be specified within the FP's contract with the police force, there were no available records to discover the actual average time delay.
- 6.142.** The concern is that a delay will allow rapidly metabolised illicit drugs to disappear from the detainee's body, resulting in both a loss of blood sample evidence to support a charge of drug driving and the disappearance of any external evidence of impairment, as initially assessed at the time of arrest, by the FIT test. By the time an FP has arrived to assess the detainee, there might not be sufficient evidence for an FP to conclude that the detainee "has a condition that might be due to a drug", with the consequence that the FP would not agree to the detainee having a blood test. However, it should be pointed out that some FPs are able to justify a blood test even in the absence

of obvious current impairment if the impairment was originally witnessed by a police constable. This would be on the basis that any rapid improvement in terms of impairment was itself suggestive of a drug-related condition.

- 6.143.** ACPO and other police representatives felt that the delay in getting a doctor to the station and in the doctor taking a view on the question was not only a barrier to the prosecution of those drug driving suspects who reached the station, but also to constables in deciding whether to take suspects back to the station in the first place.

#### *The role of the forensic physician*

- 6.144.** Consultation witnesses expressed very differing views regarding expectations of an FP in their role in assessing the accused's condition. The Faculty of Forensic and Legal Medicine (FFLM) considered that FPs may give an opinion as to whether a person's ability to drive is impaired, whereas some police forces considered that this should be solely a matter for the police constable's opinion.
- 6.145.** PACTS were among a number of witnesses who felt that the FP's role could be fulfilled by a nurse. ACPO pointed out to the Review that police custody suites now routinely had access to a nurse either on site or on-call. They therefore suggested that allowing a nurse to authorise the taking of blood would speed up the process of getting a sample, given nurses' greater availability.
- 6.146.** The Faculty of Forensic and Legal Medicine (FFLM) considered that "the primary role of the FP... is not to assess impairment but is to ensure that the suspect is fit to be detained – patient safety. The FP has a duty of care." They thought that the FP should be able to exclude any recent or current medical problem that may affect the interpretation of any tests used to assess fitness to drive e.g. a current ear infection which may have an affect on balance which is part of the FIT test. They were not convinced that, at present, all custody nurses would routinely be in a position to make this assessment.
- 6.147.** The BMA thought it important to distinguish between the medical care role being fulfilled by the FP and the role in the criminal justice process. The FP played an important role in deciding whether suspects who showed signs of impairment had more deep-seated health difficulties which needed further assessment or treatment – for example, head injuries, stroke or diabetic coma. In this respect, there were similarities with many others taken into custody, for example after a fight. For other types of offences, this role – an assessment of fitness to detain or to interview – was now often undertaken by a nurse.
- 6.148.** The BMA saw the second role of the FP in the case of suspected drug driving as being to determine whether the suspect should be subjected to a blood or urine test, in answering the question of whether the person might have a condition due to a drug.
- 6.149.** The BMA suggested that it might not be untoward for a doctor to make a later 'medical' assessment to exclude a more serious cause of that impairment within a timeframe that suited the clinical state of the detainee

but with an earlier judgment by a trained police constable that a blood or urine test was justified.

### The test applied by the courts

- 6.150.** In discussion with the police, cases were brought up which showed a difference of opinion in respect of the need to have evidence of *impaired driving* in order to obtain a conviction. It appeared that, notwithstanding evidence of general impairment, in England and Wales, some Magistrates and the CPS required evidence from the police that driving was impaired. Thus, it was said that there were cases where there was evidence from the laboratory of drugs in the blood and from the FIT test of the impairment of the driver which were thwarted by the unwillingness of the CPS to pursue them, or by Magistrates' insistence that evidence of impaired driving was required to convict.
- 6.151.** Police constables were frustrated by this, feeling that the implication was that somebody who had been stopped and who was impaired by a drug, and who the constable suspected would be too impaired to drive, should be allowed to continue to drive because of the lack of evidence of actual impaired driving.

### Medicines

- 6.152.** It was widely acknowledged by witnesses that impairment of driving by a legal medicine was little different from impairment by a controlled drug: both were a danger to drivers themselves and to the public.
- 6.153.** The consultations with the British Medical Association, the MHRA and the Association of the British Pharmaceutical Industry (ABPI) highlighted the importance of user-friendly packaging, labelling and patient information leaflets, particularly for over the counter medicines which may be purchased in the absence of a health care professional. The MHRA and the ABPI also drew attention to the lack of evidence of any association between prescribed or over-the-counter medicines and a significant road casualty problem.

# Chapter 7: Drug driving – Conclusions and recommendations

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## Evidence of the problem

- 7.1. It is striking how poor the evidence is in relation to drug driving. In part this is inevitable: a consequence of the illegality of the possession and supply of controlled drugs in society and the ethical problems associated with obtaining samples. It also stems from the fact that, when drivers have consumed alcohol and drugs in combination, the police will not pursue, or may not be aware of, any drugs element where the driver provides a positive breathalyser test for alcohol.
- 7.2. However, this makes it all the more important that those opportunities to obtain data are taken. Two important studies<sup>250</sup> by the Transport Research Laboratory (TRL) in 1989 and 2001, based on work with coroners, into the prevalence of illegal and legal drugs among road fatalities showed evidence of a worrying trend over that twelve year period, with the presence of illegal drugs rising from 3% to 18% and the presence of all drugs rising from 7.4% to 24.1%. These studies should have been followed up with comparable repeat studies, but have not been.
- 7.3. As observed in Chapter 3, coroners and procurators fiscal provide data on the blood alcohol concentration of driver fatalities in a sufficiently routine fashion that Government has data for about 70% of drink driver fatalities. In the case of drugs, there is minimal screening of fatalities by coroners and procurators fiscal. Given the high prevalence of drugs in road fatalities found by the TRL studies and the rising trend, there is a strong case for coroners and procurators fiscal routinely to require screening for the most prevalent drugs which impair driving as part of the statutory investigation into how the deceased came to die.
- 7.4. In England and Wales, the Coroners & Justice Act 2009 and the creation of the new judicial office of Chief Coroner offer an opportunity to reconsider the coroner role and the purpose of coroner commissioned post-mortem examinations. These could enable routine testing of road fatalities for drugs, whether through requirement by the Lord Chancellor for the Chief Coroner to cover the issue in his annual report or by the Chief Coroner emphasising the need for drug testing of road fatalities in the guidance to be issued to coroners. At present, there does not appear to be any evidence of an intention to change the responsibilities or powers of procurators fiscal in Scotland.

**Recommendation (1): The Ministry of Justice and the new Chief Coroner should ensure that coroners test for, and provide data on, the presence of drugs in road fatalities. The Scottish Executive should ensure that similar action is taken by procurators fiscal in Scotland.**

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<sup>250</sup> Everest *et al*, 1989 & Tunbridge *et al*, 2001 – see Chapter 3



7.5. It is not a simple matter to construct research studies into the prevalence of drug drivers among the living. However, it is disappointing that the United Kingdom's participation in the EU's DRUID research project has been minimal. Furthermore, other countries which are bound by the European Convention on Human Rights (and, indeed, Scotland which has conducted studies of drug prevalence among the driving population, referred to in Chapter 6) seem to be able to overcome any ethical and human rights issues associated with roadside drug driving studies.

7.6. As a consequence of the paucity of evidence, it is not possible to determine definitively what the scale of the problem of driving whilst impaired by drugs is in Great Britain. However, it seems reasonable to assume, on the basis of the, admittedly old, TRL reports, the research on the general prevalence of misuse of drugs, the international research on drug driving and the research showing self-reported drug driving, that there is a significant drug driving problem, which is likely to be much more widespread than suggested by the 168 drug driving convictions in England and Wales in 2008. It is interesting to note that, in Scotland, the number of drug only driving offences is not recorded; data is only available on the combined category of drink or drug driving offences. It is clear that steps need to be taken to address this shortage of hard evidence of the extent of the drug driving problem in Great Britain.

**Recommendation (2): The Government should commission more research in the driving community to understand better the prevalence of drug driving in Great Britain and should monitor the impact of changes in law or policy.**

### Current law and process

7.7. Beyond the concerns over the evidence of the prevalence of drug driving, there is also a problem in Great Britain in understanding the impact of the current law and processes on the level of offending. The data on the number of police constables trained to perform Field Impairment Tests (FIT test) is poor and the number of FIT tests carried out and the number of drug driving cases proceeding to prosecution is low.

**Recommendation (3): The Government should improve the clarity of its information on drug driving by:**

- collecting data from Chief Constables on the numbers of constables trained to carry out the Field Impairment Test (FIT);
- collecting data on the number of FIT tests carried out by police constables; and
- making clear distinctions in its collected statistics between offences for driving whilst impaired (a) by alcohol, (b) by drugs and (c) by both alcohol and drugs.

7.8. The FIT test provides an effective means of identifying impairment due to drugs. As deployed by some police forces, it provides a means of gathering evidence not only of the impairment itself, but also of the drug class to which the impairment is due, serving the police themselves in their

management of the case and assisting the laboratory staff in targeting the screening for impairing substances in blood samples.

- 7.9. Notwithstanding the success of the approach of Northumbria police, which focuses on obtaining other evidence of impairment rather than using evidence obtained from observations made during a FIT test, the Review considers that more widespread use of the test by trained officers would assist greatly in improving the identification of cases of drug driving and the prosecution rate for that offence.

**Recommendation (4): Each police force should invest in training constables to conduct the Field Impairment Test (FIT). The number of FIT tests conducted should increase significantly, with forces making it a matter of policy to carry out the test in all cases where impaired driving is suspected, notwithstanding a negative breathalyser test.**

- 7.10. The Review has also noted, from the evidence that has been received, that there appears in some drug driving cases to be a requirement on the part of prosecutors for evidence of actual impaired driving before they will pursue a case, and on the part of some magistrates before they will convict. Whilst this is an issue which is best dealt with on a case-by-case basis, it should be pointed out that the Traffic Act provides (section 4(5)) that 'a person shall be taken to be unfit to drive if his ability to drive properly is for the time being impaired'. The Review has concluded, therefore, that there will be cases where evidence of general impairment – other than from observation of actual driving – will be such that the inability of the accused to drive properly is clear. Where, for example, a police constable has not seen a suspect actually driving or where the driving itself does not provide evidence of impairment but it becomes clear that the suspect is incapable, as where there is evidence of their inability to stand up, and that impairment can be associated with a drug in the suspect's blood, this ought to be sufficient for the CPS to pursue the case and the magistrates to convict.

**Recommendation (5): The Crown Prosecution Service and Crown Office, in deciding whether to proceed with cases, and magistrates and sheriffs, in determining cases, should take greater account of evidence of general impairment of a driver other than while actually driving.**

- 7.11. It is also important to give drug driving appropriate priority in the enforcement regime (see the Review's conclusions in Chapter 4 in relation to Offences Brought to Justice and the priority given to drink driving). Given the potentially deadly consequences of driving whilst impaired by drugs, the police must be clearly incentivised to tackle the problem with greater energy.

**Recommendation (6): The principal drug driving offence in section 4(1) of the Road Traffic Act 1988 should be included in the 'Offences Brought to Justice' determined by the Home Office and monitored by police forces in England and Wales. The Scottish Executive should also endeavour to ensure that this offence is given appropriately high priority by the police in Scotland.**

## Improving the law and drug testing process: the road map

- 7.12.** Improving the detection and deterrence of drug driving should be a staged process. The current process, explained in full in Chapter 5, is summarised below:
- A police officer requires a person to cooperate with one of more of the preliminary tests contained in section 6 of the Traffic Act because they suspect that the person may be under the influence of a drug, has committed a traffic offence or has been involved in an accident. The police may administer a breathalyser test to test for alcohol and whether or not that is positive, a preliminary impairment test (the FIT test). The legislation also provides for the administration of a preliminary drug test, however a type approved device is not currently available.
  - A police constable suspects that a person has committed the impairment offence, either as a result of the observations and inferences made from the person's performance of the FIT test, or, where the FIT test was not or could not be administered, from the suspect's general demeanour, driving or other relevant factors which give rise to a suspicion that the person concerned is unfit to drive.
  - As a result of this suspicion, the person is arrested and taken to the police station where the FP is asked to consider whether the person has a condition which might be due to a drug.
  - Where the FP answers this question in the affirmative, the police constable will require the person to provide a specimen of blood or urine, the decision as to which lies with the police constable.
  - The specimen of blood or urine is sent to a laboratory for analysis. Where the analysis shows that a drug was present, the person may be charged with driving while unfit due to a drug, provided there is sufficient evidence of impairment at the time of driving.
- 7.13.** The Review has identified five stages of progress to an optimal position in detecting and deterring drug driving.
- 7.14.** The third, fourth and fifth stages would require considerable development of technology, but the first two stages rely on developments which are close at hand and which need, more than anything, a show of will on the part of Government and the police. The Review makes specific recommendations in respect of these first two stages.

### Stage one: improving the current drug testing process

- 7.15.** The efficiency and effectiveness of the process can be improved through reducing the time between suspicion of impaired driving and the taking of blood for testing. As recommended above, there should, first of all, be more frequent FIT testing of those suspected of driving whilst unfit due to a drug.
- 7.16.** Under section 7(3)(c) of the Traffic Act, a blood (or urine) test cannot be taken from a person suspected of drug driving at the police station unless a forensic physician (FP) determines that the suspect has a 'condition which might be due to a drug'.

- 7.17. This requirement introduces delay to the blood-testing of the suspect in two respects: the delay in getting the doctor to the station and the time spent by the doctor in carrying out the examination to determine the answer to the question. Whilst the second delay may be justified, the first appears to the Review to be unacceptable.
- 7.18. Delays in the arrival of the FP appear to be due to the fact that doctors often have to travel long distances to the station and that there are often too few individuals on call to meet all the police needs quickly. In Cheshire and Hampshire, for example, the Review heard that there is often only a single doctor on call to cover the whole county at night. Quite rightly, that doctor will give priority to any case involving the medical needs of somebody in custody over cases involving evidential requirements, such as drug driving.
- 7.19. In the opinion of the Review, there seems to be no reason why properly trained custody nurses, in addition to doctors, could not fulfil the role under section 7(3)(c) of the Traffic Act in relation to suspected drug driving, given the contemporary role of nurses in protocol-led decision making in other contexts, such as in minor treatment centres, NHS Direct and in triage at A&E. The extension of this role to nurses is particularly appealing in light of the fact that many police forces now routinely employ nurses to provide round the clock cover for their custody suites.
- 7.20. Crucial to fulfilling the section 7(3)(c) role in relation to drug driving is appropriate and ongoing training. Whatever the healthcare discipline of the person making the assessment, it is essential that they are trained for the specific task: understanding, and identifying, the drugs which might be involved and their effects. Where there is less evidence of a clear drug-related condition, it is also important that the suspect can be assessed appropriately to exclude any other medical conditions which might also be present and which might account for the person's condition. In addition, persons who are under the influence of drugs or alcohol may well have medical needs relating to their intoxication which require attention. The need to ensure adequate training for the specific role of any healthcare professional working in police stations seems entirely in the spirit of the increasing specialisation within healthcare professions. It is also consistent with the wider role that nurses are already playing in the custody process, such as in making judgments on fitness for detention and for interview.
- 7.21. In order to allow nurses to participate in the procedure set out in section 7(3)(c) of the Traffic Act, an amendment to the Traffic Act, would be required to replace the reference to medical practitioner in that section with a reference that includes nurses. Such a minor amendment should take no more than a year as it would be capable of being implemented through any Bill concerned with criminal justice reform.

**Recommendation (7): Within a year, section 7(3)(c) of the Road Traffic Act 1988 should be amended to allow nurses also to take on the role currently fulfilled by the forensic physician in determining whether the drug driving suspect has 'a condition which might be due to a drug'.**

**Recommendation (8): Appropriate training should be provided to all health care professionals who undertake the role of assessing**

**whether suspects have a 'condition which might be due to a drug' in accordance with section 7(3)(c) of the Road Traffic Act 1988, to ensure an understanding of their specific role and of the potential medical complications which may arise in relation to persons in custody.**

- 7.22. The Review has also considered the role of the FP (or, in future, a healthcare professional) under section 7(3)(c) of the Traffic Act. The statute appears clear: the FP is required to confirm that the suspect has a condition and that the condition might be due to a drug, as a prior requirement for any blood (or urine) test. In this sense, the FP's role is to act as a 'gatekeeper', standing between the suspect and a blood (or urine) test and ensuring, for example, that suspects who are not impaired by a drug, but have an underlying medical condition requiring prompt attention, get the attention they require.
- 7.23. It is clear, however, that many FPs also seek to determine whether the suspect is impaired. This is not strictly their role, though it is understandable that, like the police, they might want to test for signs of impairment typical of drugs in order to be able to answer the question required by the law.
- 7.24. Some police forces and FPs clearly liaise and work productively, with the FP keen to hear details of the police officers' prior observations of behaviour and impairment, in order to help inform their own judgment of the suspect in accordance with their role under section 7(3)(c) of the Traffic Act. Notwithstanding the benefits of this co-operation, it is not the role of the FP to provide a supplementary assessment of, or supplementary evidence of, impairment. In particular the FP should not be drawn into questions of impairment in court. This is because the magistrates and sheriffs should make a judgment on the basis of the evidence of impairment gathered by the police.

**Recommendation (9): The training of forensic physicians and custody nurses to carry out the role under section 7(3)(c) of the Road Traffic Act 1988 of determining whether a suspect 'has a condition that might be due to a drug' should be clear in describing the limits of that role. The training should encourage discussion between the healthcare professionals and the police officers involved in the case, as the observations of the officers might well assist healthcare professionals in answering the question. However, training should discourage their becoming involved in consideration of the evidence of impairment in court, since this is not required under the legislation.**

- 7.25. In visiting one of the main laboratories contracted to test blood, and urine samples for the police, the Review was made aware that, while some samples arrive with helpful background notes on the case and instructions for the laboratory staff as to what drugs to look for, such as indications of impairment, behaviour and substances which should be screened for, others arrive with little or no details at all. This can cause difficulties for the laboratory as there are a finite number of tests that can be done on any one specimen before the specimen is expended. Since the police are provided with an MG DD/E form to provide a clear structure for such advice, this

seems a baffling oversight, and undoubtedly thwarts prosecutions and is a lamentably inefficient use of police and laboratory resources.

**Recommendation (10): Chief Constables should ensure that no samples are submitted by their force to laboratories for analysis without the MG DD/E form or other details of the circumstances of the case which can aid laboratory analysis.**

### Stage two: preliminary screening tests

- 7.26. The second stage identified by the Review involves activating the use of preliminary drug screening tests under section 6C of the Traffic Act in relation to the investigation of the impairment offence under section 4 of the Traffic Act, and using such tests to determine whether a blood (or urine) test can be required in accordance with section 7(3)(bc) of the Traffic Act. This would avoid the need for the FP (or nurse) to determine whether a person 'has a condition that might be due to a drug' under section 7(3)(c) which is currently required before a blood or urine specimen can be obtained at a police station.
- 7.27. As explained in Chapter 5 and above in paragraph 7.26, the current legislation (section 6C(1) of the Traffic Act) allows for the preliminary testing of a specimen of saliva or sweat as a screening test. The Review has concluded from the evidence of witnesses and from research that sweat is not as reliable a testing medium as saliva, and is therefore of the view that saliva should, in practice, be the medium used for such preliminary screening tests. The remainder of this section therefore considers the benefit of preliminary screening tests using saliva. Whilst the Traffic Act currently provides a power to use preliminary drug screening devices which use saliva, the actual use of such equipment first requires the type approval of such technology.
- 7.28. The Government's effort in recent years with regard to type approval of drug screening equipment for drivers has focussed on the development of portable drug screening equipment which can be used for drug testing anywhere (e.g. at the roadside). Such technology is undoubtedly desirable, but the evidence to the Review shows that development of suitable portable drug screening technology is confounded by difficulties relating to accuracy and interference from substances in the outdoor environment. It therefore makes sense for Government to focus its short term efforts on the type approval of more robust and reliable devices for preliminary drug screening in the more controlled environment of the police station.
- 7.29. Accordingly, in stage two of the road map, where a person is suspected of driving while unfit through drugs, the process would move as follows:
- where, following observations from the FIT test or otherwise, a police officer suspects a person to have committed the impairment offence, the person would be arrested and taken to the police station;
  - at the station, the police would require the suspect to cooperate with a preliminary drug test by providing a specimen of saliva. This could be taken anywhere in the station and obtained by means of a swab testing device administered by an officer;

- the specimen of saliva would be inserted into a type approved immunoassay (or other) device to screen for a number of different drug types. The selection of which drug types are tested for would be determined by the screening device selected by the police, a decision which would be based on intelligence relating to local drug use patterns;
- where the preliminary screening device indicated that one or more of the drug types was present, this indication would provide the authority for the police to require a specimen of blood, taken by a health care professional, or a specimen of urine, which would subsequently be submitted for analysis at a laboratory (subject to the existing condition that blood may not be required where a healthcare professional is of the opinion that the person should or could not provide a specimen of blood for medical reasons);
- a positive analysis of the specimen of blood or urine would form part of the evidence submitted to the court in seeking to prove the commission of the impaired driving offence under section 4 of the Traffic Act.

**7.30.** This stage two regime requires the additional FIT training recommended in stage one above. It would also require the provision of type-approved preliminary drug screening devices in police stations to be used in accordance with section 6C of the Traffic Act. Section 7(3)(bc) of the Traffic Act already provides that a positive result of a preliminary drug test allows police to require a specimen of blood (or urine) for analysis without the need for a healthcare professional to have to consider whether the person has a condition which might be due to a drug under section 7(3)(c) of the Traffic Act. Thus no legislative amendment would be required.

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

**7.32.** It is envisaged that preliminary drug screening devices of this kind would be used to screen for drugs which are known to impair driving, which are widely misused, including among drivers, and which represent a substantial part of the drug driving problem. The devices would be based on technology used routinely in other contexts in Great Britain – such as are used in routine drug screening tests for certain offences in other areas of the criminal justice system (as is the case of around 215,000 suspected ‘trigger’ offences e.g. robbery and burglary, which are often linked to drug addiction problems) and in the workplace.

**7.33.** Preliminary drug screening devices will require type approval prior to being used by the police. Type approving a device to be used in police stations ought to take no more than two years.

**7.34.** Given that it would be beneficial for the police to be able to administer more than one drug screening test, for example, in order to test for a wider range of drugs or categories of drugs, consideration needs to be given to whether the power to administer a preliminary drug test in section 6C of the

Traffic Act would need to be amended to allow for more than one test to be administered.

**Recommendation (11): Steps should be taken for the earliest practicable type approval and supply to police stations of preliminary drug screening devices to be used in accordance with section 6C of the Road Traffic Act 1988. This should be achieved within two years. Type approval ought in the first instance to focus on devices capable, in aggregate, of detection of those drugs or categories of drugs which are the most prevalent, including amongst drivers, namely:**

- opiates;
- amphetamines;
- methamphetamine;
- cocaine;
- benzodiazepines;
- cannabinoids;
- methadone;
- ecstasy (MDMA).

**7.35.** Where a preliminary screening test for a listed drug or category of drug indicated a negative result, but the police officer continued to suspect impairment, the Review considers that the police officer, must be able to revert to the existing procedure in section 7(3)(c) of the Traffic Act, as improved through the recommendations outlined in stage one and call for the FP or nurse to consider whether the suspect had a condition which might be due to a drug, prior to the administration of any blood (or urine) test. This is essential in order to be able to detect drugs that the preliminary screening device is not capable of testing for.

**7.36.** In addition to the benefits of shortening the time involved in the process, the Review considers that the introduction of such preliminary screening devices will have the additional benefit of conveying to the wider community that the police have technology which can readily detect common drug use among drivers.

### **Stage three: a specific prescribed limit drug drive offence**

**7.37.** The third stage of the road map involves the introduction of a new specific offence of driving with certain controlled drugs or categories of drugs in the body in excess of a statutory prescribed level at which those drugs or categories of drugs are deemed to be impairing, akin to the existing excess alcohol offence. The introduction of this third stage would necessitate:

- research into, and agreement upon, levels at which particular controlled drugs which are prevalent among drivers could be deemed to be impairing;
- the creation of a new offence in primary legislation of driving with a level of a drug (or category of drug) in the body in excess of the prescribed limit for that drug (or category of drug); and



- the creation of a power to provide, in secondary legislation, for a list of controlled drugs, the presence of which in the body above the specified statutory prescribed level would be unlawful when driving (or attempting to drive etc).

**7.38.** The procedure for stage three would move largely as for stage two in the following manner:

- where, following observations from the FIT test or otherwise, the police suspected a person to be committing a drug driving offence (the impaired driving offence or the proposed, new specific offence of driving under the influence of a drug in excess of a prescribed level) the person would be arrested and taken to the police station;
- at the police station, the police officer would require the suspect to cooperate with a preliminary drug test by providing a specimen of saliva, which could be taken anywhere in the police station and obtained by means of a swab administered by an officer;
- the swab with the specimen of saliva would be inserted into a type approved immunoassay (or other) device to screen for the presence of particular drug types. Driving with those drugs above specified statutory prescribed levels would be an offence. The 'panel' of drug types would be selected, based on intelligence relating to local drug use patterns, from a longer, statutory, list of specified controlled drugs;
- where the preliminary drug test indicated that one or more of the specified drugs was present, a blood (or urine) sample would be required to be taken, by a health care professional (or, in the case of urine, by a police constable or healthcare professional), and subsequently submitted for analysis at a laboratory to test for the level of the drug or drug type present;
- where the result from the laboratory analysis showed that one or more of the listed drugs or drug types were present above the specified statutory prescribed limit for that drug or drug type, the accused would face prosecution, regardless of any evidence of impairment.

**7.39.** The timescale for the implementation of this third stage depends on the time taken to research appropriate impairing levels of relevant drugs. The current EU DRUID research might shorten timescales significantly, should it offer advice on impairing levels of commonly misused drugs among drivers. The timetable should therefore be clearer on publication of the DRUID research, currently expected to be by early 2012.

**Recommendation (12): The Government should actively pursue research to determine the levels of the active and impairing metabolites of the following controlled drugs or categories of controlled drugs which can be deemed to be impairing (as the prescribed limit currently does in relation to alcohol):**

- opiates;
- amphetamines;
- methamphetamine;

- cocaine;
- benzodiazepines;
- cannabinoids;
- methadone;
- ecstasy (MDMA).

7.40. It will be important to focus this research on the active and impairing metabolites of these drugs to ensure that impairment can be fairly assumed.

**Recommendation (13): As and when research has established the impairing levels of the active and impairing metabolites of particular controlled drugs or categories of controlled drugs, prescribed levels for such drugs or categories of drugs should be set in legislation and a new offence introduced which makes it unlawful to drive with any of the listed drugs in the body in excess of the prescribed level.**

7.41. The Review considers that a new offence should, in the first instance, target the drugs or categories of drugs listed above, since these are known to be widely misused, including by drivers. However, the list of drugs or categories of drugs and their prescribed levels should be capable of ready amendment, by secondary legislation, to allow for new drugs to be added, and should ultimately include all controlled drugs regularly associated with driving impairment in the different regions of Great Britain. Driving (or attempting to drive etc) with any of the listed substances in the body above the level of deemed impairment (the prescribed limit) should be an offence punishable in line with the current offence of driving whilst impaired by drink or drugs, subject to a medical defence as explained in Recommendation 14, below.

7.42. The establishment of a 'long list' of drugs which are proscribed for driving and the specified levels in blood at which those drugs are assumed to be impairing is not a trivial task. However, it is a necessary step in order substantially to improve the record in Great Britain in tackling driving whilst impaired by drugs. It might be that it is not possible to achieve a consensus as to the impairing levels for particular drugs, as set out above, which could be specified in law. In that event, it would be necessary to give fresh consideration to whether the public interest would be better served by a 'zero tolerance' offence of driving with traces of particular impairing drugs in the system, or by continued use of an offence based on impairment of driving.

*Medical defence for offence of driving above the statutory prescribed drug limit*

7.43. Some drugs which may be proscribed for driving might also be used legitimately, in accordance with medical advice (for example morphine may be prescribed for chronic pain or diazepam (a benzodiazepine) may be prescribed for anxiety). Indeed, the Review recognises that in some circumstances it may be more dangerous for a person to drive having *not* taken their medically prescribed drug than driving without having taken it. Drugs have different effects on different people and levels at which they are prescribed are likely to reflect this. It would clearly be wrong to put in jeopardy of prosecution those who are properly and safely taking medically

prescribed drugs and driving in accordance with medical advice, for whom, despite the presence of a proscribed drug, there is no evidence of any driving impairment.

**Recommendation (14): A statutory defence should be available in respect of any new offence of driving with a listed drug or category of drug in the body above the statutory prescribed level if the defendant had taken the drug in accordance with medical advice. This defence should not be available in respect of the impairment offence under section 4 of the Road Traffic Act 1988 of driving while unfit due to drugs.**

**Recommendation (15): If, despite the above recommendations, it should prove beyond scientific reach to set specific levels of deemed impairment, the Government should consider whether a 'zero tolerance' offence should be introduced in relation to the following drugs and categories of drugs:**

- opiates;
- amphetamines;
- methamphetamine;
- cocaine;
- benzodiazepines;
- cannabinoids;
- methadone;
- ecstasy (MDMA);

**rather than continuing to rely solely on the offence of impaired driving under section 4 of the Road Traffic Act 1988.**

- 7.44.** A new offence of driving with a specified drug or category of drug present in the body in excess of the statutory prescribed limit would provide a means of tackling the major part of our drug driving problem, dealing as it would with the most regularly used controlled drugs. However, the Review recognises that such an offence would not deal with the vast majority of prescribed and over-the-counter medicines, nor could it deal with all controlled drugs, new social drugs or legal substances taken for their impairing effects, including so-called 'legal highs'. The Review therefore considers that it would be necessary to maintain the existing impairment offence under section 4 of the Traffic Act as a 'catch-all' to cover other impairing drugs, including prescribed and over-the-counter medicines.

**Recommendation (16): The current offence under section 4 of the Road Traffic Act 1988 of driving while unfit due to a drug should be retained in order to deal with impairment from prescribed and over-the-counter medicines, new drugs or other drugs for which it is not possible to determine an impairing level.**

#### **Stage four: preliminary drug screening at the roadside**

- 7.45.** The Review is of the view that it would assist in the detection and deterrence of drug driving to introduce a system as similar as possible to drink driving, where a positive breathalyser test for alcohol routinely leads to evidential

breath testing in the police station. As breath is not a medium in which drugs can readily be detected, saliva is much more suitable for testing in such circumstances.

- 7.46.** As explained above, the Review has concluded that the Government's efforts to type approve preliminary drug screening devices to be used in accordance with section 6C of the Traffic Act should currently be focussed on obtaining screening devices for use in police stations rather than the more complex task of developing devices which could be used at the roadside. However, once technology is type-approved for use in police stations, the Government should continue its work on developing and type approving roadside drug screening devices, since experience in other parts of the world shows promise.
- 7.47.** The fourth stage depends on the development of preliminary drug screening equipment in a way which is analogous to the development of drink driving technology. The introduction of roadside preliminary screening devices for drugs, by means of testing a specimen of saliva, would be extremely beneficial to the enforcement process. It is likely that, as this technology developed, it may be felt that there may be less need for the FIT test. However, as explained in paragraph 7.49 below, the Review considers that it is essential that training and use of the FIT test does not diminish.

**Recommendation (17): Once preliminary drug screening devices have been type approved for use in police stations, the Government should continue to work on type approval of preliminary drug screening devices which are capable of being used at the roadside, drawing from overseas experience.**

- 7.48.** Once roadside preliminary drug screening tests are type approved, the Review envisages that, where a preliminary screening test conducted at the roadside indicated a positive result, the driver would be arrested and taken to the police station. At the police station the driver would be obliged to provide a specimen of blood (or urine) for analysis at a laboratory. The specimen of blood would be taken by a healthcare professional (specimens of urine by police constables as at present).
- 7.49.** Again, the Review considers that it would be necessary to maintain the impairment offence under section 4 of the Traffic Act to allow for the detection and prosecution of drivers who have drugs in the body that are not capable of being detected by the preliminary drug screening device. It would, therefore, be important for the police to maintain the capacity to conduct the FIT test.

### Stage five: evidential saliva testing

- 7.50.** Stage five relies upon the development of evidential testing of specimens of saliva, thereby removing the need for an evidential specimen of blood (or urine) to be taken. In the first instance, such an evidential testing device might only be capable of use in a controlled environment, which would most sensibly be the police station. In such circumstances, the procedure would follow stage four above, with the administration of a preliminary

roadside screening test followed by the administration of an evidential saliva test at the police station, instead of a blood (or urine) test.

- 7.51. If problems of environmental interference can be overcome, it would be hoped that evidential drug testing of specimens of saliva could ultimately be conducted at the roadside.
- 7.52. It is important to note that the impaired driving offence under section 4 of the Traffic would nevertheless need to be retained in order to deal with any non-listed substances including prescribed drugs and over-the-counter medicines.
- 7.53. The introduction of evidential drug testing of saliva, either at the police station or at the roadside, would require an amendment to primary legislation.

**Recommendation (18): Following type approval of roadside preliminary drug screening devices, research should continue in the quest for reliable evidential saliva testing devices for an appropriate range of drugs at prescribed levels. This should focus first on the type approval of indoor testing devices. Subsequently, research and development should focus on roadside evidential drug testing devices. However, such research and development should not be at the expense of reaching the achievable goal of developing and type approving a preliminary drug screening device for use at the police station in accordance with section 6C of the Road Traffic Act 1988 as soon as possible.**

### High risk offender scheme

- 7.54. The Review has observed that drug-drive offenders are conspicuously absent from the High Risk Offenders Scheme (the HRO Scheme) which is considered in full in Chapters 2 and 4. The Scheme is aimed at dealing with drivers whose dependence on alcohol presents a serious road safety risk. This alcohol-related objective explains the lacuna in relation to drug-drivers. However, the Review considers that the omission is a loophole that needs to be addressed.
- 7.55. The HRO Scheme applies to offenders in the following categories:
- (a) those disqualified twice, within a ten-year period, for drink drive offences involving mandatory disqualification;
  - (b) those disqualified for driving or attempting to drive with a proportion of alcohol in the body at least two and a half times the legal limit; and
  - (c) those disqualified for failing, without reasonable cause, to provide a specimen of breath, blood or urine for analysis.
- 7.56. An offender who falls into one of the three categories of offender must submit themselves for a medical examination with a Department for Transport-approved medical practitioner for the purpose of determining whether or not they are physically or psychologically dependent on alcohol and are therefore safe to be allowed to drive before their licence is returned.
- 7.57. The Review notes that an offender convicted of an offence under section 7(6) of the Road Traffic Act may well be a drug-driver. However, it is only the obvious inability, in the absence of a specimen of breath, blood or urine, to

prove whether the person concerned has committed a drink- or drug driving offence that results in the inclusion of drug-drivers in the HRO Scheme in this way.

- 7.58.** However, drug misuse and addiction is as much a danger to road safety as alcohol misuse and addiction. Clearly, HRO category (b) is not relevant to the current drug driving offence. Nevertheless, the Review finds the specific exclusion of the impairment offence in relation to drug driving to be an anomaly.
- 7.59.** This anomaly is further demonstrated by the statutory provisions behind the HRO Scheme which are contained in the Traffic Act and the Motor Vehicle (Driving Licences) Regulations 1999<sup>251</sup> (the 1999 Regulations).
- 7.60.** The 1999 Regulations provide the three reasons for disqualification which will result in a person being required to be examined by a medical practitioner. Persons who fall within these categories are, by virtue of section 94(4) of the Traffic Act, considered to have a disability. Section 92(2) of the Traffic Act defines disability as including the persistent misuse of drugs or alcohol, whether or not such misuse amounts to dependency.
- 7.61.** Thus, whilst drug misuse or dependency is considered to be a disability within the meaning of the Traffic Act, the exclusion of drug- drive offences from the 1999 Regulations means that a person who, within a ten year period, is disqualified twice for driving whilst unfit through drugs or, indeed, for one drink drive offence and one drug drive offence involving mandatory disqualification will not be caught by the HRO Scheme.
- 7.62.** The Review considers this situation to be highly unsatisfactory, The Review accepts that the diversity amongst drug users means that it does not necessarily follow that a repeat drug offender will have physical or psychological dependency issues in the same way that a repeat drink driver might have. However, there will be drug drive offenders for whom the HRO Scheme is appropriate and the Review therefore considers that to continue to exclude repeat drug drivers from the HRO Scheme is unsatisfactory.

**Recommendation (19): Regulation 74 of the Motor Vehicle (Driving Licences) Regulations 1999 should be amended to also include offenders who are disqualified for driving whilst unfit due to drugs under section 4 of the Road Traffic Act 1988, thereby resulting in the inclusion of drug driving offences in the High Risk Offender scheme. This would mean that those who are disqualified twice, within a ten-year period, for any drink or drug driving offences involving mandatory disqualification are subject to assessment by a Department for Transport-approved doctor prior to regaining their licence to ascertain whether they have a drink or drug dependency or misuse problem.**

### Drug driver rehabilitation courses

- 7.63.** For drink driving offenders, there is now a regular use of rehabilitation courses. The courts are able to refer offenders to approved courses, enabling an offender's disqualification period to be reduced by up to one-

<sup>251</sup> S.I. 1999/2864

quarter. These courses have been shown to be effective in reducing repeat offending.<sup>252</sup>

- 7.64. There is no such regime for drug driving. This is understandable, given how few cases currently lead to conviction. It is also true that the variety of drug driving offences is much greater. For example, a heroin addict convicted of driving under the influence of heroin is likely to have a different problem from that of the social cannabis user returning from a night out.
- 7.65. However, the Review considers that there is potential in such rehabilitation schemes to benefit both the offender and the wider community. Therefore, if there is a step change in conviction numbers as a result of the staged changes in the process and law relating to drug driving, then the potential for drug driver rehabilitation courses to improve driver behaviour and reoffending rates should be reconsidered.

**Recommendation (20): Following reform of the drug driving law and process, the Government should consider the case for the introduction of drug driver rehabilitation courses.**

### Medicines and medical advice

- 7.66. A driver impaired by a prescribed or over-the-counter drug is as much a danger to the public as one impaired by controlled drugs. However, prescribed and over-the-counter drugs by their nature offer different means of addressing the potential for impaired driving. This is through advice to those taking these drugs: from healthcare professionals in the case of prescribed drugs; and from patient information leaflets in the case of both prescribed and over-the-counter drugs.
- 7.67. However, recent research<sup>253</sup> makes clear that doctors' advice on driving given to patients with medical conditions which may impair driving is sporadic at best and non-existent at worst and there is no reason to believe that advice on drugs which may impair driving is any better. The patient information leaflets provided with both prescribed and over-the-counter medicines might well contain useful advice about potential impairing effects of the medicines on driving, but are very lengthy and difficult to navigate and can lack clarity in the advice provided in relation to driving. In this regard, there is appeal in the conspicuous labelling system introduced in France (see paragraph 6.58) warning the public of the potential effects of the given drug or medicine on their driving.
- 7.68. The medical profession and pharmaceutical industry have argued that there is no evidence that impairment through use (as opposed to misuse) of prescribed and over-the-counter medicines is linked to a significant road casualty problem. Whilst there is evidence that use of prescribed benzodiazepines may increase risk of accidents over the first few weeks of a person taking them, generally, it is true to say that the evidence of the impact of medicines is poor. It is hoped that results from the EU study, DRUID, due in early 2012, may help improve our understanding of this.

252 Inwood *et al*, Extended Monitoring of Drink Drive Rehabilitation Courses, TRL Report 662 for DfT, 2007

253 Hawley *et al*, University of Warwick for DfT, January 2010 <http://www.dft.gov.uk/pgr/roadsafety/research/rsrr/theme6/report91/pdf/report91summary.pdf>

- 7.69. Given what is known about the potential for some medicines to impair driving and about the inherent risk to the driver and others of driving with a less than sharp mind, it is equally reasonable to expect that those levers which are available, in terms of professional advice to patients and information provided with over-the-counter medication, should be used on a routinely precautionary basis to guard against road accidents caused by use of these legal drugs.

**Recommendation (21): 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.**

**Recommendation (22): 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.**

### Drugs and drink in combination

- 7.70. Lastly, it is clear, from the evidence considered, that the problem of driving having taken drugs and alcohol in combination is a serious one. The international evidence shows how relatively low levels of drugs combined with relatively low levels of alcohol can be very impairing and are not uncommon among drivers. For example, alcohol at a level below the legal limit combined with cannabis is found by the research to be very impairing.
- 7.71. There is certainly an issue that the police will not generally choose to pursue a drug driving offence in the event of a positive breathalyser test for alcohol. This is unfortunate in terms of gathering better evidence and identifying those who are doubly reckless. However, it is a reasonable and practical response by the police, given that the consequences of conviction will be similar, if not the same.
- 7.72. The Review has considered the case for a specific new offence to deal with drink and drugs in combination. However, the current offence of driving while unfit due to drink or drugs is a perfectly adequate legislative response, if it is pursued more regularly. The Review considers that the recommendations made above offer the means to ensure that more cases of drink and drug driving are prosecuted.
- 7.73. More and better FIT testing will help police officers to assess and bring to justice cases where a driver is impaired by both drink and drugs. The proposal that the police should, as a matter of routine, conduct a FIT test (or, in time, a preliminary screening drug test) of an impaired driving suspect, who gives a breath reading below the drink drive limit, should assist with this. The improvement in data from coroners and procurators fiscal will provide annual evidence of the prevalence of driving with drugs and alcohol combined among driver fatalities.



- 7.74. However, it is notable that the Magistrates' Court Sentencing Guidelines for England and Wales do not cite the combination of drugs and alcohol as an aggravating factor in cases of drink or drug driving; nor is there provision in Scotland to consider this issue. This should be addressed.

**Recommendation (23): The Magistrates' Court Sentencing Guidelines should be revised by the Sentencing Council to ensure that in England and Wales the combination of alcohol and drugs is made an aggravating factor in all drink and drug driving cases where there is evidence of a combination of drugs and alcohol present. Similar provision should be made in Scotland by any new equivalent Scottish sentencing body.**

## List of abbreviations

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AA	Automobile Association
ABPI	Association of the British Pharmaceutical Industry
ACMD	Advisory Council on the Misuse of Drugs
ACPO	Association of Chief Police Officers
ACPOS	Association of Chief Police Officers in Scotland
ALS	Administrative licence suspension
BAC	Blood alcohol concentration
BCS	British Crime Survey
BMA	British Medical Association
BNF	British National Formulary
BVRLA	British Vehicle Rental and Leasing Association
BZP	1-Benzylpiperazine
CBA	Criminal Bar Association
COTS	Commercial-off-the-shelf
CPS	Crown Prosecution Service
DEC	Drug Evaluation and Classification programme
DfT	Department for Transport
DIP	Drug Interventions Programme
DRUID	DRiving Under the Influence of Drugs, Alcohol and Medicines study
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ETSC	European Transport Safety Council
FFLM	Faculty of Forensic and Legal Medicine
FIT	Field impairment test
FP	Forensic physician
FSS	Forensic Science Service
GB	Great Britain
GHB	Gamma-hydroxybutyrate
HGVs	Heavy goods vehicles
HOSDB	Home Office Scientific Development Branch
HRO	High risk offender
ICADTS	International Council on Alcohol, Drugs and Traffic Safety
IMMORTAL	Impaired Motorists, Methods Of Roadside Testing and Assessment for Licensing study
KSI	Killed and seriously injured
LGC	LGC – (formerly the Laboratory of the Government Chemist)
LSD	Lysergic acid diethylamide
MDMA	3,4-Methylenedioxymethamphetamine or ecstasy
MG DD/E	National police proforma: Drug sample information form

MG DD/F	National police proforma: Preliminary impairment test form
MHRA	Medicines and Healthcare Products Regulatory Agency
MoJ	Ministry of Justice
NHS	National Health Service
NICE	The Centre for Public Health Excellence of the National Institute of Health and Clinical Excellence
NTA	National Treatment Agency for Substance Misuse
OECD	Organisation for Economic Cooperation and Development
OF	Oral fluid
OTC	Over the counter
PACE	Police and Criminal Evidence Act 1984
PACTS	Parliamentary Advisory Council on Transport Safety
PSVs	Public service vehicles
RAC	Royal Automobile Club
ROSITA	ROadSIde Testing Assessment Study
RoSPA	Royal Society for the Prevention of Accidents
RRCGB	Reported Road Casualties of Great Britain
RTA	Road traffic accident
RTOA	Road Traffic Offenders Act 1988
SCJS	Scottish Crime and Justice Survey
ScORSA	Scottish Occupational Road Safety Alliance
SERS	Surface-enhanced Raman spectroscopy
SFST	Standardised field sobriety tests
STATS19	Road Accident Statistics
TfL	Transport for London
THC	Tetrahydrocannabinol
TISPOL	European traffic police network
TRL	Transport Research Laboratory Ltd
UK	United Kingdom
USA	United States of America
Units of measurement	<ul style="list-style-type: none"> <li>▪ ng/100 ml – nanogrammes per 100 millilitres</li> <li>▪ mcg/100 ml – microgrammes per 100 millilitres (also known as µg/100 ml)</li> <li>▪ µg/100 ml – microgrammes per 100 millilitres (also known as mcg/100 ml)</li> <li>▪ mg/100 ml – milligrammes per 100 millilitres</li> </ul>

# Annexes

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## Annex A: Consultation questions

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### Drug driving

1. Do you consider the current offence under s4(1) of the Road Traffic Act 1988 of driving while unfit due to drugs to be effective and adequate?
2. Do you think that the current law is adequately enforced by the police? Do you think the police should have greater powers to stop drivers to test if they are impaired?

### A new offence

3. Do you consider that a new offence that prohibits driving with a specific drug or level of drug in the body would make the regulation of drug driving more effective?
4. Should any new or amended offence be based on:
  - (a) an absolute ban on driving with drugs in the system?
  - (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?
5. If a new offence is created for some drugs, do you think that the existing offence of driving while unfit due to drugs needs to be retained for others?

### The approach to drugs

6. Do you consider that any new offence should apply to:
  - (a) all controlled drugs (e.g. heroin, cannabis, cocaine)?
  - (b) prescribed or over the counter drugs which are used inappropriately or may otherwise have impairing effects?
7. Do you think that the law should also specifically address impairment caused by combining drugs with alcohol?
8. What is your view on compulsory drug testing of all drivers involved in fatal (or serious) road accidents?

### The current procedures

9. Do you think that there are any legal or procedural barriers to securing a conviction for drug driving? What alternatives or improvements can you suggest?
10. What is your knowledge and view of the effectiveness of available drug testing equipment?
11. Do you consider that the procedures for drug testing at the police station (including the role of the Forensic Medical Examiner) need to be improved?

### International comparisons

12. Do you think that the drug drive laws in other countries provide examples of practice that could be adopted in the UK?

## Drink driving

The current drink driving regime

1. Do you think that the current prescribed blood alcohol limit of 80 mg/100 ml should be reduced to 50 mg/100 ml or less?
2. Do you think that the current penalty regime for drink driving offences is sufficient?

Drink drive penalty regime			
Offence	Maximum Punishment	Disqualification	Penalty points (if not disqualified)
S 4(1) Road Traffic Act 1988 Driving or attempting to drive while unfit	6 months or £5000 or both	Obligatory minimum 12 months	3–11+
S4(2) In charge while unfit	3 months or £2500 or both	Discretionary (mandatory 3 years for repeat offences committed within a ten year period)	10
S5(1)(a) Driving or attempting to drive with alcohol above the prescribed limit	6 months or £5000 or both	obligatory minimum 12 months (mandatory 3 years for repeat offences committed within a ten year period)	3–11+
S5(1)(b) In charge with alcohol above the prescribed limit	3 months or £2500 or both	discretionary	10
S6 Failing to cooperate with a preliminary test	£1000	Discretionary	4
S7 Failing to provide a specimen to be subjected to a laboratory test	(a) 6 months or £5000 or both where test is to establish ability to drive or proportion of alcohol	Obligatory in (a)	(a) 3–11
	(b) 3 months or £2500 in other cases	Discretionary in (b)	(b) 10
S7A Failing to allow a specimen to be subjected to a laboratory test	(a) 6 months or £5000 or both where test is to establish ability to drive or proportion of alcohol	Obligatory in (a)	(a) 3–11
	3 months or £2500 in other cases	Discretionary in (b)	(b) 10

3. Do you think that the current penalty regime is effective in tackling repeat offenders? How do you think repeat offenders should be dealt with?
4. What other measures (other than stricter limits) do you consider could be effective in addressing drink driving?
5. Do you think that the current law is adequately enforced by the police? Do you think the police should have greater powers to stop drivers to test if they are impaired or over the limit (e.g. random testing)?
6. What is your view of the Government's drink and drug drive message and the relationship between that message and the law?

### **A new offence**

7. If the blood alcohol limit were to be reduced, do you think that the penalty attached to a lower limit should be changed?
8. Do you think there that different prescribed limit (or limits) should be imposed on different classes of drivers and riders (e.g. novice drivers, drivers of Public Service Vehicles (e.g. buses and coaches), HGVs and those driving for hire or reward)?
9. Do you think that there is a case for immediate suspension of a person's driving licence where that person fails a breath test?

### **The current procedures**

10. Do you think that the right (under s8(2) of the Road Traffic Act 1988) to have a breath specimen replaced with a specimen of blood or urine where the lower of the two breath specimens is less than 50 mcg/100 ml is justified in light of modern testing equipment?
11. Do you consider there to be any legal or procedural barriers to enforcing the current law and/or securing a conviction for driving over the limit? What alternatives or improvements can you suggest?

### **The impact of a reduced limit**

12. What do you consider the impacts of any lowering of the blood alcohol limit may be on casualties, other health outcomes, businesses and on the economy more widely?

### **International comparisons**

13. Do you think that the drink drive laws in other countries provide examples of practice that could be adopted in the UK?

## **Annex B: Organisations and individuals who submitted written representation and evidence**

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Academy of Medical Royal Colleges and Faculties in Scotland

Dr K Agath

Alcohol Focus Scotland

Allen D

Apps B

Association of British Drivers

Association of British Insurers

Association of Chief Police Officers in Scotland

Automobile Association

Baxter S

Lord W Bradshaw

Brake in partnership with Direct Line Insurance

Bray J

British Vehicle Rental and Leasing Association

Bull S

Candor Trust, New Zealand

Chadwick A

Cheshire Police

Clynch M

Collier S, Cranfield University

Concateno plc

Corbin H

Criminal Bar Association of England and Wales

Crown Office & Procurator Fiscal Service Scotland

Cruse R

Cunningham A

Draeger Safety UK Ltd

Dtec International Ltd

Dunne M

East Lothian Council (Transportation Division)

Falkirk Council

Farrimond G

Federation Of Licensed Victuallers Associations

Fife Road Safety Unit

Fox C



Gell E – Lincolnshire Road Safety Partnership  
Gin and Vodka Association  
Greater Manchester Joint Road Safety Team  
Hanrahan M  
Hunter S  
Institute of Advanced Motorists  
Intelligent Transport Society for the United Kingdom  
Lewis E  
LGC (formerly the Laboratory of the Government Chemist)  
Liberty  
Lion Laboratories Limited  
London Borough of Camden (Public Safety Team)  
Dr R Lowe  
Merseyside Police (Roads Policing Unit)  
Merseyside Road Safety Partnership  
Metropolitan Police Service (Roads Policing Policy Unit)  
Meylan F  
Dr W Morrison – Special Advisor to the Chief Medical Officer, Scottish Executive  
Moss L  
Napp Pharmaceuticals Limited  
Nottinghamshire Police (Traffic Management)  
O’Keeffe K  
Pink R  
Police Federation of England and Wales (Roads Policing Group)  
Poots Edwin MLA – Minister of the Environment, Department of the Environment in Northern Ireland  
Professor L Ritchie – University of Aberdeen, Adviser to the Chief Medical Officer, Scottish Executive  
RoadSafe  
Scotch Whisky Association  
Scottish Accident Prevention Council  
Scottish Association of NHS Medical Directors  
Scottish Executive  
Scottish Health Action on Alcohol Problems  
Scottish Occupational Road Safety Alliance  
Strathclyde Fire and Rescue Service  
Tayside Fire and Rescue  
Thames Valley Police (Roads Policing Department)  
Transport for London

TTC 2000

Tucknutt B

Dr R Tunbridge

UK Drug Policy Commission

Unite – the union

Walker J

Ward C

Wells A

Weston R

Whitford B

Young R

### **International organisations and governments who submitted evidence**

Boase P – Transport Canada, Government of Canada

Grabek M – Ministry of Infrastructure, Government of Poland

Siegrist S – Deputy Director Swiss Council for Accident Prevention

Tidström C – Deputy Director, Division for Transport, Government of Sweden

## Annex C: Organisations and individuals who gave oral evidence to the review

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(o indicates those who also gave written evidence to the Review)

- o Advisory Council on the Misuse of Drugs
- o Association of Chief Police Officers
- o Association of Directors of Environment, Economy, Planning and Transport (formerly the County Surveyors' Society)
- o Association of the British Pharmaceutical Industry
- o Automobile Association
- o Brake
- o British Beer & Pub Association
- o British Institute of Innkeeping
- o British Medical Association
- o Cheshire Police
- o Confederation of Passenger Transport
- o Crown Prosecution Service
- o Department of Health
- o Department for Transport
- o District Judges (Magistrates' Courts)
- o Faculty of Forensic and Legal Medicine of the Royal College of Physicians
- o Forensic Science Service Ltd
- o Home Office
- o Justices' Clerks' Society (England and Wales)
- o Licensed Private Hire Car Association
- o Magistrates' Association (England and Wales)
- o Medicines and Healthcare Products Regulatory Agency
- o Ministry of Justice
- o National Private Hire Association
- o Parliamentary Advisory Council for Transport Safety
- o Professor Richard Allsop, University College London
- o Road Safety GB
- o RoadPeace
- o Royal Automobile Club Foundation
- o Royal College of Nursing
- o Royal Society for the Prevention of Accidents
- o Secretary of State for Transport's Honorary Medical Advisory Panel On Alcohol, Drugs And Substance Misuse And Driving

- o The Coroners' Society of England and Wales
- Transport for London
- UK Youth
- Wine & Spirit Trade Association

## Annex D: Visits

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In order to gather evidence for the Review visits were made to the following:

### **Laboratory**

LGC (formerly the Laboratory of the Government Chemist) 24 February 2010

### **Magistrates' Court**

Westminster Magistrates' Court, Horseferry Road, London 26 January 2010 and 11 February 2010

### **Police force**

Hampshire Constabulary 4 January 2010 and 26 February 2010

## **Annex E: Other sources of information**

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This annex contains a list of statutory provisions, text books, policy documents, articles, websites and television programmes considered in the course of the Review

### **Primary legislation**

Medicines Act 1968  
Misuse of Drugs Act 1971  
Bail Act 1976  
Criminal Justice Act 1982  
Police and Criminal Evidence Act 1984  
Road Traffic Act 1988  
Road Traffic Offenders Act 1988  
Transport and Works Act 1992  
Road Traffic (New Drivers) Act 1995  
Powers of Criminal Courts (Sentencing) Act 2000  
Railways and Transport Safety Act 2003  
Criminal Justice Act 2003  
Road Safety Act 2006  
Coroners and Justice Act 2009

### **Secondary legislation**

Medicines for Human Use (Marketing Authorisations Etc.) Regulations 1994 (S.I. 1994/3144)  
Motor Vehicle (Driving Licences) Regulations 1999 (S.I. 1999/2864)

### **Codes of Practice**

Field Impairment Test Code of Practice  
Police and Criminal Evidence Act Code C

### **Text books**

British National Formulary (BNF) 58, September 2009. (2009). 58th Ed., Derby, Great Britain, British Medical Association and the Royal Pharmaceutical Society of Great Britain.  
Carter T. Fitness to drive: A guide for health professionals. Department for Transport. 2006.  
PACE: a practical guide to the Police and Criminal Evidence Act 1984. Paul Ozin, Heather Norton and Perry Spivey. 1st Ed. 2006. Oxford University Press.  
Wilkinson's Road Traffic Offences. McCormac and Wallis. Riddle & Swift, 24th Ed. 2009.

### **Government publications**

Commission on Scottish Devolution. Serving Scotland Better: Scotland and the United Kingdom in the 21st Century: Final Report, June 2009  
British Crime Survey 2008-2009. Home Office 2010.  
British Social Attitudes Survey 2009. National Centre for Social Research. In press.  
Crown Prosecution Guidance, Road Traffic Offences: Drink Driving.

Department for Transport. A Safer Way: Consultation on Making Britain's Roads the Safest in the World.

Department for Transport. Reported Road Casualties Great Britain: 2008.

Department for Transport/Driving Standards Agency. Learning to Drive. May 2008.

Department of Health/Home Office (2007). Safe, sensible, social: The next steps in the national alcohol strategy. London: Department of Health.

Department of the Environment (1976). Drinking and Driving. TSO Ltd

Department of the Environment Report. Drinking and Driving. Blennerhassett F *et al.* HMSO 1976.

DVLA. At a glance guide to the current medical standards of fitness to drive. Sep 09.

Home Office Circular 1983/46.

Magistrates' Court Sentencing Guidelines. Sentencing Guidelines Council. Aug 2008.

ONS (2006) Drinking: adults' behaviour and knowledge in 2006. Omnibus Survey report No 31.

Scotland's Future in the UK. Scotland Office. Nov 2009.

THINK! Road Safety Annual Survey 2008. BMRB for the Department for Transport

### **Publications of non-Governmental organisations**

Evaluation of Christmas Drink Drive Campaign 2009. Association of Chief Police Officers (Scotland), February 2010.

General Medical Council. Confidentiality: reporting concerns about patients to the DVLA or the DVA. Supplementary Guidance. Sep 09.

Royal College of Nursing. Health and Nursing Care in the Criminal Justice System: RCN guidance for nursing staff. 2008.

### **Articles and press releases**

Association of Chief Police Officers (ACPO) Press Release 006/10, 21 January 2010.

Brake/Direct Line Report on Safe Driving, 2009-2011 Part Two, Fit to Drive?, February 2010.

Mixmag (2010) "Drugs Survey". Issue 225. February 2010.

### **Websites**

Crown Prosecution Service. Website: [www.cps.gov.uk](http://www.cps.gov.uk)

DRUID. Website: <http://www.druid-project.eu/>

Faculty of Forensic and Legal Medicine. Website: <http://fflm.ac.uk/>

Office of National Statistics. Website: <http://www.statistics.gov.uk/hub/>

PubMed. Website: <http://www.ncbi.nlm.nih.gov/pubmed/>

ROSITA Study. Website: <http://www.rosita.org/>

Sentencing Council. Website: [www.sentencing-guidelines.gov.uk](http://www.sentencing-guidelines.gov.uk)

THINK! Road Safety Campaign. Website: <http://www.dft.gov.uk/think/>

Transport Advice Portal. Website: <http://www.tap.iht.org/>

### **Television programmes**

Police, Camera, Action!" Optomen Productions, aired Feb 2010.

## Annex F: Research evidence

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- Achterberg F. Raising Compliance with Road Safety Law. 1st Road Safety PIN Report. European Transport Safety Council. 2008.
- AFSSAPS. Mise au point. Médicaments et conduite automobile. Actualisation – Mars 2009.
- Albalade D. Lowering blood alcohol content levels to save lives: the European experience. *Journal of Policy Analysis and Management* 39. 2006.
- Assum T, Mathijssen MP, Houwing S, Buttress SC, Sexton B, Tunbridge RJ and Oliver J. The prevalence of drug driving and relative risk estimations. A study conducted in The Netherlands, Norway and United Kingdom. IMMORTAL EU research project, Deliverable D-R4.2. 2005.
- Bartl G, Esberger R. Effects of lowering the legal BAC limit in Austria. Proceedings of 15th Conference on Alcohol Drugs and Traffic Safety Stockholm. International Council on Alcohol, Drugs and Traffic Safety. 2000.
- Beirness D, Clayton A, Vanlaar W. An investigation of the usefulness, the acceptability and impact on lifestyle of alcohol ignition interlocks in drink driving offenders. DfT, Road Safety Research Report No 88. Nov 2008.
- Beirness D, Swan P, Logan B. ITF/OECD Report on Drugs in Traffic. 2010. In press.
- Bond P, Kingston P, Nevill A. Operational efficiency of healthcare in police custody suites: comparison of nursing and medical provision. *Journal of Advanced Nursing* 60 (2) 127-134. 2007.
- Borkenstein RF, Crowther RP, Shumate WB *et al.* The role of the drinking driver in traffic accidents. *Blutalkohol* 11 (supplement 1) :1–132. 1974.
- Borkenstein RF, Smith HW. The Breathalyzer and its applications. *Med Sci Law* 1 13-23. 1961.
- Brooks C, Zaal D. Effects of a reduced alcohol limit for driving. Australia: Federal Office of Road Safety. 1993.
- Burns M, Dioquino T. A Florida Validation study of SFSTs. US Department of Transportation Report No AL-97-05-14-01. 1997.
- Caldwell JA *et al.* Efficacy of Dexedrine for maintaining aviator performance during 64 hours of sustained wakefulness: a simulator study. *Aviat Space Environ Med.* 2000 Jan;71(1):7-18.
- Cobb P, Dabbs M. The Paton Review: Report on the performance of the Lion intoximeter 3000 and the Camic Breath Analyser evidential breath alcohol measuring instruments during the period 16 April 1984 to 15 October 1984. 1985.
- Couto JE *et al.* High rates of inappropriate drug use in the chronic pain population. *Population Health Management.* 12(4): 185-190. August 2009.
- Davies GP and Broughton J. Criminal and motoring offences of drink-drivers who are High Risk Offenders. TRL Report. 2002.
- Dee TS. Does setting limits save lives? The case of 0.08 BAC laws. *Journal of Policy Analysis and Management* 20 (1): 111–128. 2001.
- Eisenberg D. Evaluating the effectiveness of policies related to drunk driving. *Journal of Policy Analysis and Management* 22 (2): 249–74. 2003.
- Elder RW, Shults RA, Sleet DA *et al.* 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): 57–65. 2004.



- Elliott S, Woolacott H and Braithwaite R. The prevalence of drugs and alcohol found in road traffic fatalities: A comparative study of victims. *Science and Justice* 49 pp. 19-23. 2009.
- EMCDDA. 2007. EMCDDA selected issue – Drugs and driving. Luxembourg: Office for Official Publications of the European Communities.
- EMCDDA. 2008. EMCDDA Insights 8 – Drug use, impaired driving and traffic accidents. Luxembourg: Office for Official Publications of the European Communities.
- EMCDDA 2009a. Annual report 2009: State of the drugs problem in Europe. Luxembourg: Publications Office of the European Union.
- Emerson VJ, Holleyhead R, Isaacs MD, Fuller NA, Hunt DJ. The measurement of breath alcohol. The laboratory evaluation of substantive breath test equipment and the report of an operational police trial, *J Forensic Sci Soc* 20 (1980) 3-70.
- ETSC. Reducing deaths from drink driving. Road Safety PIN No 5. 2007.
- European Commission (EC) 2007a: Attitudes towards alcohol. Special Eurobarometer.
- Everest JT, Tunbridge RJ, and Widdop B. The incidence of drugs in road accident fatalities. TRL Report RR202. Crowthorne: TRL. 1989.
- Freeman D. Drunk driving legislation and traffic fatalities: new evidence on BAC 08 laws. *Contemporary Economic Policy*. 25 (3) 293–308. 2007.
- Hawley D *et al.* The attitudes of health professionals to giving advice on fitness to drive. DfT 2010.
- Henstridge J, Homel R, Mackay P. The long-term effects of random breath testing in Adelaide. In Kloeden CN and McLean AJ Editors. Proceedings of the 13th international conference on alcohol, drugs and traffic safety. 13–18 August 1995. Adelaide, Australia: International Council on Alcohol, Drugs and Traffic Safety. 1995.
- Henstridge 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.
- Hoare J. British Crime Survey, 2008-2009: Special licence access, drug use module (BCS). Home Office. 2010.
- ICADTS. Categorisation system for medicinal drugs affecting driving performance. 2007.
- Inwood C *et al.* Extended monitoring of drink drive rehabilitation courses. TRL Report 662 for DfT. 2007.
- Jackson PG, Hilditch CJ. A review of evidence related to drug driving in the UK. Clockwork Research Ltd. 2010.
- Jones AW. Driving under the influence of drugs in Sweden with zero concentration limits in blood for controlled substances. *Traffic Injury Prevention*, 6:317-322. 2005.
- Jones AW. Urine as a biological specimen for forensic analysis of alcohol and variability in the urine-to-blood relationship. *Toxicol Rev* 2006; 25 (1): 15-35.
- Jones AW. The relationship between blood alcohol concentration (BAC) and breath alcohol concentration (BrAC): a review of the evidence. Department for Transport. 2010.
- Kaplan S, Prato CG. Impact of BAC limit reduction on different population segments: a Poisson fixed effect analysis. *Accident Analysis & Prevention* 39 (6): 1146–54. 2007.
- Killoran A, Canning U, Doyle N, Sheppard L. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. National Institute of Health and Clinical Excellence (NICE). 2010.

- Lamers CT, Ramaekers JG. Visual search and urban driving under the influence of marijuana and alcohol. *Hum Psychopharmacol.* 16(5):393-401. 2001.
- Liang L, Huang J. Go out or stay in? The effects of zero tolerance laws on alcohol use and drinking and driving patterns among college students. *Health Economics* 17 (11): 1261–75. 2008.
- Logan BK, Couper FJ 3,4-Methylenedioxymethamphetamine (MDMA, ecstasy) and driving impairment. *J Forensic Sci.* 46(6): 1426-33. 2001.
- MacLeod P *et al.* Results from the drug use module of the 2008-09 Scottish Crime and Justice Survey. National Statistics Publication for Scotland. 2010.
- Makinen T, Zaidel DM. Traffic enforcement in Europe: effects, measures, needs and future. Final report of the ESCAPE consortium. Brussels: European Commission. 2003.
- Mathijssen MP. Drink driving policy and road safety in the Netherlands: a retrospective analysis. *Transportation Research (Part E) Logistics and Transportation Review* 41 (5): 395–408. 2005.
- Maycock G. Drinking and Driving in GB -a review Transport Research Laboratory TRL report 232. 1991.
- Myant K, Hope S, McIntosh J, O'Brien T, McKeganey N and Stradling S. Illicit drugs and driving. Transport Research Series. Edinburgh: Scottish Executive Social Research. 2006.
- Officer J. Trends in drug use of Scottish drivers arrested under Section 4 of the Road Traffic Act – A 10 year review. *Science and Justice* 49 pp.237–241. 2009.
- Oliver JS, Seymour A, Wylie FM, Torrance H and RA Anderson. Monitoring the effectiveness of UK field impairment tests. Road Safety Research Report No. 63. London: Department for Transport. 2006.
- Peden M. World report on road traffic injury prevention. Geneva: World Health Organization. 2004.
- Peek-Asa C. The effect of random alcohol screening in reducing motor vehicle crash injuries (structured abstract). *American Journal of Preventive Medicine* 16 (1 supplement): 57–67. 1999.
- Povey *et al.* Police Powers and Procedures 2008/09. Home Office Statistical Bulletin. 2010.
- Rafia R, Brennan A. Modelling methods to estimate the potential impact of lowering the blood alcohol concentration limit from 80 mg/100 ml to 50 mg/100 ml in England and Wales. Report to the National Institute for Health and Clinical Excellence. School of Health and Related Research (SchARR), University of Sheffield. 2010.
- Ramaekers JG, Robbe HW, O'Hanlon JF. Marijuana, alcohol and actual driving performance. *Hum Psychopharmacol.* 15(7):551-558. 2000.
- Rapoport M *et al.* Benzodiazepine use and driving: a meta-analysis. *J Clin Psychiatry.* 2005 Dec;70(12):1727-9.
- SARTRE. European drivers and road risk, SARTRE 3 Reports., Part I, Report on principal report and analyses. INRETS, Arcueil. 2004.
- Shults RA, Elder RW, Sleet DA *et al.* Reviews of evidence regarding interventions to reduce alcohol-impaired driving (Brief record). *American Journal of Preventive Medicine* 21 (4 supplement): 66–88. 2001.
- Sykes W *et al.* A qualitative study of drinking and driving: Report of findings. DfT Road Safety Research Report 114. Feb 2010.

- T Miller, M Blewden, J Zhang. Cost savings from a sustained compulsory breath testing and media campaign in New Zealand. 36 *Accid. Anal.* 2004.
- Tay R. General and specific deterrent effects of traffic enforcement. 39 *Journal of Transport Economics and Policy* 209. 2005.
- Tippetts AS, Voas RB, Fell JC *et al.* A meta-analysis of .08 BAC laws in 19 jurisdictions in the United States. *Accident Analysis & Prevention* 37 (1): 149–61. 2005.
- Townsend, Achterberg F, Janitzek T. Traffic law enforcement across the EU: An overview. European Transport Safety Council (ETSC). 2006.
- Tunbridge RJ, Keigan M and James F. The incidence of drugs and alcohol in road accident fatalities. TRL Report 495, Crowthorne: TRL. 2001.
- Van Laar M, Volkerts E. Driving and benzodiazepine use: Evidence that they do not mix. *CND Drugs*. Vol 10, (5), Nov 1998, pp383-396(14).
- Verstraete A, Raes E. Rosita-2 Project Final Report. 2006.
- Villaveces A, Cummings P, Koepsell TD. *et al.* Association of alcohol-related laws with deaths due to motor vehicle and motorcycle crashes in the United States, 1980–1997. *American Journal of Epidemiology* 157 (2): 131–40. 2003.
- Voas RB, Tippetts AS, Fell JC. Assessing the effectiveness of minimum legal drinking age and zero tolerance laws in the United States. *Accident Analysis & Prevention* 35 (4): 579–87. 2003.
- Wagenaar AC, Maldonado-Molina MM. Effects of drivers' license suspension policies on alcohol-related crash involvement: long-term follow-up in forty-six states. *Alcoholism: Clinical & Experimental Research* 31 (8): 1399–406. 2007.
- Wagenaar AC, O'Malley PM, LaFond C. Lowered legal blood alcohol limits for young drivers: effects on drinking, driving, and driving-after-drinking behaviors in 30 states. *American Journal of Public Health* 91 (5): 801–4. 2001.
- Wigmore JW, Langille RM. Six generations of breath alcohol testing instruments: changes in the detection of breath alcohol since 1930: a historical review. *Can J Forensic Sci J.* 42. 276-283. 2009.
- Wingen M, Bothmer J, Langer S, Ramaekers JG. Actual driving performance and psychomotor function in healthy subjects after acute and subchronic treatment with escitalopram, mirtazapine, and placebo: a crossover trial. *J Clin Psychiatry* 66(4):436-43. 2005.
- Wolshrijn H, De Gier JJ, De Smet PA. Drugs and driving: a new categorization system for drugs affecting psychomotor performance. Institute for Drugs, Safety and Behaviour, University of Limburg, The Netherlands. Tech Report. 1991.
- Woolley J, Baldock M. Review of Western Australian Drug Driving Laws. Centre for Automotive Safety Research Report. 2009.
- Zwerling C, Jones MP. Evaluation of the effectiveness of low blood alcohol concentration laws for younger drivers (structured abstract). *American Journal of Preventive Medicine* 16 (1 supplement): 76–80. 1999.
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## Annex G: Relevant statutory provisions

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This annex contains the relevant sections of the following statutes:

Misuse of Drugs Act 1971

Bail Act 1976

Criminal Justice Act 1982

Police and Criminal Evidence Act 1984

Road Traffic Act 1988

Road Traffic Offenders Act 1988

Transport and Works Act 1992

Road Traffic (New Drivers) Act 1995

Powers of Criminal Courts (Sentencing) Act 2000

Railways and Transport Safety Act 2003

Criminal Justice Act 2003

Coroners and Justice Act 2009

### **Misuse of Drugs Act 1971 c. 38**

#### **Controlled drugs and their classification**

##### *2 Controlled drugs and their classification for purposes of this Act*

(1) In this Act—

(a) the expression “controlled drug” means any substance or product for the time being specified in Part I, II, or III of Schedule 2 to this Act; and

(b) the expressions “Class A drug”, “Class B drug” and “Class C drug” mean any of the substances and products for the time being specified respectively in Part I, Part II and Part III of that Schedule;

and the provisions of Part IV of that Schedule shall have effect with respect to the meanings of expressions used in that Schedule.

(2) Her Majesty may by Order in Council make such amendments in Schedule 2 to this Act as may be requisite for the purpose of adding any substance or product to, or removing any substance or product from, any of Parts I to III of that Schedule, including amendments for securing that no substance or product is for the time being specified in a particular one of those Parts or for inserting any substance or product into any of those Parts in which no substance or product is for the time being specified.

(3) An Order in Council under this section may amend Part IV of Schedule 2 to this Act, and may do so whether or not it amends any other Part of that Schedule.

(4) An Order in Council under this section may be varied or revoked by a subsequent Order in Council there under.

(5) No recommendation shall be made to Her Majesty in Council to make an Order under this section unless a draft of the Order has been laid before Parliament and approved by a resolution of each House of Parliament; and the Secretary of State shall not lay a draft of such an Order before Parliament except after consultation with or on the recommendation of the Advisory Council.

## **Bail Act 1976 c. 63**

Incidents of bail in criminal proceedings

### 3 General provisions

(1) A person granted bail in criminal proceedings shall be under a duty to surrender to custody, and that duty is enforceable in accordance with section 6 of this Act.

(2) No recognizance for his surrender to custody shall be taken from him.

(3) Except as provided by this section—

(a) no security for his surrender to custody shall be taken from him,

(b) he shall not be required to provide a surety or sureties for his surrender to custody, and

(c) no other requirement shall be imposed on him as a condition of bail.

(4) He may be required, before release on bail, to provide a surety or sureties to secure his surrender to custody.

(5) . . . He may be required, before release on bail, to give security for his surrender to custody.

The security may be given by him or on his behalf.

(6) He may be required . . . to comply, before release on bail or later, with such requirements as appear to the court to be necessary . . .—

(a) to secure that he surrenders to custody,

(b) to secure that he does not commit an offence while on bail,

(c) to secure that he does not interfere with witnesses or otherwise obstruct the course of justice whether in relation to himself or any other person,

(ca) for his own protection or, if he is a child or young person, for his own welfare or in his own interests,

(d) to secure that he makes himself available for the purpose of enabling inquiries or a report to be made to assist the court in dealing with him for the offence

(e) to secure that before the time appointed for him to surrender to custody, he attends an interview with a person who, for the purposes of the Legal Services Act 2007, is an authorised person in relation to an activity which constitutes the exercise of a right of audience or the conduct of litigation (within the meaning of that Act);

and, in any Act, “the normal powers to impose conditions of bail” means the powers to impose conditions under paragraph (a), (b), (c) or (ca) above.

## Criminal Justice Act 1982 c. 48

### Introduction of standard scale of fines

#### *37 The standard scale of fines for summary offences*

(1) There shall be a standard scale of fines for summary offences, which shall be known as “the standard scale”.

(2) The standard scale is shown below—

Level on the scale	Amount of fine
1	£200
2	£500
3	£1,000
4	£2,500
5	£5,000

(3) Where any enactment (whether contained in an Act passed before or after this Act) provides—

(a) that a person convicted of a summary offence shall be liable on conviction to a fine or a maximum fine by reference to a specified level on the standard scale; or

(b) confers power by subordinate instrument to make a person liable on conviction of a summary offence (whether or not created by the instrument) to a fine or maximum fine by reference to a specified level on the standard scale,

it is to be construed as referring to the standard scale for which this section provides as that standard scale has effect from time to time by virtue either of this section or of an order under section 143 of the Magistrates’ Courts Act 1980.

## Police and Criminal Evidence Act 1984 c. 60

#### *62 Intimate samples*

(1) Subject to section 63B below, an intimate sample may be taken from a person in police detention only—

(a) if a police officer of at least the rank of inspector authorises it to be taken; and

(b) if the appropriate consent is given.

(1A) An intimate sample may be taken from a person who is not in police detention but from whom, in the course of the investigation of an offence, two or more non-intimate samples suitable for the same means of analysis have been taken which have proved insufficient—

(a) if a police officer of at least the rank of inspector authorises it to be taken; and

(b) if the appropriate consent is given.

(2) An officer may only give an authorisation under subsection (1) or (1A) above if he has reasonable grounds—

(a) for suspecting the involvement of the person from whom the sample is to be taken in a recordable offence; and

(b) for believing that the sample will tend to confirm or disprove his involvement.

(2A) An intimate sample may be taken from a person where—

- (a) two or more non-intimate samples suitable for the same means of analysis have been taken from the person under section 63(3E) below (persons convicted of offences outside England and Wales etc) but have proved insufficient;
- (b) a police officer of at least the rank of inspector authorises it to be taken; and
- (c) the appropriate consent is given.

(2B) An officer may only give an authorisation under subsection (2A) above if the officer is satisfied that taking the sample is necessary to assist in the prevention or detection of crime.

(3) An officer may give an authorisation under subsection (1) or (1A) or (2A) above orally or in writing but, if he gives it orally, he shall confirm it in writing as soon as is practicable.

(4) The appropriate consent must be given in writing.

(5) Where—

- (a) an authorisation has been given; and
- (b) it is proposed that an intimate sample shall be taken in pursuance of the authorisation,

an officer shall inform the person from whom the sample is to be taken—

- (i) of the giving of the authorisation; and
- (ii) of the grounds for giving it.

(6) The duty imposed by subsection (5)(ii) above includes a duty to state the nature of the offence in which it is suspected that the person from whom the sample is to be taken has been involved.

(7) If an intimate sample is taken from a person—

- (a) the authorisation by virtue of which it was taken;
  - (b) the grounds for giving the authorisation; and
  - (c) the fact that the appropriate consent was given,
- shall be recorded as soon as is practicable after the sample is taken.

(7A) If an intimate sample is taken from a person at a police station—

- (a) before the sample is taken, an officer shall inform him that it may be the subject of a speculative search; and
- (b) the fact that the person has been informed of this possibility shall be recorded as soon as practicable after the sample has been taken.

(5) Before an intimate sample is taken from a person, an officer shall inform him of the following—

- (a) the reason for taking the sample;
- (b) the fact that authorisation has been given and the provision of this section under which it has been given; and
- (c) if the sample was taken at a police station, the fact that the sample may be the subject of a speculative search.

(6) The reason referred to in subsection (5)(a) above must include, except in a case where the sample is taken under subsection (2A) above, a statement of the nature of the offence in which it is suspected that the person has been involved.

(7) After an intimate sample has been taken from a person, the following shall be recorded as soon as practicable—

- (a) the matters referred to in subsection (5)(a) and (b) above;
- (b) if the sample was taken at a police station, the fact that the person has been informed as specified in subsection (5)(c) above; and
- (c) the fact that the appropriate consent was given.

(8) If an intimate sample is taken from a person detained at a police station, the matters required to be recorded by subsection (7) or (7A) above shall be recorded in his custody record.

(9) In the case of an intimate sample which is a dental impression, the sample may be taken from a person only by a registered dentist.

(9A) In the case of any other form of intimate sample, except in the case of a sample of urine, the sample may be taken from a person only by—

- (a) a registered medical practitioner; or
- (b) a registered health care professional.

(10) Where the appropriate consent to the taking of an intimate sample from a person was refused without good cause, in any proceedings against that person for an offence—

- (a) the court, in determining—
    - (i) whether to commit that person for trial; or
    - (ii) whether there is a case to answer; and
    - (aa) a judge, in deciding whether to grant an application made by the accused under—
      - (i) section 6 of the Criminal Justice Act 1987 (application for dismissal of charge of serious fraud in respect of which notice of transfer has been given under section 4 of that Act); or
      - (ii) paragraph 5 of Schedule 6 to the Criminal Justice Act 1991 (application for dismissal of charge of violent or sexual offence involving child in respect of which notice of transfer has been given under section 53 of that Act); and
  - paragraph 2 of Schedule 3 to the Crime and Disorder Act 1998 (applications for dismissal); and
  - (b) the court or jury, in determining whether that person is guilty of the offence charged,
- may draw such inferences from the refusal as appear proper . . .

(11) Nothing in this section applies to the taking of a specimen for the purposes of any of the provisions of sections 4 to 11 of the Road Traffic Act 1988 or of sections 26 to 38 of the Transport and Works Act 1992.

(12) Nothing in this section applies to a person arrested or detained under the terrorism provisions; and subsection (1A) shall not apply where the non-intimate



samples mentioned in that subsection were taken under paragraph 10 of Schedule 8 to the Terrorism Act 2000.

## **Road Traffic Act 1988 c. 52**

### **Part I Principal Road Safety Provisions**

#### **Driving offences**

##### *4 Driving, or being in charge, when under influence of drink or drugs*

(1) A person who, when driving or attempting to drive a mechanically propelled vehicle on a road or other public place, is unfit to drive through drink or drugs is guilty of an offence.

(2) Without prejudice to subsection (1) above, a person who, when in charge of a mechanically propelled vehicle which is on a road or other public place, is unfit to drive through drink or drugs is guilty of an offence.

(3) For the purposes of subsection (2) above, a person shall be deemed not to have been in charge of a mechanically propelled vehicle if he proves that at the material time the circumstances were such that there was no likelihood of his driving it so long as he remained unfit to drive through drink or drugs.

(4) The court may, in determining whether there was such a likelihood as is mentioned in subsection (3) above, disregard any injury to him and any damage to the vehicle.

(5) For the purposes of this section, a person shall be taken to be unfit to drive if his ability to drive properly is for the time being impaired.

##### *5 Driving or being in charge of a motor vehicle with alcohol concentration above prescribed limit*

(1) If a person—

(a) drives or attempts to drive a motor vehicle on a road or other public place, or  
(b) is in charge of a motor vehicle on a road or other public place,  
after consuming so much alcohol that the proportion of it in his breath, blood or urine exceeds the prescribed limit he is guilty of an offence.

(2) It is a defence for a person charged with an offence under subsection (1)(b) above to prove that at the time he is alleged to have committed the offence the circumstances were such that there was no likelihood of his driving the vehicle whilst the proportion of alcohol in his breath, blood or urine remained likely to exceed the prescribed limit.

(3) The court may, in determining whether there was such a likelihood as is mentioned in subsection (2) above, disregard any injury to him and any damage to the vehicle.

##### *6 Power to administer preliminary tests*

(1) If any of subsections (2) to (5) applies a constable may require a person to co-operate with any one or more preliminary tests administered to the person by that constable or another constable.

- (2) This subsection applies if a constable reasonably suspects that the person—
- (a) is driving, is attempting to drive or is in charge of a motor vehicle on a road or other public place, and
  - (b) has alcohol or a drug in his body or is under the influence of a drug.
- (3) This subsection applies if a constable reasonably suspects that the person—
- (a) has been driving, attempting to drive or in charge of a motor vehicle on a road or other public place while having alcohol or a drug in his body or while unfit to drive because of a drug, and
  - (b) still has alcohol or a drug in his body or is still under the influence of a drug.
- (4) This subsection applies if a constable reasonably suspects that the person—
- (a) is or has been driving, attempting to drive or in charge of a motor vehicle on a road or other public place, and
  - (b) has committed a traffic offence while the vehicle was in motion.
- (5) This subsection applies if—
- (a) an accident occurs owing to the presence of a motor vehicle on a road or other public place, and
  - (b) a constable reasonably believes that the person was driving, attempting to drive or in charge of the vehicle at the time of the accident.
- (6) A person commits an offence if without reasonable excuse he fails to co-operate with a preliminary test in pursuance of a requirement imposed under this section.
- (7) A constable may administer a preliminary test by virtue of any of subsections (2) to (4) only if he is in uniform.
- (8) In this section—
- (a) a reference to a preliminary test is to any of the tests described in sections 6A to 6C, and
  - (b) “traffic offence” means an offence under—
    - (i) a provision of Part II of the Public Passenger Vehicles Act 1981 (c 14),
    - (ii) a provision of the Road Traffic Regulation Act 1984 (c 27),
    - (iii) a provision of the Road Traffic Offenders Act 1988 (c 53) other than a provision of Part III, or
    - (iv) a provision of this Act other than a provision of Part V.

### *6B Preliminary impairment test*

- (1) A preliminary impairment test is a procedure whereby the constable administering the test—
- (a) observes the person to whom the test is administered in his performance of tasks specified by the constable, and
  - (b) makes such other observations of the person’s physical state as the constable thinks expedient.
- (2) The Secretary of State shall issue (and may from time to time revise) a code of practice about—

- (a) the kind of task that may be specified for the purpose of a preliminary impairment test,
  - (b) the kind of observation of physical state that may be made in the course of a preliminary impairment test,
  - (c) the manner in which a preliminary impairment test should be administered, and
  - (d) the inferences that may be drawn from observations made in the course of a preliminary impairment test.
- (3) In issuing or revising the code of practice the Secretary of State shall aim to ensure that a preliminary impairment test is designed to indicate—
- (a) whether a person is unfit to drive, and
  - (b) if he is, whether or not his unfitness is likely to be due to drink or drugs.
- (4) A preliminary impairment test may be administered—
- (a) at or near the place where the requirement to co-operate with the test is imposed, or
  - (b) if the constable who imposes the requirement thinks it expedient, at a police station specified by him.
- (5) A constable administering a preliminary impairment test shall have regard to the code of practice under this section.
- (6) A constable may administer a preliminary impairment test only if he is approved for that purpose by the chief officer of the police force to which he belongs.
- (7) A code of practice under this section may include provision about—
- (a) the giving of approval under subsection (6), and
  - (b) in particular, the kind of training that a constable should have undergone, or the kind of qualification that a constable should possess, before being approved under that subsection.

#### *6C Preliminary drug test*

- (1) A preliminary drug test is a procedure by which a specimen of sweat or saliva is—
- (a) obtained, and
  - (b) used for the purpose of obtaining, by means of a device of a type approved by the Secretary of State, an indication whether the person to whom the test is administered has a drug in his body.
- (2) A preliminary drug test may be administered—
- (a) at or near the place where the requirement to co-operate with the test is imposed, or
  - (b) if the constable who imposes the requirement thinks it expedient, at a police station specified by him.

#### *6D Arrest*

- (1) A constable may arrest a person without warrant if as a result of a preliminary breath test the constable reasonably suspects that the proportion of alcohol in the person's breath or blood exceeds the prescribed limit.

(1A) The fact that specimens of breath have been provided under section 7 of this Act by the person concerned does not prevent subsection (1) above having effect if the constable who imposed on him the requirement to provide the specimens has reasonable cause to believe that the device used to analyse the specimens has not produced a reliable indication of the proportion of alcohol in the breath of the person.

(2) A constable may arrest a person without warrant if—

(a) the person fails to co-operate with a preliminary test in pursuance of a requirement imposed under section 6, and

(b) the constable reasonably suspects that the person has alcohol or a drug in his body or is under the influence of a drug.

(2A) A person arrested under this section may, instead of being taken to a police station, be detained at or near the place where the preliminary test was, or would have been, administered, with a view to imposing on him there a requirement under section 7 of this Act.

(3) A person may not be arrested under this section while at a hospital as a patient.

#### *6E Power of entry*

(1) A constable may enter any place (using reasonable force if necessary) for the purpose of—

(a) imposing a requirement by virtue of section 6(5) following an accident in a case where the constable reasonably suspects that the accident involved injury of any person, or

(b) arresting a person under section 6D following an accident in a case where the constable reasonably suspects that the accident involved injury of any person.

(2) This section—

(a) does not extend to Scotland, and

(b) is without prejudice to any rule of law or enactment about the right of a constable in Scotland to enter any place.

#### *7 Provision of specimens for analysis*

(1) In the course of an investigation into whether a person has committed an offence under section 3A, 4 or 5 of this Act a constable may, subject to the following provisions of this section and section 9 of this Act, require him—

(a) to provide two specimens of breath for analysis by means of a device of a type approved by the Secretary of State, or

(b) to provide a specimen of blood or urine for a laboratory test.

(2) A requirement under this section to provide specimens of breath can only be made—

(a) at a police station,

(b) at a hospital, or

(c) at or near a place where a relevant breath test has been administered to the person concerned or would have been so administered but for his failure to co-operate with it.

(2A) For the purposes of this section “a relevant breath test” is a procedure involving the provision by the person concerned of a specimen of breath to be used for the purpose of obtaining an indication whether the proportion of alcohol in his breath or blood is likely to exceed the prescribed limit.

(2B) A requirement under this section to provide specimens of breath may not be made at or near a place mentioned in subsection (2)(c) above unless the constable making it—

(a) is in uniform, or

(b) has imposed a requirement on the person concerned to co-operate with a relevant breath test in circumstances in which section 6(5) of this Act applies.

(2C) Where a constable has imposed a requirement on the person concerned to co-operate with a relevant breath test at any place, he is entitled to remain at or near that place in order to impose on him there a requirement under this section.

(2D) If a requirement under subsection (1)(a) above has been made at a place other than at a police station, such a requirement may subsequently be made at a police station if (but only if)—

(a) a device or a reliable device of the type mentioned in subsection (1)(a) above was not available at that place or it was for any other reason not practicable to use such a device there, or

(b) the constable who made the previous requirement has reasonable cause to believe that the device used there has not produced a reliable indication of the proportion of alcohol in the breath of the person concerned.

(3) A requirement under this section to provide a specimen of blood or urine can only be made at a police station or at a hospital; and it cannot be made at a police station unless—

(a) the constable making the requirement has reasonable cause to believe that for medical reasons a specimen of breath cannot be provided or should not be required, or

(b) specimens of breath have not been provided elsewhere and at the time the requirement is made a device or a reliable device of the type mentioned in subsection (1)(a) above is not available at the police station or it is then for any other reason not practicable to use such a device there, or

(bb) a device of the type mentioned in subsection (1)(a) above has been used (at the police station or elsewhere) but the constable who required the specimens of breath has reasonable cause to believe that the device has not produced a reliable indication of the proportion of alcohol in the breath of the person concerned, or

(bc) as a result of the administration of a preliminary drug test, the constable making the requirement has reasonable cause to believe that the person required to provide a specimen of blood or urine has a drug in his body, or

(c) the suspected offence is one under section 3A or 4 of this Act and the constable making the requirement has been advised by a medical practitioner that the condition of the person required to provide the specimen might be due to some drug;

but may then be made notwithstanding that the person required to provide the specimen has already provided or been required to provide two specimens of breath.

(4) If the provision of a specimen other than a specimen of breath may be required in pursuance of this section the question whether it is to be a specimen of blood or a specimen of urine and, in the case of a specimen of blood, the question who is to be asked to take it shall be decided (subject to subsection (4A)) by the constable making the requirement.

(4A) Where a constable decides for the purposes of subsection (4) to require the provision of a specimen of blood, there shall be no requirement to provide such a specimen if—

(a) the medical practitioner who is asked to take the specimen is of the opinion that, for medical reasons, it cannot or should not be taken; or

(b) the registered health care professional who is asked to take it is of that opinion and there is no contrary opinion from a medical practitioner;

and, where by virtue of this subsection there can be no requirement to provide a specimen of blood, the constable may require a specimen of urine instead.

(5) A specimen of urine shall be provided within one hour of the requirement for its provision being made and after the provision of a previous specimen of urine.

(6) A person who, without reasonable excuse, fails to provide a specimen when required to do so in pursuance of this section is guilty of an offence.

(7) A constable must, on requiring any person to provide a specimen in pursuance of this section, warn him that a failure to provide it may render him liable to prosecution.

#### *7A Specimens of blood taken from persons incapable of consenting*

(1) A constable may make a request to a medical practitioner for him to take a specimen of blood from a person (“the person concerned”) irrespective of whether that person consents if—

(a) that person is a person from whom the constable would (in the absence of any incapacity of that person and of any objection under section 9) be entitled under section 7 to require the provision of a specimen of blood for a laboratory test;

(b) it appears to that constable that that person has been involved in an accident that constitutes or is comprised in the matter that is under investigation or the circumstances of that matter;

(c) it appears to that constable that that person is or may be incapable (whether or not he has purported to do so) of giving a valid consent to the taking of a specimen of blood; and

(d) it appears to that constable that that person’s incapacity is attributable to medical reasons.

(2) A request under this section—

(a) shall not be made to a medical practitioner who for the time being has any responsibility (apart from the request) for the clinical care of the person concerned; and

- (b) shall not be made to a medical practitioner other than a police medical practitioner unless—
- (i) it is not reasonably practicable for the request to be made to a police medical practitioner; or
  - (ii) it is not reasonably practicable for such a medical practitioner (assuming him to be willing to do so) to take the specimen.
- (3) It shall be lawful for a medical practitioner to whom a request is made under this section, if he thinks fit—
- (a) to take a specimen of blood from the person concerned irrespective of whether that person consents; and
  - (b) to provide the sample to a constable.
- (4) If a specimen is taken in pursuance of a request under this section, the specimen shall not be subjected to a laboratory test unless the person from whom it was taken—
- (a) has been informed that it was taken; and
  - (b) has been required by a constable to give his permission for a laboratory test of the specimen; and
  - (c) has given his permission.
- (5) A constable must, on requiring a person to give his permission for the purposes of this section for a laboratory test of a specimen, warn that person that a failure to give the permission may render him liable to prosecution.
- (6) A person who, without reasonable excuse, fails to give his permission for a laboratory test of a specimen of blood taken from him under this section is guilty of an offence.
- (7) In this section “police medical practitioner” means a medical practitioner who is engaged under any agreement to provide medical services for purposes connected with the activities of a police force.

### *8 Choice of specimens of breath*

- (1) Subject to subsection (2) below, of any two specimens of breath provided by any person in pursuance of section 7 of this Act that with the lower proportion of alcohol in the breath shall be used and the other shall be disregarded.
- (2) If the specimen with the lower proportion of alcohol contains no more than 50 microgrammes of alcohol in 100 millilitres of breath, the person who provided it may claim that it should be replaced by such specimen as may be required under section 7(4) of this Act and, if he then provides such a specimen, neither specimen of breath shall be used.
- (2A) If the person who makes a claim under subsection (2) above was required to provide specimens of breath under section 7 of this Act at or near a place mentioned in subsection (2)(c) of that section, a constable may arrest him without warrant.
- (3) The Secretary of State may by regulations substitute another proportion of alcohol in the breath for that specified in subsection (2) above.

### 9 Protection for hospital patients

(1) While a person is at a hospital as a patient he shall not be required to co-operate with a preliminary test or to provide a specimen under section 7 of this Act unless the medical practitioner in immediate charge of his case has been notified of the proposal to make the requirement; and—

- (a) if the requirement is then made, it shall be for co-operation with a test administered, or for the provision of a specimen, at the hospital, but
- (b) if the medical practitioner objects on the ground specified in subsection (2) below, the requirement shall not be made.

(1A) While a person is at a hospital as a patient, no specimen of blood shall be taken from him under section 7A of this Act and he shall not be required to give his permission for a laboratory test of a specimen taken under that section unless the medical practitioner in immediate charge of his case—

- (a) has been notified of the proposal to take the specimen or to make the requirement; and
- (b) has not objected on the ground specified in subsection (2).

(2) The ground on which the medical practitioner may object is—

- (a) in a case falling within subsection (1), that the requirement or the provision of the specimen or (if one is required) the warning required by section 7(7) of this Act would be prejudicial to the proper care and treatment of the patient; and
- (b) in a case falling within subsection (1A), that the taking of the specimen, the requirement or the warning required by section 7A(5) of this Act would be so prejudicial.

### 11 Interpretation of sections 4 to 10

(1) The following provisions apply for the interpretation of sections 3A to 10 of this Act.

(2) In those sections—

...

“drug” includes any intoxicant other than alcohol,

“fail” includes refuse,

“hospital” means an institution which provides medical or surgical treatment for in-patients or out-patients,

“the prescribed limit” means, as the case may require—

- (a) 35 microgrammes of alcohol in 100 millilitres of breath,
- (b) 80 milligrammes of alcohol in 100 millilitres of blood, or
- (c) 107 milligrammes of alcohol in 100 millilitres of urine,

or such other proportion as may be prescribed by regulations made by the Secretary of State,

“registered health care professional” means a person (other than a medical practitioner) who is—

- (a) a registered nurse; or



(b) a registered member of a health care profession which is designated for the purposes of this paragraph by an order made by the Secretary of State.

(2A) A health care profession is any profession mentioned in section 60(2) of the Health Act 1999 (c 8) other than the profession of practising medicine and the profession of nursing.

(2B) An order under subsection (2) shall be made by statutory instrument; and any such statutory instrument shall be subject to annulment in pursuance of a resolution of either House of Parliament.

(3) A person does not co-operate with a preliminary test or provide a specimen of breath for analysis unless his co-operation or the specimen—

(a) is sufficient to enable the test or the analysis to be carried out, and

(b) is provided in such a way as to enable the objective of the test or analysis to be satisfactorily achieved.

(4) A person provides a specimen of blood if and only if—

(a) he consents to the taking of such a specimen from him; and

(b) the specimen is taken from him by a medical practitioner or, if it is taken in a police station, either by a medical practitioner or by a registered health care professional.

### **Part III Licensing of drivers of vehicles**

#### *92 Requirements as to physical fitness of drivers*

(1) An application for the grant of a licence must include a declaration by the applicant, in such form as the Secretary of State may require, stating whether he is suffering or has at any time (or, if a period is prescribed for the purposes of this subsection, has during that period) suffered from any relevant disability or any prospective disability.

(2) In this Part of this Act—

“disability” includes disease and the persistent misuse of drugs or alcohol, whether or not such misuse amounts to dependency,

“relevant disability” in relation to any person means—

(a) any prescribed disability, and

(b) any other disability likely to cause the driving of a vehicle by him in pursuance of a licence to be a source of danger to the public, and

“prospective disability” in relation to any person means any other disability which—

(a) at the time of the application for the grant of a licence or, as the case may be, the material time for the purposes of the provision in which the expression is used, is not of such a kind that it is a relevant disability, but

(b) by virtue of the intermittent or progressive nature of the disability or otherwise, may become a relevant disability in course of time.

(3) If it appears from the applicant’s declaration, or if on inquiry the Secretary of State is satisfied from other information, that the applicant is suffering from a relevant

disability, the Secretary of State must, subject to the following provisions of this section, refuse to grant the licence.

(4) The Secretary of State must not by virtue of subsection (3) above refuse to grant a licence—

(a) on account of any relevant disability which is prescribed for the purposes of this paragraph, if the applicant has at any time passed a relevant test and it does not appear to the Secretary of State that the disability has arisen or become more acute since that time or was, for whatever reason, not disclosed to the Secretary of State at that time,

(b) on account of any relevant disability which is prescribed for the purposes of this paragraph, if the applicant satisfies such conditions as may be prescribed with a view to authorising the grant of a licence to a person in whose case the disability is appropriately controlled,

(c) on account of any relevant disability which is prescribed for the purposes of this paragraph, if the application is for a provisional licence.

(5) Where as a result of a test of competence to drive or of information obtained under the relevant powers the Secretary of State is satisfied that the person who took the test or in relation to whom the information was obtained is suffering from a disability such that there is likely to be a danger to the public—

(a) if he drives any vehicle, . . .

(b) if he drives a vehicle other than a vehicle of a particular class, or

(c) if he drives a vehicle except in accordance with particular conditions,

the Secretary of State must serve notice in writing to that effect on that person and must include in the notice a description of the disability.

(6) Where a notice is served in pursuance of subsection (5)(a) above, then—

(a) if the disability is not prescribed under subsection (2) above, it shall be deemed to be so prescribed in relation to the person on whom the notice is served, and

(b) if the disability is prescribed for the purposes of subsection (4)(c) above it shall be deemed not to be so prescribed in relation to him.

(7) Where a notice is served in pursuance of subsection (5)(b) above, the Secretary of State may—

(a) if the person on whom the notice is served is an applicant for a licence, grant him a licence limited to vehicles of the particular class specified in the notice, or

(b) if he held a licence which is revoked by the Secretary of State and he complies with subsection (7ZB) below, grant him a licence limited to vehicles of that class, and, if the Secretary of State so directs in the notice, his entitlement to drive other classes of vehicle by virtue of section 98(2) of this Act shall be limited as specified in the notice.

(7ZA) Where a notice is served in pursuance of subsection (5)(c) above, the Secretary of State may—

(a) if the person on whom the notice is served is an applicant for a licence, grant him a licence authorising him to drive vehicles subject to the particular conditions specified in the notice, or

(b) if he held a licence which is revoked by the Secretary of State and he complies with subsection (7ZB) below, grant him a licence authorising him to drive vehicles subject to those conditions,

and, if the Secretary of State so directs in the notice, any entitlement which the person has to drive vehicles by virtue of section 98(2) of this Act shall be subject to conditions as specified in the notice.

(7ZB) A person complies with this subsection if—

(a) he surrenders the existing licence and its counterpart, and

(b) where the Secretary of State so requires, he provides evidence of his name, address, sex and date and place of birth and a photograph which is a current likeness of him.

(7A) If he considers it appropriate to do so, the Secretary of State may, after serving a notice under any of the paragraphs of subsection (5) above, serve a further notice under that paragraph or a notice under another of those paragraphs; and on his serving the later notice the notice previously served shall cease to have effect and any licence previously granted in accordance with it shall be revoked by the later notice.

(7B) In subsection (5) above the references to a test of competence to drive and to information obtained under the relevant powers are references respectively to a test of competence prescribed for the purposes of section 89 or so much of such a test as is required to be taken in pursuance of section 94(5)(c) of this Act and to information obtained in pursuance of section 94(5)(a) or (b) of this Act.

(7C) A person whose licence is revoked by virtue of subsection (7A) above must deliver the licence and its counterpart to the Secretary of State forthwith after the revocation and a person who, without reasonable excuse, fails to do so is guilty of an offence.

(7D) In subsection (7B) above the references to section 94 of this Act include references to that section as applied by section 99D or 109C of this Act.

(8) In this section “relevant test”, in relation to an application for a licence, means any such test of competence as is mentioned in section 89 of this Act or a test as to fitness or ability in pursuance of section 100 of the Road Traffic Act 1960 as originally enacted, being a test authorising the grant of a licence in respect of vehicles of the classes to which the application relates.

(9) Without prejudice to subsection (8) above, for the purposes of subsection (4)(a) above—

(a) an applicant shall be treated as having passed a relevant test if, and on the day on which, he passed a test of competence to drive which—

(i) under a provision of the law of Northern Ireland or a relevant external law corresponding to subsections (3) and (4) or (6) of section 89 of this Act, either is prescribed in relation to vehicles of classes corresponding to the classes to which the application relates or is sufficient under that law for the granting of a licence authorising the driving of vehicles of those classes, or

(ii) is sufficient for the granting of a British Forces licence authorising the driving of vehicles of those classes and

(b) in the case of an applicant who is treated as having passed a relevant test by virtue of paragraph (a) above, disclosure of a disability to his licensing authority shall be treated as disclosure to the Secretary of State.

...

(10) A person who holds a licence authorising him to drive a motor vehicle of any class and who drives a motor vehicle of that class on a road is guilty of an offence if the declaration included in accordance with subsection (1) above in the application on which the licence was granted was one which he knew to be false.

*94 Provision of information, etc relating to disabilities*

(1) If at any time during the period for which his licence remains in force, a licence holder becomes aware—

(a) that he is suffering from a relevant or prospective disability which he has not previously disclosed to the Secretary of State, or

(b) that a relevant or prospective disability from which he has at any time suffered (and which has been previously so disclosed) has become more acute since the licence was granted,

the licence holder must forthwith notify the Secretary of State in writing of the nature and extent of his disability.

(2) The licence holder is not required to notify the Secretary of State under subsection (1) above if—

(a) the disability is one from which he has not previously suffered, and

(b) he has reasonable grounds for believing that the duration of the disability will not extend beyond the period of three months beginning with the date on which he first becomes aware that he suffers from it.

(3) A person who fails without reasonable excuse to notify the Secretary of State as required by subsection (1) above is guilty of an offence.

(3A) A person who holds a licence authorising him to drive a motor vehicle of any class and who drives a motor vehicle of that class on a road is guilty of an offence if at any earlier time while the licence was in force he was required by subsection (1) above to notify the Secretary of State but has failed without reasonable excuse to do so.

(4) If the prescribed circumstances obtain in relation to a person who is an applicant for, or the holder of, a licence or if the Secretary of State has reasonable grounds for believing that a person who is an applicant for, or the holder of, a licence may be suffering from a relevant or prospective disability, subsection (5) below applies for the purpose of enabling the Secretary of State to satisfy himself whether or not that person may be suffering from that or any other relevant or prospective disability.

(5) The Secretary of State may by notice in writing served on the applicant or holder—

(a) require him to provide the Secretary of State, within such reasonable time as may be specified in the notice, with such an authorisation as is mentioned in subsection (6) below, or

(b) require him, as soon as practicable, to arrange to submit himself for examination—

(i) by such registered medical practitioner or practitioners as may be nominated by the Secretary of State, or

(ii) with respect to a disability of a prescribed description, by such officer of the Secretary of State as may be so nominated,

for the purpose of determining whether or not he suffers or has at any time suffered from a relevant or prospective disability, or

(c) except where the application is for, or the licence held is, a provisional licence, require him to submit himself for such a test of competence to drive as the Secretary of State directs in the notice.

(6) The authorisation referred to in subsection (5)(a) above—

(a) shall be in such form and contain such particulars as may be specified in the notice by which it is required to be provided, and

(b) shall authorise any registered medical practitioner who may at any time have given medical advice or attention to the applicant or licence holder concerned to release to the Secretary of State any information which he may have, or which may be available to him, with respect to the question whether, and if so to what extent, the applicant or licence holder concerned may be suffering, or may at any time have suffered, from a relevant or prospective disability.

(7) If he considers it appropriate to do so in the case of any applicant or licence holder, the Secretary of State—

(a) may include in a single notice under subsection (5) above requirements under more than one paragraph of that subsection, and

(b) may at any time after the service of a notice under that subsection serve a further notice or notices under that subsection.

(8) If any person on whom a notice is served under subsection (5) above—

(a) fails without reasonable excuse to comply with a requirement contained in the notice, or

(b) fails any test of competence which he is required to take as mentioned in paragraph (c) of that subsection,

the Secretary of State may exercise his powers under sections 92 and 93 of this Act as if he were satisfied that the applicant or licence holder concerned is suffering from a relevant disability which is not prescribed for the purposes of any paragraph of section 92(4) of this Act or, if the Secretary of State so determines, as if he were satisfied that the applicant or licence holder concerned is suffering from a prospective disability.

(9) Except where the requirement is made in the circumstances prescribed for the purposes of subsection (5) above, it shall be for the Secretary of State (and not for any other person) to defray any fees or other reasonable expenses of a registered medical practitioner in connection with—

(a) the provision of information in pursuance of an authorisation required to be provided under subsection (5)(a) above, or

(b) any examination which a person is required to undergo as mentioned in subsection (5)(b) above.

### *163 Power of police to stop vehicles*

- (1) A person driving a mechanically propelled vehicle on a road must stop the vehicle on being required to do so by a constable in uniform or a traffic officer.
- (2) A person riding a cycle on a road must stop the cycle on being required to do so by a constable in uniform or a traffic officer.
- (3) If a person fails to comply with this section he is guilty of an offence.

## **Road Traffic Offenders Act 1988 c. 53**

### **Part I Trial**

#### *15 Use of specimens in proceedings for an offence under section 4 or 5 of the Road Traffic Act*

- (1) This section and section 16 of this Act apply in respect of proceedings for an offence under section 3A, 4 or 5 of the Road Traffic Act 1988 (driving offences connected with drink or drugs); and expressions used in this section and section 16 of this Act have the same meaning as in sections 3A to 10 of that Act.
- (2) Evidence of the proportion of alcohol or any drug in a specimen of breath, blood or urine provided by or taken from the accused shall, in all cases (including cases where the specimen was not provided or taken in connection with the alleged offence), be taken into account and, subject to subsection (3) below, it shall be assumed that the proportion of alcohol in the accused's breath, blood or urine at the time of the alleged offence was not less than in the specimen.
- (3) That assumption shall not be made if the accused proves—
  - (a) that he consumed alcohol before he provided the specimen or had it taken from him and—
    - (i) in relation to an offence under section 3A, after the time of the alleged offence, and
    - (ii) otherwise, after he had ceased to drive, attempt to drive or be in charge of a vehicle on a road or other public place, and
  - (b) that had he not done so the proportion of alcohol in his breath, blood or urine would not have exceeded the prescribed limit and, if it is alleged that he was unfit to drive through drink, would not have been such as to impair his ability to drive properly.
- (4) A specimen of blood shall be disregarded unless—
  - (a) it was taken from the accused with his consent and either—
    - (i) in a police station by a medical practitioner or a registered health care professional; or
    - (ii) elsewhere by a medical practitioner;
  - or
  - (b) it was taken from the accused by a medical practitioner under section 7A of the Road Traffic Act 1988 and the accused subsequently gave his permission for a laboratory test of the specimen.

(5) Where, at the time a specimen of blood or urine was provided by the accused, he asked to be provided with such a specimen, evidence of the proportion of alcohol or any drug found in the specimen is not admissible on behalf of the prosecution unless—

(a) the specimen in which the alcohol or drug was found is one of two parts into which the specimen provided by the accused was divided at the time it was provided, and

(b) the other part was supplied to the accused.

(5A) Where a specimen of blood was taken from the accused under section 7A of the Road Traffic Act 1988, evidence of the proportion of alcohol or any drug found in the specimen is not admissible on behalf of the prosecution unless—

(a) the specimen in which the alcohol or drug was found is one of two parts into which the specimen taken from the accused was divided at the time it was taken; and

(b) any request to be supplied with the other part which was made by the accused at the time when he gave his permission for a laboratory test of the specimen was complied with.

### *33A Forfeiture of vehicles: Scotland*

(1) Where a person commits an offence to which this subsection applies by—

(a) driving, attempting to drive, or being in charge of a vehicle; or

(b) failing to comply with a requirement made under section 7 of the Road Traffic Act 1988 (failure to provide specimen for analysis or laboratory test) in the course of an investigation into whether the offender had committed an offence while driving, attempting to drive or being in charge of a vehicle, or

(c) failing, as the driver of a vehicle, to comply with subsections (2) and (3) of section 170 of the Road Traffic Act 1988 (duty to stop and give information or report accident),

the court may, on an application under this subsection, make an order forfeiting the vehicle concerned; and any vehicle forfeited under this subsection shall be disposed of as the court may direct.

(2) Subsection (1) above applies—

(a) to an offence under the Road Traffic Act 1988 which is punishable with imprisonment; and

(b) to an offence of culpable homicide.

(3) An application under subsection (1) above shall be at the instance of the prosecutor made when he moves for sentence (or, if the person has been remitted for sentence under section 195 of the Criminal Procedure (Scotland) Act 1995) made before sentence is pronounced.

(4) Where—

(a) the court is satisfied, on an application under this subsection by the prosecutor—

(i) that proceedings have been, or are likely to be, instituted against a person in Scotland for an offence to which subsection (1) above applies allegedly committed in the manner specified in paragraph (a), (b) or (c) of that subsection; and

(ii) that there is reasonable cause to believe that a vehicle specified in the application is to be found in a place or in premises so specified; and

(b) it appears to the court that there are reasonable grounds for thinking that in the event of the person being convicted of the offence an order under subsection (1) above might be made in relation to the vehicle,

the court may grant a warrant authorising a person named therein to enter and search the place or premises and seize the vehicle.

(5) Where the court has made an order under subsection (1) above for the forfeiture of a vehicle, the court or any justice may, if satisfied on evidence on oath—

(a) that there is reasonable cause to believe that the vehicle is to be found in any place or premises; and

(b) that admission to the place or premises has been refused or that a refusal of such admission is apprehended,

issue a warrant of search which may be executed according to law.

(6) In relation to summary proceedings, the reference in subsection (5) above to a justice includes a reference to the sheriff and to a magistrate.

(7) Part II of the Proceeds of Crime (Scotland) Act 1995 shall not apply in respect of a vehicle in relation to which this section applies.

(8) This section extends to Scotland only.

#### *34 Disqualification for certain offences*

(1) Where a person is convicted of an offence involving obligatory disqualification, the court must order him to be disqualified for such period not less than twelve months as the court thinks fit unless the court for special reasons thinks fit to order him to be disqualified for a shorter period or not to order him to be disqualified.

(1A) Where a person is convicted of an offence under section 12A of the Theft Act 1968 (aggravated vehicle-taking), the fact that he did not drive the vehicle in question at any particular time or at all shall not be regarded as a special reason for the purposes of subsection (1) above.

(2) Where a person is convicted of an offence involving discretionary disqualification, and either—

(a) the penalty points to be taken into account on that occasion number fewer than twelve, or

(b) the offence is not one involving obligatory endorsement,

the court may order him to be disqualified for such period as the court thinks fit.

(3) Where a person convicted of an offence under any of the following provisions of the Road Traffic Act 1988, that is—

(aa) section 3A (causing death by careless driving when under the influence of drink or drugs),

(a) section 4(1) (driving or attempting to drive while unfit),

(b) section 5(1)(a) (driving or attempting to drive with excess alcohol), . . .



(c) section 7(6) (failing to provide a specimen) where that is an offence involving obligatory disqualification,

(d) section 7A(6) (failing to allow a specimen to be subjected to laboratory test) where that is an offence involving obligatory disqualification,

has within the ten years immediately preceding the commission of the offence been convicted of any such offence, subsection (1) above shall apply in relation to him as if the reference to twelve months were a reference to three years.

(4) Subject to subsection (3) above, subsection (1) above shall apply as if the reference to twelve months were a reference to two years—

(a) in relation to a person convicted of—

(i) manslaughter, or in Scotland culpable homicide, or

(ii) an offence under section 1 of the Road Traffic Act 1988 (causing death by dangerous driving), or

(iii) an offence under section 3A of that Act (causing death by careless driving while under the influence of drink or drugs), and

(b) in relation to a person on whom more than one disqualification for a fixed period of 56 days or more has been imposed within the three years immediately preceding the commission of the offence.

(4A) For the purposes of subsection (4)(b) above there shall be disregarded any disqualification imposed under section 26 of this Act or section 147 of the Powers of Criminal Courts (Sentencing) Act 2000 or section 223A or 436A of the Criminal Procedure (Scotland) Act 1975 (offences committed by using vehicles) and any disqualification imposed in respect of an offence of stealing a motor vehicle, an offence under section 12 or 25 of the Theft Act 1968, an offence under section 178 of the Road Traffic Act 1988, or an attempt to commit such an offence.

(4AA) For the purposes of subsection (4)(b), a disqualification is to be disregarded if the period of disqualification would have been less than 56 days but for an extension period added pursuant to—

(a) section 35A or 35C,

(b) section 248D of the Criminal Procedure (Scotland) Act 1995, or

(c) section 147A of the Powers of Criminal Courts (Sentencing) Act 2000.

(4B) Where a person convicted of an offence under section 40A of the Road Traffic Act 1988 (using vehicle in dangerous condition etc) has within the three years immediately preceding the commission of the offence been convicted of any such offence, subsection (1) above shall apply in relation to him as if the reference to twelve months were a reference to six months.

(5) The preceding provisions of this section shall apply in relation to a conviction of an offence committed by aiding, abetting, counselling or procuring, or inciting to the commission of, an offence involving obligatory disqualification as if the offence were an offence involving discretionary disqualification.

(5A) In relation to Scotland, references in this section to the court include the district court justice of the peace court.

(6) This section is subject to section 48 of this Act.

*34A Reduced disqualification period for attendance on courses*

(1) This section applies where—

(a) a person is convicted of an offence under section 3A (causing death by careless driving when under influence of drink or drugs), 4 (driving or being in charge when under influence of drink or drugs), 5 (driving or being in charge with excess alcohol) or 7 (failing to provide a specimen) of the Road Traffic Act 1988, and

(b) the court makes an order under section 34 of this Act disqualifying him for a period of not less than twelve months (disregarding any extension period added pursuant to section 35A or 35C).

(2) Where this section applies, the court may make an order that the period of disqualification imposed under section 34 (disregarding any extension period added pursuant to section 35A or 35C) (“the unreduced period”) shall be reduced if, by a date specified in the order under this section, the offender satisfactorily completes a course approved by the Secretary of State for the purposes of this section and specified in the order.

(3) The reduction made by an order under this section in a period of disqualification imposed under section 34 (disregarding any extension period added pursuant to section 35A or 35C) shall be a period specified in the order of not less than three months and not more than one quarter of the unreduced period (and accordingly where the period imposed under section 34 (disregarding any extension period added pursuant to section 35A or 35C) is twelve months, the reduced period shall be nine months).

(3A) “The reduced period” is the period of disqualification imposed under section 34 of this Act (disregarding any extension period added pursuant to section 35A or 35C) as reduced by an order under this section.

(4) The court shall not make an order under this section unless—

(a) it is satisfied that a place on the course specified in the order will be available for the offender,

(b) the offender appears to the court to be of or over the age of 17,

(c) the court has explained the effect of the order to the offender in ordinary language, and has informed him of the amount of the fees for the course and of the requirement that he must pay them before beginning the course, and

(d) the offender has agreed that the order should be made.

(5) The date specified in an order under this section as the latest date for completion of a course must be at least two months before the last day of the period of disqualification as reduced by the order but including any extension period added pursuant to section 35A or 35C.

(6) An order under this section shall name the petty sessions area (or in Scotland the sheriff court district or, where an order has been made under this section by a stipendiary magistrate, the commission area) in which the offender resides or will reside.

(1) This section applies where—

(a) a person is convicted of a relevant drink offence or a specified offence by or before a court, and

(b) the court makes an order under section 34 of this Act disqualifying him for a period of not less than twelve months (disregarding any extension period added pursuant to section 35A or 35C).

(2) In this section “relevant drink offence” means—

(a) an offence under paragraph (a) of subsection (1) of section 3A of the Road Traffic Act 1988 (causing death by careless driving when unfit to drive through drink) committed when unfit to drive through drink,

(b) an offence under paragraph (b) of that subsection (causing death by careless driving with excess alcohol),

(c) an offence under paragraph (c) of that subsection (failing to provide a specimen) where the specimen is required in connection with drink or consumption of alcohol,

(d) an offence under section 4 of that Act (driving or being in charge when under influence of drink) committed by reason of unfitness through drink,

(e) an offence under section 5(1) of that Act (driving or being in charge with excess alcohol),

(f) an offence under section 7(6) of that Act (failing to provide a specimen) committed in the course of an investigation into an offence within any of the preceding paragraphs, or

(g) an offence under section 7A(6) of that Act (failing to allow a specimen to be subjected to a laboratory test) in the course of an investigation into an offence within any of the preceding paragraphs.

(3) In this section “specified offence” means—

(a) an offence under section 3 of the Road Traffic Act 1988 (careless, and inconsiderate, driving),

(b) an offence under section 36 of that Act (failing to comply with traffic signs),

(c) an offence under section 17(4) of the Road Traffic Regulation Act 1984 (use of special road contrary to scheme or regulations), or

(d) an offence under section 89(1) of that Act (exceeding speed limit).

(4) But the Secretary of State may by regulations amend subsection (3) above by adding other offences or removing offences.

(5) Where this section applies, the court may make an order that the period of disqualification imposed under section 34 of this Act (disregarding any extension period added pursuant to section 35A or 35C) (“the unreduced period”) shall be reduced if, by the relevant date, the offender satisfactorily completes an approved course specified in the order.

(6) In subsection (5) above—

“an approved course” means a course approved by the appropriate national authority for the purposes of this section in relation to the description of offence of which the offender is convicted, and

“the relevant date” means such date, at least two months before the last day of the period of disqualification as reduced by the order (but including any extension period added pursuant to section 35A or 35C), as is specified in the order.

(7) The reduction made in a period of disqualification by an order under this section is a period specified in the order of—

- (a) not less than three months, and
  - (b) not more than one quarter of the unreduced period,
- (and, accordingly, where the unreduced period is twelve months, the reduced period is nine months).

(7A) The reduced period” is the period of disqualification imposed under section 34 of this Act (disregarding any extension period added pursuant to section 35A or 35C) as reduced by an order under this section.

(8) A court shall not make an order under this section in the case of an offender convicted of a specified offence if—

- (a) the offender has, during the period of three years ending with the date on which the offence was committed, committed a specified offence and successfully completed an approved course pursuant to an order made under this section or section 30A of this Act on conviction of that offence, or
- (b) the specified offence was committed during his probationary period.

(9) A court shall not make an order under this section in the case of an offender unless—

- (a) the court is satisfied that a place on the course specified in the order will be available for the offender,
- (b) the offender appears to the court to be of or over the age of 17,
- (c) the court has informed the offender (orally or in writing and in ordinary language) of the effect of the order and of the amount of the fees which he is required to pay for the course and when he must pay them, and
- (d) the offender has agreed that the order should be made.

### *34C Provisions supplementary to sections 34A and 34B*

(1) The Secretary of State may issue guidance to course organisers, or to any category of course organiser as to the conduct of courses approved for the purposes of section 34A of this Act; and—

- (a) course organisers shall have regard to any guidance given to them under this subsection, and
- (b) in determining for the purposes of section 34B(6) whether any instructions or requirements of an organiser were reasonable, a court shall have regard to any guidance given to him under this subsection.

(2) In sections 34A and 34B and this section—

“course organiser”, in relation to a course, means the person who, in accordance with regulations made by the Secretary of State, is responsible for giving the certificates mentioned in section 34B(1) in respect of the completion of the course;

“proper officer” means—

- (a) in relation to a magistrates’ court in England and Wales, the justices’ chief executive for the court, and
- (b) in relation to a sheriff court in Scotland, the clerk of the court;

“supervising court”, in relation to an order under section 34A, means—

- (a) in England and Wales, a magistrates’ court acting for the petty sessions area named in the order as the area where the offender resides or will reside;
- (b) in Scotland, the sheriff court for the district where the offender resides or will reside or, where the order is made by a stipendiary magistrate and the offender resides or will reside within his commission area, the district court for that area or the justice of the peace court for the district where the offender resides or will reside,

(3) Any power to make regulations under section 34B or this section—

- (a) includes power to make different provision for different cases, and to make such incidental or supplemental provision as appears to the Secretary of State to be necessary or expedient;
- (b) shall be exercisable by statutory instrument, which shall be subject to annulment in pursuance of a resolution of either House of Parliament.

(1) The appropriate national authority may issue guidance to course providers, or to any category of course provider, as to the conduct of courses approved for the purposes of section 34A of this Act; and—

- (a) course providers shall have regard to any guidance given to them under this subsection, and
- (b) in determining for the purposes of section 34B of this Act whether any instructions or requirements of a course provider were reasonable, a court shall have regard to any guidance given to him under this subsection.

(2) The Secretary of State may by regulations make provision—

- (a) amending section 34A(1)(b) of this Act by substituting for the period for the time being specified there a different period,
- (b) amending section 34A(7) of this Act by substituting for the period for the time being specified there a different period, or by substituting for the fraction of the unreduced period for the time being specified there a different fraction of that period, (or by doing both), or
- (c) amending section 34A(8)(a) of this Act by substituting for the period for the time being specified there a different period.

(3) In sections 34A to 34BA of this Act and this section—

“appropriate national authority” means (as respects Wales) the National Assembly for Wales and (otherwise) the Secretary of State;

“course provider”, in relation to a course, means the person by whom it is, or is to be, provided;

“probationary period” has the meaning given in section 1 of the Road Traffic (New Drivers) Act 1995;

“proper officer” means—

- (a) in relation to a magistrates’ court in England and Wales, the designated officer for the court, and
- (b) otherwise, the clerk of the court;

“relevant local court”, in relation to an order under section 34A of this Act in the case of an offender, means—

(a) in England and Wales, a magistrates' court acting for the local justice area in which the offender resides, and

(b) in Scotland, the sheriff court for the district where the offender resides or, where the order is made by a stipendiary magistrate and the offender resides within his commission area, the district court for that area; and

"supervising court", in relation to an order under section 34A of this Act, means—

(a) in England and Wales, if the Crown Court made the order the Crown Court and otherwise a magistrates' court acting for the same local justice area as the court which made the order, and

(b) in Scotland, the court which made the order.

(4) Any power to make regulations under section 34A, 34B or 34BA of this Act or this section includes power to make different provision for different cases, and to make such incidental or supplementary provision as appears necessary or appropriate.

(5) Any power to make regulations under section 34A, 34B or 34BA of this Act or this section shall be exercisable by statutory instrument.

(6) No regulations shall be made under section 34A of this Act or this section unless a draft of the regulations has been laid before, and approved by a resolution of, each House of Parliament.

(7) A statutory instrument containing regulations made under section 34B or 34BA of this Act by the Secretary of State shall be subject to annulment in pursuance of a resolution of either House of Parliament.

#### *42 Removal of disqualification*

(1) Subject to the provisions of this section, a person who by an order of a court is disqualified may apply to the court by which the order was made to remove the disqualification.

(2) On any such application the court may, as it thinks proper having regard to—

(a) the character of the person disqualified and his conduct subsequent to the order,

(b) the nature of the offence, and

(c) any other circumstances of the case,

either by order remove the disqualification as from such date as may be specified in the order or refuse the application.

(3) No application shall be made under subsection (1) above for the removal of a disqualification before the expiration of whichever is relevant of the following periods from the date of the order by which the disqualification was imposed the relevant date, that is—

(a) two years, if the disqualification is for less than four years (disregarding any extension period),

(b) one half of the period of disqualification, if the disqualification is (disregarding any extension period) for less than ten years but not less than four years,

(c) five years in any other case;

and in determining the expiration of the period after which under this subsection a person may apply for the removal of a disqualification, any time after the conviction

during which the disqualification was suspended or he was not disqualified shall be disregarded.

(3A) In subsection (3) “the relevant date” means—

- (a) the date of the order imposing the disqualification in question, or
- (b) if the period of the disqualification is extended by an extension period, the date in paragraph (a) postponed by a period equal to that extension period.

(3B) Extension period” means an extension period added pursuant to—

- (a) section 35A or 35C,
- (b) section 248D of the Criminal Procedure (Scotland) Act 1995, or
- (c) section 147A of the Powers of Criminal Courts (Sentencing) Act 2000.

(4) Where an application under subsection (1) above is refused, a further application under that subsection shall not be entertained if made within three months after the date of the refusal.

(5) If under this section a court orders a disqualification to be removed, the court—

(a) must—

(i) if particulars of the disqualification were previously endorsed on the counterpart of any licence previously held by the applicant, cause particulars of the order to be endorsed on that counterpart, and

(ii) if particulars of the disqualification were previously endorsed on the driving record of the applicant, send notice of the order to the Secretary of State, and

(b) may in any case order the applicant to pay the whole or any part of the costs of the application.

(5A) Subsection (5)(a)(i) above shall apply only where the disqualification was imposed in respect of an offence involving obligatory endorsement; and in any other case the court must send notice of the order made under this section to the Secretary of State.

(5AA) If the disqualification was imposed in respect of an offence involving obligatory endorsement, the Secretary of State must, on receiving notice of an order under subsection (5)(a)(ii) (5)(a) above, make any necessary adjustments to the endorsements on the person’s driving record to reflect the order.

(5B) A notice under subsection (5)(a)(ii) or (5A) (5)(a) above must be sent in such manner and to such address, and must contain such particulars, as the Secretary of State may determine.

(6) The preceding provisions of this section shall not apply where the disqualification was imposed by order under section 36(1) of this Act.

## **Transport and Works Act 1992 c. 42**

### *27 Offences involving drink or drugs on transport systems*

(1) If a person works on a transport system to which this Chapter applies—

- (a) as a driver, guard, conductor or signaller or in any other capacity in which he can control or affect the movement of a vehicle, or

(b) in a maintenance capacity or as a supervisor of, or look-out for, persons working in a maintenance capacity,

when he is unfit to carry out that work through drink or drugs, he shall be guilty of an offence.

(2) If a person works on a transport system to which this Chapter applies—

(a) as a driver, guard, conductor or signaller or in any other capacity in which he can control or affect the movement of a vehicle, or

(b) in a maintenance capacity or as a supervisor of, or look-out for, persons working in a maintenance capacity,

after consuming so much alcohol that the proportion of it in his breath, blood or urine exceeds the prescribed limit, he shall be guilty of an offence.

(3) For the purposes of this section, a person works on a transport system in a maintenance capacity if his work on the system involves maintenance, repair or alteration of—

(a) the permanent way or other means of guiding or supporting vehicles,

(b) signals or any other means of controlling the movement of vehicles, or

(c) any means of supplying electricity to vehicles or to the means of guiding or supporting vehicles,

or involves coupling or uncoupling vehicles or checking that they are working properly before they are used on any occasion.

(4) For the purposes of subsection (1) above, a person shall be taken to be unfit to carry out any work if his ability to carry out that work properly is for the time being impaired.

### *28 Offences by operators of transport systems*

(1) If a person commits an offence under section 27 above, the responsible operator shall also be guilty of an offence.

(2) In this section “the responsible operator” means—

(a) in a case where the transport system on which the offence under section 27 above is committed has only one operator, that operator;

(b) in a case where the transport system on which the offence under section 27 above is committed has more than one operator, whichever of them is responsible for the work giving rise to the offence.

(3) No offence is committed under subsection (1) above if the responsible operator has exercised all due diligence to prevent the commission on the transport system of any offence under section 27 above.

(4) If a person commits an offence under section 27 above in the course of his employment with a person other than the responsible operator, his employer shall (without prejudice to any liability of that operator under subsection (1) above) also be guilty of an offence.

(5) No offence is committed under subsection (4) above if the employer has exercised all due diligence to prevent the commission on the transport system by any of his employees of any offence under section 27 above.



## Police powers etc

### *29 Breath tests*

- (1) Where a constable in uniform has reasonable cause to suspect—
- (a) that a person working on a transport system to which this Chapter applies in any capacity mentioned in section 27(1) and (2) above has alcohol in his body, or
  - (b) that a person has been working on a transport system to which this Chapter applies in any capacity mentioned in section 27(1) and (2) above with alcohol in his body and still has alcohol in his body,
- he may require that person to provide a specimen of breath for a breath test.
- (2) Where an accident or dangerous incident occurs on a transport system to which this Chapter applies, a constable in uniform may require a person to provide a specimen of breath for a breath test if he has reasonable cause to suspect that—
- (a) at the time of the accident or incident that person was working on the transport system in a capacity mentioned in section 27(1) and (2) above, and
  - (b) an act or omission of that person while he was so working may have been a cause of the accident or incident.
- (3) In subsection (2) above “dangerous incident” means an incident which in the constable’s opinion involved a danger of death or personal injury.
- (4) A person may be required under subsection (1) or subsection (2) above to provide a specimen either at or near the place where the requirement is made or, if the requirement is made under subsection (2) above and the constable making the requirement thinks fit, at a police station specified by the constable.
- (5) A person who, without reasonable excuse, fails to provide a specimen of breath when required to do so in pursuance of this section shall be guilty of an offence.

### *30 Powers of arrest and entry*

- (1) . . .
- (2) A constable may arrest a person without warrant if—
- (a) as a result of a breath test under section 29 above he has reasonable cause to suspect that the proportion of alcohol in that person’s breath or blood exceeds the prescribed limit, or
  - (b) that person has failed to provide a specimen of breath for a breath test when required to do so in pursuance of section 29 above and the constable has reasonable cause to suspect that he has alcohol in his body.
- (3) . . .
- (4) A constable may, for the purpose of—
- (a) requiring a person to provide a specimen of breath under section 29(2) above in the case of an accident which the constable has reasonable cause to suspect involved the death of or injury to, another person, or
  - (b) arresting a person in such a case under subsection (2) above,

enter (if need be by force) any place where that person is or where the constable, with reasonable cause, suspects him to be.

### *31 Provision of specimens for analysis*

(1) In the course of an investigation into whether a person has committed an offence under section 27 above, a constable may require him—

(a) to provide two specimens of breath for analysis by means of a device of a type approved by the Secretary of State, or

(b) to provide a specimen of blood or urine for a laboratory test.

(2) A requirement under this section to provide specimens of breath shall only be made at a police station.

(3) A requirement under this section to provide a specimen of blood or urine shall only be made at a police station or at a hospital; and it shall not be made at a police station unless subsection (4) below applies.

(4) This subsection applies if—

(a) the constable making the requirement has reasonable cause to believe that for medical reasons a specimen of breath cannot be provided or should not be required,

(b) at the time the requirement is made, either a device (or reliable device) of the type mentioned in subsection (1)(a) above is not available at the police station or it is for any other reason not practicable to use such a device there,

(bb) a device of the type mentioned in subsection (1)(a) above has been used at the police station but the constable who required the specimens of breath has reasonable cause to believe that the device has not produced a reliable indication of the proportion of alcohol in the breath of the person concerned, or

(c) the suspected offence is one under section 27(1) above and the constable making the requirement has been advised by a medical practitioner that the condition of the person required to provide the specimen might be due to a drug.

(5) A person may be required to provide a specimen of blood or urine in pursuance of this section notwithstanding that he has already provided or been required to provide two specimens of breath.

(6) If the provision of a specimen other than a specimen of breath may be required in pursuance of this section, the question whether it is to be a specimen of blood or a specimen of urine and, in the case of a specimen of blood, the question who is to be asked to take it shall be decided (subject to subsection (6A)) by the constable making the requirement.

(6A) Where a constable decides for the purposes of subsection (6) to require the provision of a specimen of blood, there shall be no requirement to provide such a specimen if—

(a) the medical practitioner who is asked to take the specimen is of the opinion that, for medical reasons, it cannot or should not be taken; or

(b) the registered health care professional who is asked to take it is of that opinion and there is no contrary opinion from a medical practitioner,

and, where by virtue of this subsection there can be no requirement to provide a specimen of blood, the constable may require a specimen of urine instead.

(7) A specimen of urine shall be provided within one hour of the requirement for its provision being made and after the provision of a previous specimen of urine.

(8) A person who, without reasonable excuse, fails to provide a specimen when required to do so in pursuance of this section shall be guilty of an offence

(9) A constable shall, on requiring a person to provide a specimen in pursuance of this section, warn him that a failure to provide it may render him liable to prosecution.

(9A) In this section “health care professional” means a person (other than a medical practitioner) who is—

(a) a registered nurse; or

(b) a registered member of a health care profession which is designated for the purposes of this paragraph by an order made by the Secretary of State.

(9B) A health care profession is any profession mentioned in section 60(2) of the Health Act 1999 (c 8) other than the profession of practising medicine and the profession of nursing.

(9C) An order under subsection (9A)(b) shall be made by statutory instrument; and any such statutory instrument shall be subject to annulment in pursuance of a resolution of either House of Parliament.

### *31A Specimens of blood taken from persons incapable of consenting*

(1) A constable may make a request to a medical practitioner for him to take a specimen of blood from a person (“the person concerned”) irrespective of whether that person consents if—

(a) that person is a person from whom the constable would (in the absence of any incapacity of that person and of any objection under section 33) be entitled under section 31 to require the provision of a specimen of blood for a laboratory test;

(b) it appears to that constable that that person has been involved in—

(i) an accident that constitutes or is comprised in the matter that is under investigation or the circumstances of that matter; or

(ii) a dangerous incident (within the meaning given by section 29(3)) that constitutes or is comprised in that matter or those circumstances;

(c) it appears to that constable that that person is or may be incapable (whether or not he has purported to do so) of giving a valid consent to the taking of a specimen of blood; and

(d) it appears to that constable that that person’s incapacity is attributable to medical reasons.

(2) A request under this section—

(a) shall not be made to a medical practitioner who for the time being has any responsibility (apart from the request) for the clinical care of the person concerned; and

- (b) shall not be made to a medical practitioner other than a police medical practitioner unless—
- (i) it is not reasonably practicable for the request to be made to a police medical practitioner; or
  - (ii) it is not reasonably practicable for such a medical practitioner (assuming him to be willing to do so) to take the specimen.
- (3) It shall be lawful for a medical practitioner to whom a request is made under this section, if he thinks fit—
- (a) to take a specimen of blood from the person concerned irrespective of whether that person consents; and
  - (b) to provide the sample to a constable.
- (4) If a specimen is taken in pursuance of a request under this section, the specimen shall not be subjected to a laboratory test unless the person from whom it was taken—
- (a) has been informed that it was taken; and
  - (b) has been required by a constable to give his permission for a laboratory test of the specimen; and
  - (c) has given his permission.
- (5) A constable must, on requiring a person to give his permission for the purposes of this section for a laboratory test of a specimen, warn that person that a failure to give the permission, may render him liable to prosecution.
- (6) A person who, without reasonable excuse, fails to give his permission for a laboratory test of a specimen of blood taken from him under this section is guilty of an offence.
- (7) In this section “police medical practitioner” means a medical practitioner who is engaged under any agreement to provide medical services for purposes connected with the activities of a police force.

### *32 Choice of specimens of breath*

- (1) Of any two specimens of breath provided by a person in pursuance of section 31 above, the one with the lower proportion of alcohol in the breath shall be used and the other shall be disregarded.
- (2) But if the specimen with the lower proportion of alcohol contains no more than 50 microgrammes of alcohol in 100 millilitres of breath, the person who provided it may claim that it should be replaced by such specimen as may be required under section 31(6) above and, if he then provides such a specimen, neither specimen of breath shall be used.
- (3) The Secretary of State may by regulations substitute another proportion of alcohol in the breath for that specified in subsection (2) above.
- (4) The power to make regulations under this section shall be exercisable by statutory instrument; and no such regulations shall be made unless a draft of the instrument containing them has been laid before, and approved by a resolution of, each House of Parliament.

### *33 Protection for hospital patients*

(1) While a person is at a hospital as a patient, he shall not be required to provide a specimen of breath for a breath test or to provide a specimen for a laboratory test unless the medical practitioner in immediate charge of his case has been notified of the proposal to make the requirement; and—

(a) if the requirement is then made, it shall be for the provision of a specimen at the hospital, but

(b) if the medical practitioner objects on the ground specified in subsection (2) below, the requirement shall not be made.

(1A) While a person is at a hospital as a patient, no specimen of blood shall be taken from him under section 31A of this Act and he shall not be required to give his permission for a laboratory test of a specimen taken under that section unless the medical practitioner in immediate charge of his case—

(a) has been notified of the proposal to take the specimen or to make the requirement; and

(b) has not objected on the ground specified in subsection (2).

(2) The ground on which the medical practitioner may object is—

(a) in a case falling within subsection (1), that the requirement or the provision of the specimen or (if one is required) the warning required by section 31(9) of this Act would be prejudicial to the proper care and treatment of the patient; and

(b) in a case falling within subsection (1A), that the taking of the specimen, the requirement or the warning required by section 31A(5) of this Act would be so prejudicial.

(3) A person shall not be arrested under section 30(2) above while he is at a hospital as a patient.

## **Evidence in proceedings for offences under section 27**

### *34 Use of specimens in proceedings*

(1) In proceedings for any offence under section 27 above—

(a) evidence of the proportion of alcohol or any drug in a specimen of breath, blood or urine provided by or taken from the accused shall be taken into account, and

(b) it shall be assumed that the proportion of alcohol in the accused's breath, blood or urine at the time of the alleged offence was not less than in the specimen.

(2) That assumption shall not be made if the accused proves—

(a) that he consumed alcohol before he provided the specimen or had it taken from him and after he had stopped work on the occasion of the alleged offence, and

(b) that, had he not done so, the proportion of alcohol in his breath, blood or urine would not have exceeded the prescribed limit and, where the offence alleged is an offence of being unfit to carry out the work in question through drink, would not have been such as to impair his ability to carry out that work properly.

(3) Where, at the time a specimen of blood or urine was provided by the accused, he asked to be provided with such a specimen, evidence of the proportion of alcohol or

any drug found in the specimen shall not be admissible in the proceedings on behalf of the prosecution unless—

(a) the specimen in which the alcohol or drug was found is one of two parts into which the specimen provided by the accused was divided at the time it was provided, and

(b) the other part was supplied to the accused.

(3A) Where a specimen of blood was taken from the accused under section 31A, evidence of the proportion of alcohol or any drug found in the specimen is not admissible on behalf of the prosecution in the proceedings unless—

(a) the specimen in which the alcohol or drug was found is one of two parts into which the specimen taken from the accused was divided at the time it was taken; and

(b) any request to be supplied with the other part which was made by the accused at the time when he gave his permission for a laboratory test of the specimen was complied with.

### *35 Documentary evidence as to specimens*

(1) In proceedings for any offence under section 27 above, evidence of the proportion of alcohol in a specimen of breath may be given by the production of a document (or documents) purporting to be—

(a) a statement automatically produced by the device by which the proportion of alcohol in the specimen was measured, and

(b) a certificate signed by a constable (which may but need not be contained in the same document as the statement) that the specimen was provided by the accused at the date and time shown in the statement.

(2) In such proceedings, evidence of the proportion of alcohol or a drug in a specimen of blood or urine may be given by the production of a document purporting to be a certificate signed by an authorised analyst identifying the specimen and stating the proportion of alcohol or drug found in it.

(3) In such proceedings, evidence that a specimen of blood was taken from the accused with his consent by a medical practitioner or a registered health care professional may be given by the production of a document purporting to be a certificate to that effect signed by the practitioner or a registered health care professional.

(4) A document such as is mentioned in subsection (1) above shall be admissible in evidence on behalf of the prosecution in pursuance of this section only if a copy of it either was handed to the accused when the document was produced or was served on him not later than seven days before the hearing.

(5) A document such as is mentioned in subsection (2) or (3) above shall be admissible in evidence on behalf of the prosecution in pursuance of this section only if a copy of it was served on the accused not later than seven days before the hearing.

(6) A document purporting to be a certificate (or so much of a document as purports to be a certificate) shall not be admissible in evidence on behalf of the prosecution in pursuance of this section if the accused, not later than three days before the hearing or within such further time as the court may in special circumstances allow,

has served notice on the prosecutor requiring the attendance at the hearing of the person by whom the document purports to be signed.

(7) In this section “served” means served personally or sent by registered post or recorded delivery service.

(8) In subsection (2) above “authorised analyst” means—

(a) any person possessing the qualifications prescribed by regulations made under section 76 of the Food Act 1984 or section 27 of the Food and Drugs (Scotland) Act 1956 as qualifying persons for appointment as public analysts under those Acts, or

(b) any other person authorised by the Secretary of State to make analyses for the purposes of this section.

## Penalties

### *36 Penalties*

(1) A person guilty of any offence under this Chapter other than an offence under section 29(5) above shall be liable on summary conviction to imprisonment for a term not exceeding six months, to a fine not exceeding level 5 on the standard scale or to both.

(2) A person guilty of an offence under section 29(5) above shall be liable on summary conviction to a fine not exceeding level 3 on the standard scale.

## Miscellaneous and supplementary

### *37 Special provision for Scotland*

(1) Section 30(3) and (4) above shall not extend to Scotland, and nothing in those subsections shall affect any rule of law in Scotland concerning the right of a constable to enter any premises for any purpose.

(2) In proceedings for any offence under section 27 above in Scotland—

(a) a document produced in evidence on behalf of the prosecution in pursuance of section 35 above and, where the person by whom the document was signed is called as a witness, the evidence of that person, shall be sufficient evidence of the facts stated in the document, and

(b) a written execution purporting to be signed by the person who handed to or served on the accused or the prosecutor a copy document or notice under section 35 above, together with, where appropriate, a post office receipt for the relevant registered or recorded delivery letter, shall be sufficient evidence of the handing or service of the copy document or notice.

### *38 Interpretation of Chapter I*

(1) In this Chapter—

“breath test” means a preliminary test for the purpose of obtaining, by means of a device of a type approved by the Secretary of State, an indication whether the proportion of alcohol in a person’s breath or blood is likely to exceed the prescribed limit;

“drug” includes any intoxicant other than alcohol;

“fail” includes refuse;

“hospital” means an institution which provides medical or surgical treatment for in-patients or out-patients.

(2) In this Chapter “the prescribed limit” means, as the case may require—

(a) 35 microgrammes of alcohol in 100 millilitres of breath,

(b) 80 milligrammes of alcohol in 100 millilitres of blood, or

(c) 107 milligrammes of alcohol in 100 millilitres of urine,

or such other proportion as may be prescribed by regulations made by the Secretary of State.

(2A) In this Chapter “registered health care professional” means a person (other than a medical practitioner) who is—

(a) a registered nurse; or

(b) a registered member of a health care profession which is designated for the purposes of this paragraph by an order made by the Secretary of State.

(2B) A health care profession is any profession mentioned in section 60(2) of the Health Act 1999 (c 8) other than the profession of practising medicine and the profession of nursing.

(2C) An order under subsection (2A)(b) shall be made by statutory instrument; and any such statutory instrument shall be subject to annulment in pursuance of a resolution of either House of Parliament.

(3) For the purposes of this Chapter, it is immaterial whether a person who works on a transport system does so in the course of his employment, under a contract for services, voluntarily or otherwise.

(4) For the purposes of this Chapter, a person does not provide a specimen of breath for a breath test or for analysis unless the specimen—

(a) is sufficient to enable the test or the analysis to be carried out, and

(b) is provided in such a way as to enable the objective of the test or analysis to be satisfactorily achieved.

(5) For the purposes of this Chapter, a person provides a specimen of blood if and only if—

(a) he consents to the taking of such a specimen from him; and

(b) the specimen is taken from him by a medical practitioner or, if it is taken in a police station, either by a medical practitioner or by a registered health care professional.

(6) The power to make regulations under subsection (2) above shall be exercisable by statutory instrument; and no such regulations shall be made unless a draft of the instrument containing them has been laid before, and approved by a resolution of, each House of Parliament.



## Road Traffic (New Drivers) Act 1995 c. 13

### *1 Probationary period for newly qualified drivers*

(1) For the purposes of this Act, a person's probationary period is, subject to section 7, the period of two years beginning with the day on which he becomes a qualified driver.

(2) For the purposes of this Act, a person becomes a qualified driver on the first occasion on which he passes—

(a) any test of competence to drive mentioned in paragraph (a) or (c) of section 89(1) of the Road Traffic Act 1988;

(b) any test of competence to drive conducted under the law of

(i) another EEA State,

(ii) the Isle of Man,

(iii) any of the Channel Islands, or

(iv) Gibraltar.

(3) In subsection (2) "EEA State" means a State which is a contracting party to the EEA Agreement but until the EEA Agreement comes into force in relation to Liechtenstein does not include the State of Liechtenstein.

(4) In subsection (3) "EEA Agreement" means the Agreement on the European Economic Area signed at Oporto on 2nd May 1992 as adjusted by the Protocol signed at Brussels on 17th March 1993.

## Revocation of licences and re-testing

### *2 Surrender of licences*

(1) Subsection (2) applies where—

(a) a person is the holder of a licence;

(b) he is convicted of an offence involving obligatory endorsement;

(c) the penalty points to be taken into account under section 29 of the Road Traffic Offenders Act 1988 on that occasion number six or more;

(d) the court makes an order falling within section 44(1)(b) of that Act in respect of the offence;

(e) the person's licence shows the date on which he became a qualified driver, or that date has been shown by other evidence in the proceedings; and

(f) it appears to the court, in the light of the order and the date so shown, that the offence was committed during the person's probationary period.

(2) Where this subsection applies, the court must send to the Secretary of State—

(a) a notice containing the particulars required to be endorsed on the counterpart of the person's licence in accordance with the order referred to in subsection (1)(d); and

(b) on their production to the court, the person's licence and its counterpart.

(3) Subsection (4) applies where—

(a) a person's licence and its counterpart have been sent to the fixed penalty clerk under section 54(7) of the Road Traffic Offenders Act 1988, retained by a vehicle

examiner under that section or delivered to the appropriate person in response to a conditional offer issued under section 75 of that Act;

(b) the offence to which the fixed penalty notice or the conditional offer relates is one involving obligatory endorsement;

(c) the appropriate person endorses the number of penalty points to be attributed to the offence on the counterpart of the licence;

(d) the penalty points to be taken into account by the appropriate person in respect of the offence number six or more;

(e) the licence shows the date on which the person became a qualified driver; and

(f) it appears to the appropriate person, in the light of the particulars of the offence endorsed on the counterpart of the licence and the date so shown, that the offence was committed during the person's probationary period.

(4) Where this subsection applies. . .—

(a) the appropriate person may not return the licence and its counterpart under section 57(3) or (4) or 77(1) of the Road Traffic Offenders Act 1988; but

(b) unless the appropriate person is the Secretary of State, he must send them to the Secretary of State.

(5) For the purposes of subsection (3)(d) the penalty points to be taken into account . . . in respect of the offence are the penalty points which would have been taken into account under section 29 of the Road Traffic Offenders Act 1988 if—

(a) the person in question had been convicted of the offence; and

(b) the number of penalty points to be attributed to the offence on that occasion had been determined in accordance with section 28(3) of that Act.

(6) In this section and section 3 "licence" includes a Northern Ireland licence.

(7) In this section and section 3—

"the appropriate person", in relation to a fixed penalty notice, means—

(a) if it was given by a constable or an authorised person, the fixed penalty clerk, and

(b) if it was given by a vehicle examiner or the Secretary of State, the Secretary of State, and

"the appropriate person", in relation to a conditional offer, means—

(a) where the conditional offer was issued under subsection (1), (2) or (3) of section 75 of the Road Traffic Offenders Act 1988, the fixed penalty clerk, and

(b) where it was issued under subsection (1A) or (3B) of that section, the Secretary of State

### *3 Revocation of licences*

(1) Where the Secretary of State receives—

(a) a notice sent to him under section 2(2)(a) of particulars required to be endorsed on the counterpart of a person's licence, or

(b) a person's licence and its counterpart sent to him in accordance with section 2(2)

(b) or (4)(b),

the Secretary of State must by notice served on that person revoke the licence.

(1ZA) Where section 2(4)(a) applies but the appropriate person is the Secretary of State, the Secretary of State must by notice served on the person to whom the fixed penalty notice or conditional offer was given or issued, revoke that person's licence.

(1A) Where the Secretary of State serves on the holder of a Northern Ireland licence a notice under subsection (1) or (1ZA), the Secretary of State must send to the licensing authority in Northern Ireland—

- (a) particulars of the notice; and
- (b) the Northern Ireland licence.

(1B) Where the Secretary of State is sent by that licensing authority particulars of a notice served on the holder of a licence under a provision of Northern Ireland law corresponding to subsection (1) or (1ZA), he must by notice served on the holder revoke the licence.

(2) A revocation under this section shall have effect from a date specified in the notice of revocation which may not be earlier than the date of service of that notice.

(3) In this section references to the revocation of a person's Northern Ireland licence are references to its revocation as respects Great Britain; and, accordingly, the person ceases to be authorised by virtue of section 109(1) of the Road Traffic Act 1988 to drive in Great Britain a motor vehicle of any class.

#### *4 Re-testing*

(1) Subject to subsection (5) and section 5, the Secretary of State may not under Part III of the Road Traffic Act 1988 grant a person whose licence has been revoked under section 3 a full licence to drive any class of vehicles in relation to which the revoked licence was issued as a full licence or (as the case may be) full Northern Ireland licence unless he satisfies the Secretary of State that within the relevant period he has passed a relevant driving test.

(1A) Subject to subsection (5), the Secretary of State may not under that Part grant a person whose Northern Ireland licence has been revoked under a provision of Northern Ireland law corresponding to section 3(1) a full licence to drive any class of vehicles in relation to which the revoked licence was issued as a full Northern Ireland licence unless he satisfies the Secretary of State as mentioned in subsection (1).

(2) In this section "relevant driving test" means, in relation to a person whose licence has been revoked, any test which—

- (a) falls within paragraph (a) or (b) of section 1(2); and
- (b) is a test of competence to drive any vehicle included in any class of vehicles in relation to which the revoked licence was issued as a full licence or (as the case may be) full Northern Ireland licence.

(3) If the Secretary of State grants a full licence to a person who is required to pass a relevant driving test in order to be granted that licence, the licence granted must (subject to section 92 and Part IV of the Road Traffic Act 1988) be one authorising that person to drive all the classes of vehicles in relation to which the revoked licence was issued as a full licence or (as the case may be) full Northern Ireland licence.

(4) In subsection (1) "the relevant period" means the period beginning—

- (a) after the date of the revocation of the licence; and

(b) not more than two years before the date on which the application for the full licence is made.

(5) Subsections (1) and (1A) do not apply to a person whose licence has been revoked under section 3 or whose Northern Ireland licence has been revoked under a provision of Northern Ireland law corresponding to section 3(1) if, before he passes a relevant driving test, an order is made in relation to him under section 36 of the Road Traffic Offenders Act 1988 (disqualification until test is passed).

## **Powers of Criminal Courts (Sentencing) Act 2000 c. 6**

### **Part VII**

#### **Further Powers of Courts**

##### **Powers to deprive offender of property used etc for purposes of crime**

###### *143 Powers to deprive offender of property used etc for purposes of crime*

(1) Where a person is convicted of an offence and the court by or before which he is convicted is satisfied that any property which has been lawfully seized from him, or which was in his possession or under his control at the time when he was apprehended for the offence or when a summons in respect of it was issued—

(a) has been used for the purpose of committing, or facilitating the commission of, any offence, or

(b) was intended by him to be used for that purpose,

the court may (subject to subsection (5) below) make an order under this section in respect of that property.

(2) Where a person is convicted of an offence and the offence, or an offence which the court has taken into consideration in determining his sentence, consists of unlawful possession of property which—

(a) has been lawfully seized from him, or

(b) was in his possession or under his control at the time when he was apprehended for the offence of which he has been convicted or when a summons in respect of that offence was issued,

the court may (subject to subsection (5) below) make an order under this section in respect of that property.

(3) An order under this section shall operate to deprive the offender of his rights, if any, in the property to which it relates, and the property shall (if not already in their possession) be taken into the possession of the police.

(4) Any power conferred on a court by subsection (1) or (2) above may be exercised—

(a) whether or not the court also deals with the offender in any other way in respect of the offence of which he has been convicted; and

(b) without regard to any restrictions on forfeiture in any enactment contained in an Act passed before 29th July 1988.

(5) In considering whether to make an order under this section in respect of any property, a court shall have regard—

(a) to the value of the property; and

(b) to the likely financial and other effects on the offender of the making of the order (taken together with any other order that the court contemplates making).

(6) Where a person commits an offence to which this subsection applies by—

(a) driving, attempting to drive, or being in charge of a vehicle, or

(b) failing to comply with a requirement made under section 7 or 7A of the Road Traffic Act 1988 (failure to provide specimen for analysis or laboratory test or to give permission for such a test) in the course of an investigation into whether the offender had committed an offence while driving, attempting to drive or being in charge of a vehicle, or

(c) failing, as the driver of a vehicle, to comply with subsection (2) or (3) of section 170 of the Road Traffic Act 1988 (duty to stop and give information or report accident), the vehicle shall be regarded for the purposes of subsection (1) above (and section 144(1)(b) below) as used for the purpose of committing the offence (and for the purpose of committing any offence of aiding, abetting, counselling or procuring the commission of the offence).

(7) Subsection (6) above applies to—

(a) an offence under the Road Traffic Act 1988 which is punishable with imprisonment;

(b) an offence of manslaughter; and

(c) an offence under section 35 of the Offences Against the Person Act 1861 (wanton and furious driving).

(8) Facilitating the commission of an offence shall be taken for the purposes of subsection (1) above to include the taking of any steps after it has been committed for the purpose of disposing of any property to which it relates or of avoiding apprehension or detection.

## **Railways and Transport Safety Act 2003 c. 20**

### **Part IV Shipping: Alcohol and drugs**

#### **Offences**

##### *78 Professional staff on duty*

(1) This section applies to—

(a) a professional master of a ship,

(b) a professional pilot of a ship, and

(c) a professional seaman in a ship while on duty.

(2) A person to whom this section applies commits an offence if his ability to carry out his duties is impaired because of drink or drugs.

(3) A person to whom this section applies commits an offence if the proportion of alcohol in his breath, blood or urine exceeds the prescribed limit.

(4) For the purposes of this section a master, pilot or seaman is professional if (and only if) he acts as master, pilot or seaman in the course of a business or employment.

(5) Where a person is charged with an offence under this section in respect of the effect of a drug on his ability to carry out duties on a fishing vessel, it is a defence for him to show that—

- (a) he took the drug for a medicinal purpose on, and in accordance with, medical advice, or
- (b) he took the drug for a medicinal purpose and had no reason to believe that it would impair his ability to carry out his duties.

#### *79 Professional staff off duty*

(1) This section applies to a professional seaman in a ship at a time when—

- (a) he is not on duty, but
- (b) in the event of an emergency he would or might be required by the nature or terms of his engagement or employment to take action to protect the safety of passengers.

(2) A person to whom this section applies commits an offence if his ability to take the action mentioned in subsection (1)(b) is impaired because of drink or drugs.

(3) A person to whom this section applies commits an offence if the proportion of alcohol in his breath, blood or urine exceeds the prescribed limit.

(4) For the purposes of this section a seaman is professional if (and only if) he acts as seaman in the course of a business or employment.

(5) Where a person is charged with an offence under this section in respect of the effect of a drug on his ability to take action it is a defence for him to show that—

- (a) he took the drug for a medicinal purpose on, and in accordance with, medical advice, or
- (b) he took the drug for a medicinal purpose and had no reason to believe that it would impair his ability to take the action.

#### *80 Non-professionals*

(1) This section applies to a person who—

- (a) is on board a ship which is under way,
- (b) is exercising, or purporting or attempting to exercise, a function in connection with the navigation of the ship, and
- (c) is not a person to whom section 78 or 79 applies.

(2) A person to whom this section applies commits an offence if his ability to exercise the function mentioned in subsection (1)(b) is impaired because of drink or drugs.

(3) A person to whom this section applies commits an offence if the proportion of alcohol in his breath, blood or urine exceeds the prescribed limit.

(4) The Secretary of State may make regulations providing for subsection (3) not to apply in specified circumstances.

(5) Regulations under subsection (4) may make provision by reference, in particular—

- (a) to the power of a motor;
- (b) to the size of a ship;

(c) to location.

### *81 Prescribed limit*

(1) The prescribed limit of alcohol for the purposes of this Part is—

- (a) in the case of breath, 35 microgrammes of alcohol in 100 millilitres,
- (b) in the case of blood, 80 milligrammes of alcohol in 100 millilitres, and
- (c) in the case of urine, 107 milligrammes of alcohol in 100 millilitres.

(2) The Secretary of State may make regulations amending subsection (1).

## **Enforcement**

### *82 Penalty*

A person guilty of an offence under this Part shall be liable—

- (a) on conviction on indictment, to imprisonment for a term not exceeding two years, to a fine or to both, or
- (b) on summary conviction, to a fine not exceeding the statutory maximum.

### *83 Specimens, &c*

(1) The provisions specified in the first column of the table below, with the modifications specified in the third column and any other necessary modifications, shall have effect in relation to an offence under this Part.

Provision	Description	Modification
<b>Road Traffic Act 1988 (c. 52)</b>		
Section 6	Power to administer preliminary tests	In place of subsections (2) to (5) the power to require a person to co-operate with a preliminary test shall apply where—  (a) a constable in uniform reasonably suspects that the person is committing an offence under section 78, 79 or 80,  (b) a constable in uniform reasonably suspects that the person has committed an offence under section 78, 79 or 80 and still has alcohol or a drug in his body or is still under the influence of a drug, or  (c) an accident occurs owing to the presence of a ship in a public place and a constable reasonably suspects that the person was at the time of the accident a person to whom section 78, 79 or 80 applied.
Sections 6A to 6E	Preliminary breath test, impairment test, and drug test	In place of sections 6A(2) and (3), 6B(4) and 6C(2), a preliminary breath test, preliminary impairment test or preliminary drug test may be administered by a constable—  (a) at or near the place where the requirement to co-operate with the test is imposed, or  (b) at a police station specified by the constable.  In section 6B(3) a reference to unfitness to drive shall be treated as a reference to having an impaired ability, because of drink or drugs, to do anything specified in section 78(2), 79(2) or 80(2).
Section 7	Provision of specimen	In subsection (1) the reference to an offence under section 3A, 4 or 5 of the 1988 Act shall be treated as a reference to an offence under section 78, 79 or 80 of this Act.  In subsection (3)(c) the reference to an offence under section 3A or 4 of the 1988 Act shall be treated as a reference to an offence under section 78(2), 79(2) or 80(2) of this Act.
Section 7A	Specimen of blood taken from person incapable of consenting	
Section 8	Choice of specimen of breath	
Section 9	Protection for hospital patient	
Section 10	Detention of person affected by alcohol or drug	In subsection (1)—
		(a) the reference to driving or attempting to drive a mechanically propelled vehicle on a road shall be treated as a reference to exercising a function in connection with the navigation of a ship, and
		(b) the reference to an offence under section 4 or 5 of the 1988 Act shall be treated as a reference to an offence under section 78, 79 or 80 of this Act.  In subsection (2) the reference to driving a mechanically propelled vehicle shall be treated as a reference to exercising a function in connection with the navigation of a ship.



Provision	Description	Modification
<b>Road Traffic Act 1988 (c. 52)</b>		
		In subsection (3) the reference to driving properly shall be treated as a reference to exercising a function in connection with the navigation of a ship.
Section 11	Interpretation	For the definition of “the prescribed limit” there shall be substituted the definition given in this Part.

Provision	Description	Modification
<b>Road Traffic Offenders Act 1988 (c. 53)</b>		
Section 15	Use of specimens	<p>In subsection (1), the reference to an offence under section 3A, 4 or 5 of the Road Traffic Act 1988 shall be treated as a reference to an offence under section 78, 79 or 80 of this Act.</p> <p>The relevant time for the consumption of alcohol for the purpose of subsection (3)(a) shall be before providing the specimen and after the time of the alleged offence.</p> <p>In subsection (3)(b) the reference to driving shall be treated as a reference to exercising a function in connection with the navigation of a ship.</p>
Section 16	Documentary evidence	

(2) The Secretary of State may by regulations amend the table in subsection (1) so as—

- (a) to add a provision relating to an offence which concerns alcohol or drugs in relation to road traffic;
- (b) to add, remove or amend a modification (whether or not in connection with an amendment of a provision specified in the table).

(3) For the purpose of the application by subsection (1) of a provision listed in the table in that subsection—

- (a) the provision shall extend to the whole of the United Kingdom, and
- (b) a reference to the provision shall be treated, unless the context otherwise requires, as including a reference to the provision as applied.

## Part V Aviation: Alcohol and Drugs

### Offences

#### *92 Being unfit for duty*

(1) A person commits an offence if—

- (a) he performs an aviation function at a time when his ability to perform the function is impaired because of drink or drugs, or
- (b) he carries out an activity which is ancillary to an aviation function at a time when his ability to perform the function is impaired because of drink or drugs.

(2) In this section “drug” includes any intoxicant other than alcohol.

(3) Section 94 defines “aviation function” and “ancillary activity” for the purposes of this Part.

### *93 Prescribed limit*

(1) A person commits an offence if—

(a) he performs an aviation function at a time when the proportion of alcohol in his breath, blood or urine exceeds the prescribed limit, or

(b) he carries out an activity which is ancillary to an aviation function at a time when the proportion of alcohol in his breath, blood or urine exceeds the prescribed limit.

(2) The prescribed limit of alcohol is (subject to subsection (3))—

(a) in the case of breath, 9 microgrammes of alcohol in 100 millilitres,

(b) in the case of blood, 20 milligrammes of alcohol in 100 millilitres, and

(c) in the case of urine, 27 milligrammes of alcohol in 100 millilitres.

(3) In relation to the aviation function specified in section 94(1)(h) the prescribed limit is—

(a) in the case of breath, 35 microgrammes of alcohol in 100 millilitres,

(b) in the case of blood, 80 milligrammes of alcohol in 100 millilitres, and

(c) in the case of urine, 107 milligrammes of alcohol in 100 millilitres.

(4) The Secretary of State may make regulations amending subsection (2) or (3).

(5) Section 94 defines “aviation function” and “ancillary activity” for the purposes of this Part.

### *94 Aviation functions*

(1) For the purposes of this Part the following (and only the following) are aviation functions—

(a) acting as a pilot of an aircraft during flight,

(b) acting as flight navigator of an aircraft during flight,

(c) acting as flight engineer of an aircraft during flight,

(d) acting as flight radio-telephony operator of an aircraft during flight,

(e) acting as a member of the cabin crew of an aircraft during flight,

(f) attending the flight deck of an aircraft during flight to give or supervise training, to administer a test, to observe a period of practice or to monitor or record the gaining of experience,

(g) acting as an air traffic controller in pursuance of a licence granted under or by virtue of an enactment (other than a licence granted to a student), and

(h) acting as a licensed aircraft maintenance engineer.

(2) For the purposes of subsection (1)(h) a person acts as a licensed aircraft maintenance engineer if—

(a) he issues a document relating to the maintenance, condition or use of an aircraft or equipment in reliance on a licence granted under or by virtue of an enactment relating to aviation, or

(b) he carries out or supervises work on an aircraft or equipment with a view to, or in connection with, the issue by him of a document of the kind specified in paragraph (a).

(3) For the purposes of this Part a reference to an activity which is ancillary to an aviation function is a reference to anything which falls to be treated as such by virtue of subsections (4) to (6).

(4) An activity shall be treated as ancillary to an aviation function if it is undertaken—

(a) by a person who has reported for a period of duty in respect of the function, and

(b) as a requirement of, for the purpose of or in connection with the performance of the function during that period of duty.

(5) A person who in accordance with the terms of an employment or undertaking holds himself ready to perform an aviation function if called upon shall be treated as carrying out an activity ancillary to the function.

(6) Where a person sets out to perform an aviation function, anything which he does by way of preparing to perform the function shall be treated as an activity ancillary to it.

(7) For the purposes of this Part it is immaterial whether a person performs a function or carries out an activity in the course of an employment or trade or otherwise.

(8) The Secretary of State may by regulations—

(a) amend this section;

(b) make an amendment of this Part which is consequential on an amendment under paragraph (a).

## **Enforcement**

### *95 Penalty*

A person guilty of an offence under this Part shall be liable—

(a) on conviction on indictment, to imprisonment for a term not exceeding two years, to a fine or to both, or

(b) on summary conviction, to a fine not exceeding the statutory maximum.

### *96 Specimens, &c*

(1) The provisions specified in the first column of the table below, with the modifications specified in the third column and any other necessary modifications, shall have effect in relation to an offence under this Part.

Provision	Description	Modification
<b>Road Traffic Act 1988 (c. 52)</b>		
Section 6	Power to administer preliminary tests	In place of subsections (2) to (5) the power to require a person to co-operate with a preliminary test shall apply where—
		(a) a constable in uniform reasonably suspects that the person is committing an offence under section 92 or 93,
		(b) a constable in uniform reasonably suspects that the person has committed an offence under section 92 or 93 and still has alcohol or a drug in his body or is still under the influence of a drug,
		(c) an aircraft is involved in an accident and a constable reasonably suspects that the person was undertaking an aviation function, or an activity ancillary to an aviation function, in relation to the aircraft at the time of the accident, or
		(d) an aircraft is involved in an accident and a constable reasonably suspects that the person has undertaken an aviation function, or an activity ancillary to an aviation function, in relation to the aircraft.
Sections 6A to 6E	Preliminary breath test, impairment test, and drug test	In place of sections 6A(2) and (3), 6B(4) and 6C(2), a preliminary breath test, preliminary impairment test or preliminary drug test may be administered by a constable—
		(a) at or near the place where the requirement to co-operate with the test is imposed, or
		(b) at a police station specified by the constable.
		In section 6B(3) a reference to unfitness to drive shall be treated as a reference to having an impaired ability, because of drink or drugs, to perform an aviation function or to carry out an activity which is ancillary to an aviation function.
Section 7	Provision of specimen	In subsection (1) the reference to an offence under section 3A, 4 or 5 of the 1988 Act shall be treated as a reference to an offence under section 92 or 93 of this Act.
		In subsection (3)(c) the reference to an offence under section 3A or 4 of the 1988 Act shall be treated as a reference to an offence under section 92 of this Act.
Section 7A	Specimen of blood taken from person incapable of consenting	
Section 8	Choice of specimen of breath	In subsection (2) the reference to 50 microgrammes of alcohol shall, except in relation to the aviation function specified in section 94(1)(h), be treated as a reference to 15 microgrammes of alcohol.
Section 9	Protection for hospital patient	
Section 10	Detention of person affected by alcohol or drug	In subsection (1)—
		(a) the reference to driving or attempting to drive a mechanically propelled vehicle on a road shall be treated as a reference to performing an aviation function of the kind in respect of which the requirement to provide a specimen was imposed, and
		(b) the reference to an offence under section 4 or 5 of the 1988 Act shall be treated as a reference to an offence under section 92 or 93 of this Act.

Provision	Description	Modification
<b>Road Traffic Act 1988 (c. 52)</b>		
		In subsection (2) the reference to driving a mechanically propelled vehicle shall be treated as a reference to performing an aviation function.
		In subsection (3) the reference to driving properly shall be treated as a reference to performing an aviation function.
Section 11	Interpretation	For the definition of “the prescribed limit” there shall be substituted the definition given in this Part.

Provision	Description	Modification
<b>Road Traffic Offenders Act 1988 (c. 53)</b>		
Section 15	Use of specimens	In subsection (1), the reference to an offence under section 3A, 4 or 5 of the Road Traffic Act 1988 shall be treated as a reference to an offence under section 92 or 93 of this Act.
		The relevant time for the consumption of alcohol for the purpose of subsection (3)(a) shall be before providing the specimen and after the time of the alleged offence.
		In subsection (3)(b) the reference to driving shall be treated as a reference to undertaking an aviation function or an activity ancillary to an aviation function.
Section 16	Documentary evidence	

(2) The Secretary of State may by regulations amend the table in subsection (1) so as—

- (a) to add a provision relating to an offence which concerns alcohol or drugs in relation to road traffic;
- (b) to add, remove or amend a modification (whether or not in connection with an amendment of a provision specified in the table).

(3) For the purpose of the application by subsection (1) of a provision listed in the table in that subsection—

- (a) the provision shall extend to the whole of the United Kingdom, and
- (b) a reference to the provision shall be treated, unless the context otherwise requires, as including a reference to the provision as applied.

## **Criminal Justice Act 2003 c. 44**

### *172 Duty of court to have regard to sentencing guidelines*

(1) Every court must—

- (a) in sentencing an offender, have regard to any guidelines which are relevant to the offender’s case, and
- (b) in exercising any other function relating to the sentencing of offenders, have regard to any guidelines which are relevant to the exercise of the function.

(2) In subsection (1) “guidelines” means sentencing guidelines issued by the Council under section 170(9) as definitive guidelines, as revised by subsequent guidelines so issued.

## Duty of court to explain sentence

### *174 Duty to give reasons for, and explain effect of, sentence*

(1) Subject to subsections (3) and (4), any court passing sentence on an offender—

(a) must state in open court, in ordinary language and in general terms, its reasons for deciding on the sentence passed, and

(b) must explain to the offender in ordinary language—

(i) the effect of the sentence,

(ii) where the offender is required to comply with any order of the court forming part of the sentence, the effects of non-compliance with the order,

(iii) any power of the court, on the application of the offender or any other person, to vary or review any order of the court forming part of the sentence, and

(iv) where the sentence consists of or includes a fine, the effects of failure to pay the fine.

(2) In complying with subsection (1)(a), the court must—

(a) where guidelines indicate that a sentence of a particular kind, or within a particular range, would normally be appropriate for the offence and the sentence is of a different kind, or is outside that range, state the court’s reasons for deciding on a sentence of a different kind or outside that range,

(a) identify any definitive sentencing guidelines relevant to the offender’s case and explain how the court discharged any duty imposed on it by section 125 of the Coroners and Justice Act 2009,

(aa) where the court did not follow any such guidelines because it was of the opinion that it would be contrary to the interests of justice to do so, state why it was of that opinion,

(b) where the sentence is a custodial sentence and the duty in subsection (2) of section 152 is not excluded by subsection (1)(a) or (b) or (3) of that section or any other statutory provision, state that it is of the opinion referred to in section 152(2) and why it is of that opinion,

(c) where the sentence is a community sentence, other than one consisting of or including a youth rehabilitation order with intensive supervision and surveillance or fostering, and the case does not fall within section 151(2), state that it is of the opinion that section 148(1) applies and why it is of that opinion,

(ca) where the sentence consists of or includes a youth rehabilitation order with intensive supervision and surveillance and the case does not fall within paragraph 5(2) of Schedule 1 to the Criminal Justice and Immigration Act 2008, state that it is of the opinion that section 1(4)(a) to (c) of that Act and section 148(1) of this Act apply and why it is of that opinion,

(cb) where the sentence consists of or includes a youth rehabilitation order with fostering, state that it is of the opinion that section 1(4)(a) to (c) of the Criminal

Justice and Immigration Act 2008 and section 148(1) of this Act apply and why it is of that opinion,

(d) where as a result of taking into account any matter referred to in section 144(1), the court imposes a punishment on the offender which is less severe than the punishment it would otherwise have imposed, state that fact, and

(e) in any case, mention any aggravating or mitigating factors which the court has regarded as being of particular importance relevant to the case.

(3) Subsection (1)(a) does not apply—

(a) to an offence the sentence for which is fixed by law (provision relating to sentencing for such an offence being made by section 270), or

(b) to an offence the sentence for which falls to be imposed under section 51A(2) of the Firearms Act 1968 (c 27), under subsection (2) of section 110 or 111 of the Sentencing Act or under section 29(4) or (6) of the Violent Crime Reduction Act 2006 (required custodial sentences).

(4) The Secretary of State Lord Chancellor may by order—

(a) prescribe cases in which subsection (1)(a) or (b) does not apply, and

(b) prescribe cases in which the statement referred to in subsection (1)(a) or the explanation referred to in subsection (1)(b) may be made in the absence of the offender, or may be provided in written form.

(4A) Subsection (4B) applies where—

(a) a court passes a custodial sentence in respect of an offence on an offender who is aged under 18, and

(b) the circumstances are such that the court must, in complying with subsection (1)(a), make the statement referred to in subsection (2)(b).

(4B) That statement must include—

(a) a statement by the court that it is of the opinion that a sentence consisting of or including a youth rehabilitation order with intensive supervision and surveillance or fostering cannot be justified for the offence, and

(b) a statement by the court why it is of that opinion.

(5) Where a magistrates' court passes a custodial sentence, it must cause any reason stated by virtue of subsection (2)(b) to be specified in the warrant of commitment and entered on the register.

(6) In this section—

“guidelines” has the same meaning as in section 172;

“definitive sentencing guidelines” means sentencing guidelines issued by the Sentencing Council for England and Wales under section 120 of the Coroners and Justice Act 2009 as definitive guidelines, as revised by any subsequent guidelines so issued;

“the register” has the meaning given by section 163 of the Sentencing Act.

## Coroners and Justice Act 2009 c. 25

### *36 Reports and advice to the Lord Chancellor from the Chief Coroner*

- (1) The Chief Coroner must give the Lord Chancellor a report for each calendar year.
- (2) The report must cover—
  - (a) matters that the Chief Coroner wishes to bring to the attention of the Lord Chancellor;
  - (b) matters that the Lord Chancellor has asked the Chief Coroner to cover in the report.
- (3) The report must contain an assessment for the year of the consistency of standards between coroners areas.
- (4) The report must also contain a summary for the year of—
  - (a) the number and length of—
    - (i) investigations in respect of which notification was given under subsection (1)(a) or (b) of section 16, and
    - (ii) investigations that were not concluded or discontinued by the end of the year and in respect of which notification was given under subsection (1)(a) of that section in a previous year,
 as well as the reasons for the length of those investigations and the measures taken with a view to keeping them from being unnecessarily lengthy;
  - (b) the number, nature and outcome of appeals under section 40(1), (3), (4), (5) or (9);
  - (c) the matters recorded under paragraph 4 of Schedule 5;
  - (d) the matters reported under paragraph 7 of that Schedule and the responses given under sub-paragraph (2) of that paragraph.
- (5) A report for a year under this section must be given to the Lord Chancellor by 1 July in the following year.
- (6) The Lord Chancellor must publish each report given under this section and must lay a copy of it before each House of Parliament.
- (7) If requested to do so by the Lord Chancellor, the Chief Coroner must give advice to the Lord Chancellor about particular matters relating to the operation of the coroner system.



# Annex H: Penalties for drink and drug driving offences under the Road Traffic Act 1988

**Schedule 2 to the Road Traffic Offenders Act 1988**

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Provision creating offence	General nature of offence in the context of drink driving	Mode of prosecution	Punishment	Disqualification	Endorsement	Penalty points
RTA section 4(1)	Driving or attempting to drive when unfit to drive through drink or drugs	Summarily	6 months or level 5 on the standard scale or both	Obligatory	Obligatory	3-11
RTA section 4(2)	Being in charge of a mechanically propelled vehicle when unfit to drive through drink or drugs	Summarily	51 weeks or level 4 on the standard scale or both	Discretionary	Obligatory	10
RTA section 5(1)(a)	Driving or attempting to drive with excess alcohol in breath, blood or urine	Summarily	6 months or level 5 on the standard scale or both	Obligatory	Obligatory	3-11
RTA section 5(1)(b)	Being in charge of a motor vehicle with excess alcohol in breath, blood or urine	Summarily	51 weeks or level 4 on the standard scale or both	Discretionary	Obligatory	10
RTA section 6	Failing to co-operate with a preliminary test	Summarily	Level 3 on the standard scale	Discretionary	Obligatory	4
RTA section 7	Failing to provide specimen for analysis or laboratory test	Summarily	(a) Where the specimen was required to ascertain ability to drive or proportion of alcohol at the time offender was driving or attempting to drive, 6 months or level 5 on the standard scale or both (b) Discretionary in any other case 51 weeks or level 4 on the standard scale or both	(a) Obligatory in case mentioned in column 4(a) (b) In any other case	Obligatory	(a) 3-11 in case mentioned in column 4(a) (b) 10 in any other case
RTA section 7A	Failing to allow specimen to be subjected to laboratory test	Summarily	(a) Where the test would be for ascertaining ability to drive or proportion of alcohol at the time offender was driving or attempting to drive, 6 months or level 5 on the standard scale or both (b) In any other case, 51 weeks or level 4 on the standard scale or both	(a) Obligatory in the case mentioned in column 4(a) (b) Discretionary in any other case	Obligatory	3-11, in case mentioned in column 4(a), 10 in any other case

# Annex I: Sentencing Council – Magistrates’ Court Sentencing Guidelines

Source: Magistrates’ Court Sentencing Guidelines. Available at: [http://www.sentencingguidelines.gov.uk/docs/magistrates\\_court\\_sentencing\\_guidelines\\_update.pdf](http://www.sentencingguidelines.gov.uk/docs/magistrates_court_sentencing_guidelines_update.pdf)

## Unfit through drink or drugs (drive/attempt to drive)

Road Traffic Act 1988, s.4(1)

Triable only summarily:

- Maximum: Level 5 fine and/or 6 months
- Must endorse and disqualify for at least 12 months
- Must disqualify for **at least** 2 years if offender has had two or more disqualifications for periods of 56 days or more in preceding 3 years – **refer to page 184 and consult your legal adviser for further guidance**
- Must disqualify for **at least** 3 years if offender has been convicted of a relevant offence in preceding 10 years – **refer to page 184 and consult your legal adviser for further guidance**

### If there is a delay in sentencing after conviction, consider interim disqualification

Note: the final column below provides guidance regarding the length of disqualification that may be appropriate in cases to which the 3 year minimum applies. The period to be imposed in any individual case will depend on an assessment of all the relevant circumstances, including the length of time since the earlier ban was imposed and the gravity of the current offence.

Offence seriousness (culpability and harm) A. Identify the appropriate starting point Starting points based on first time offender pleading not guilty				
Examples of nature of activity	Starting point	Range	Disqualification	Disqual. 2nd offence in 10 years
Evidence of moderate level of impairment and no aggravating factors	Band C fine	Band C fine	12–16 months	36–40 months
Evidence of moderate level of impairment and presence of one or more aggravating factors listed below	Band C fine	Band C fine	17–22 months	36–46 months
Evidence of high level of impairment and no aggravating factors	Medium level community order	Low level community order to high level community order	23–28 months	36–52 months
Evidence of high level of impairment and presence of one or more aggravating factors listed below	12 weeks custody	High level community order to 26 weeks custody	29–36 months	36–60 months

Offence seriousness (culpability and harm)

B. Consider the effect of aggravating and mitigating factors  
(other than those within examples above)

Common aggravating and mitigating factors are identified in the pullout card – the following may be particularly relevant but these lists are not exhaustive

<p><b>Factors indicating higher culpability</b></p> <ol style="list-style-type: none"> <li>1. LGV, HGV, PSV etc.</li> <li>2. Poor road or weather conditions</li> <li>3. Carrying passengers</li> <li>4. Driving for hire or reward</li> <li>5. Evidence of unacceptable standard of driving</li> </ol> <p><b>Factors indicating greater degree of harm</b></p> <ol style="list-style-type: none"> <li>1. Involved in accident</li> <li>2. Location e.g. near school</li> <li>3. High level of traffic or pedestrians in the vicinity</li> </ol>	<p><b>Factors indicating lower culpability</b></p> <ol style="list-style-type: none"> <li>1. Genuine emergency established *</li> <li>2. Spiked drinks *</li> <li>3. Very short distance driven *</li> </ol> <p>* even where not amounting to special reasons</p>
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Form a preliminary view of the appropriate sentence, then consider offender mitigation  
Common factors are identified in the pullout card

Consider a reduction for guilty plea

Consider offering drink/drive rehabilitation course  
Consider ancillary orders  
Refer to pages 168–174 for guidance on available ancillary orders

Decide sentence  
Give reasons

<b>Unfit through drink or drugs (in charge)</b>	Road Traffic Act 1988, s.4(2)
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Triable only summarily:

- Maximum: Level 4 fine and/or 3 months
- Must endorse and may disqualify. If no disqualification, impose 10 points

Offence seriousness (culpability and harm) A. Identify the appropriate starting point Starting points based on first time offender pleading not guilty		
Examples of nature of activity	Starting point	Range
Evidence of moderate level of impairment and no aggravating factors	Band B fine	Band B fine 10 points
Evidence of moderate level of impairment and presence of one or more aggravating factors listed below	Band B fine	Band B fine 10 points or consider disqualification
Evidence of high level of impairment and no aggravating factors	Band C fine	Band C fine to medium level community order 10 points or consider disqualification
Evidence of high level of impairment and presence of one or more aggravating factors listed below	High level community order	Medium level community order to 12 weeks custody Consider disqualification OR 10 points

Offence seriousness (culpability and harm) B. Consider the effect of aggravating and mitigating factors (other than those within examples above) Common aggravating and mitigating factors are identified in the pullout card – the following may be particularly relevant but these lists are not exhaustive	
<b>Factors indicating higher culpability</b> 1. LGV, HGV, PSV etc. 2. High likelihood of driving 3. Driving for hire or reward	<b>Factor indicating lower culpability</b> 1. Low likelihood of driving

Form a preliminary view of the appropriate sentence, then consider offender mitigation  
Common factors are identified in the pullout card

Consider a reduction for guilty plea

Consider ancillary orders  
Refer to pages 168–174 for guidance on available ancillary orders

Decide sentence  
Give reasons

Triable only summarily:

- Maximum: Level 5 fine and/or 6 months
- Must endorse and disqualify for at least 12 months
- Must disqualify for **at least 2 years** if offender has had two or more disqualifications for periods of 56 days or more in preceding 3 years – **refer to page 184 and consult your legal adviser for further guidance**
- Must disqualify for **at least 3 years** if offender has been convicted of a relevant offence in preceding 10 years – **refer to page 184 and consult your legal adviser for further guidance**

**If there is a delay in sentencing after conviction, consider interim disqualification**

Note: the final column below provides guidance regarding the length of disqualification that may be appropriate in cases to which the 3 year minimum applies. The period to be imposed in any individual case will depend on an assessment of all the relevant circumstances, including the length of time since the earlier ban was imposed and the gravity of the current offence.

Offence seriousness (culpability and harm)						
A. Identify the appropriate starting point						
Starting points based on first time offender pleading not guilty						
Level of alcohol			Starting point	Range	Disqualification	Disqual. 2nd offence in 10 years – see note above
<b>Breath (ug)</b>	<b>Blood (mg)</b>	<b>Urine(mg)</b>				
36–59	81–137	108–183	Band C fine	Band C fine	12–16 months	36–40 months
60–89	138–206	184–274	Band C fine	Band C fine	17–22 months	36–46 months
90–119	207–275	275–366	Medium level community order	Low level community order to high level community order	23–28 months	36–52 months
120–150 and above	276–345 and above	367–459 and above	12 weeks custody	High level community order to 26 weeks custody	29–36 months	36–60 months

Offence seriousness (culpability and harm)  
B. Consider the effect of aggravating and mitigating factors  
(other than those within examples above)  
Common aggravating and mitigating factors are identified in the pullout card – the following may be particularly relevant but these lists are not exhaustive

<p><b>Factors indicating higher culpability</b></p> <ol style="list-style-type: none"><li>1. LGV, HGV, PSV etc.</li><li>2. Poor road or weather conditions</li><li>3. Carrying passengers</li><li>4. Driving for hire or reward</li><li>5. Evidence of unacceptable standard of driving</li></ol> <p><b>Factors indicating greater degree of harm</b></p> <ol style="list-style-type: none"><li>1. Involved in accident</li><li>2. Location e.g. near school</li><li>3. High level of traffic or pedestrians in the vicinity</li></ol>	<p><b>Factors indicating lower culpability</b></p> <ol style="list-style-type: none"><li>1. Genuine emergency established *</li><li>2. Spiked drinks *</li><li>3. Very short distance driven *</li></ol> <p>* even where not amounting to special reasons</p>
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Form a preliminary view of the appropriate sentence, then consider offender mitigation  
Common factors are identified in the pullout card

Consider a reduction for guilty plea

Consider offering drink/drive rehabilitation course  
Consider ancillary orders, including forfeiture or suspension of personal liquor licence  
Refer to pages 168–174 for guidance on available ancillary orders

Decide sentence  
Give reasons

<b>Excess alcohol (in charge)</b>	Road Traffic Act 1988, s.5(1)(b)
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Triable only summarily:

- Maximum: Level 4 fine and/or 3 months
- Must endorse and may disqualify. If no disqualification, impose 10 points

Offence seriousness (culpability and harm) A. Identify the appropriate starting point Starting points based on first time offender pleading not guilty				
Level of alcohol <b>Breath (mg)</b>	<b>Blood (ml)</b>	<b>Urine (ml)</b>	Starting point	Range
36–59	81–137	108–183	Band B fine	Band B fine 10 points
60–89	138–206	184–274	Band B fine	Band B fine 10 points OR consider disqualification
90–119	207–275	275–366	Band C fine	Band C fine to medium level community order Consider disqualification up to 6 months OR 10 points
120–150 and above	276–345 and above	367–459 and above	Medium level community order	Low level community order to 6 weeks custody Disqualify 6–12 months

Offence seriousness (culpability and harm) B. Consider the effect of aggravating and mitigating factors (other than those within examples above) Common aggravating and mitigating factors are identified in the pullout card – the following may be particularly relevant but these lists are not exhaustive	
<b>Factors indicating higher culpability</b> 1. LGV, HGV, PSV etc. 2. Ability to drive seriously impaired 3. High likelihood of driving 4. Driving for hire or reward	<b>Factor indicating lower culpability</b> 1. Low likelihood of driving

Form a preliminary view of the appropriate sentence, then consider offender mitigation  
Common factors are identified in the pullout card

Consider a reduction for guilty plea

Consider ancillary orders, including forfeiture or suspension of personal liquor licence  
Refer to pages 168-174 for guidance on available ancillary orders

Decide sentence  
Give reasons

**Fail to provide specimen for analysis  
(drive/attempt to drive)**

Road Traffic Act 1988, s.7(6)

Triable only summarily:

- Maximum: Level 5 fine and/or 6 months
- Must endorse and disqualify for at least 12 months
- Must disqualify for **at least 2 years** if offender has had two or more disqualifications for periods of 56 days or more in preceding 3 years – **refer to page 184 and consult your legal adviser for further guidance**
- Must disqualify for **at least 3 years** if offender has been convicted of a relevant offence in preceding 10 years – **refer to page 184 and consult your legal adviser for further guidance**

**If there is a delay in sentencing after conviction, consider interim disqualification**

Note: the final column below provides guidance regarding the length of disqualification that may be appropriate in cases to which the 3 year minimum applies. The period to be imposed in any individual case will depend on an assessment of all the relevant circumstances, including the length of time since the earlier ban was imposed and the gravity of the current offence.

Offence seriousness (culpability and harm)				
A. Identify the appropriate starting point				
Starting points based on first time offender pleading not guilty				
Examples of nature of activity	Starting point	Range	Disqualification	Disqual. 2nd offence in 10 years
Defendant refused test when had honestly held but unreasonable excuse	Band C fine	Band C fine	12–16 months	36–40 months
Deliberate refusal or deliberate failure	Low level community order	Band C fine to high level community order	17–28 months	36–52 months
Deliberate refusal or deliberate failure where evidence of serious impairment	12 weeks custody	High level community order to 26 weeks custody	29–36 months	36–60 months



<p>Offence seriousness (culpability and harm)</p> <p>B. Consider the effect of aggravating and mitigating factors (other than those within examples above)</p> <p>Common aggravating and mitigating factors are identified in the pullout card – the following may be particularly relevant but these lists are not exhaustive</p>	
<p><b>Factors indicating higher culpability</b></p> <ol style="list-style-type: none"><li>1. Evidence of unacceptable standard of driving</li><li>2. LGV, HGV, PSV etc.</li><li>3. Obvious state of intoxication</li><li>4. Driving for hire or reward</li></ol> <p><b>Factor indicating greater degree of harm</b></p> <ol style="list-style-type: none"><li>1. Involved in accident</li></ol>	<p><b>Factor indicating lower culpability</b></p> <ol style="list-style-type: none"><li>1. Genuine but unsuccessful attempt to provide specimen</li></ol>
<p>Form a preliminary view of the appropriate sentence, then consider offender mitigation Common factors are identified in the pullout card</p>	
<p>Consider a reduction for guilty plea</p>	
<p>Consider offering drink/drive rehabilitation course; consider ancillary orders Refer to pages 168–174 for guidance on available ancillary orders</p>	
<p>Decide sentence Give reasons</p>	

## Fail to provide specimen for analysis (in charge)

Road Traffic Act 1988, s.7(6)

Triable only summarily:

- Maximum: Level 4 fine and/or 3 months
- Must endorse and may disqualify. If no disqualification, impose 10 points

Offence seriousness (culpability and harm) A. Identify the appropriate starting point Starting points based on first time offender pleading not guilty		
Examples of nature of activity	Starting point	Range
Defendant refused test when had honestly held but unreasonable excuse	Band B fine	Band B fine 10 points
Deliberate refusal or deliberate failure	Band C fine	Band C fine to medium level community order Consider disqualification OR 10 points
Deliberate refusal or deliberate failure where evidence of serious impairment	Medium level community order	Low level community order to 6 weeks custody Disqualify 6–12 months

Offence seriousness (culpability and harm) B. Consider the effect of aggravating and mitigating factors (other than those within examples above) Common aggravating and mitigating factors are identified in the pullout card – the following may be particularly relevant but these lists are not exhaustive	
<b>Factors indicating higher culpability</b>	<b>Factors indicating lower culpability</b>
<ol style="list-style-type: none"> <li>1. Obvious state of intoxication</li> <li>2. LGV, HGV, PSV etc.</li> <li>3. High likelihood of driving</li> <li>4. Driving for hire or reward</li> </ol>	<ol style="list-style-type: none"> <li>1. Genuine but unsuccessful attempt to provide specimen</li> <li>2. Low likelihood of driving</li> </ol>

Form a preliminary view of the appropriate sentence, then consider offender mitigation  
Common factors are identified in the pullout card

Consider a reduction for guilty plea

Consider ancillary orders  
Refer to pages 168–174 for guidance on available ancillary orders

Decide sentence  
Give reasons

## Annex J: Magistrates' Court Sentencing Guidelines fine bands

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	Starting point	Range
<b>Fine band A</b>	50% of relevant weekly income	25–75% of relevant weekly income
<b>Fine band B</b>	100% of relevant weekly income	75–125% of relevant weekly income
<b>Fine band C</b>	150% of relevant weekly income	125–175% of relevant weekly income

Source: Magistrates' Court Sentencing Guidelines ([http://www.sentencing-guidelines.gov.uk/docs/magistrates\\_court\\_sentencing\\_guidelines\\_update.pdf](http://www.sentencing-guidelines.gov.uk/docs/magistrates_court_sentencing_guidelines_update.pdf))

## Annex K: The presentation of drink drive statistics<sup>254</sup>

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### Drink drive limits and definitions

For the purposes of drink drive statistics, a drink drive accident is defined as being an incident on a public road in which someone is killed or injured and where one or more of the motor vehicle drivers or riders involved either refused to give a breath test specimen when requested to do so by the police (other than when incapable of doing so for medical reasons), or failed a roadside breath test by registering over 35 microgrammes of alcohol per 100 millilitres of breath.

### Data sources and completeness

When producing the departmental estimates of the total number of drink drive casualties in Great Britain, two sources of data are used. These are:

(i) Coroners' data: Information about the level of alcohol in the blood of road accident fatalities aged 16 or over who die within 12 hours of a road accident is provided by coroners in England and Wales and by procurators fiscal in Scotland. This information is subsequently added to the STATS19 record for relevant fatalities.

(ii) STATS19 breath test data: The personal injury road accident reporting system (STATS19) provides data on injury accidents in which the driver or rider survived and was also breath tested at the roadside. If the driver or rider refused to provide a breath test specimen, then they are considered to have failed the test unless they are deemed unable to take the test for medical reasons.

Both of the above sources of data are incomplete. In the case of the STATS19 data, not all drivers are breath tested; some drivers may have left the scene (hit and run accidents) or may be too seriously injured to provide a breath test. In the case of the coroner's data, a post mortem test may not be available, because the casualty died more than 12 hours after the accident, no test was carried out or because some of the data are not reported to the Department.

### Producing the drink drive estimates

To produce an overall estimate of the number of accidents and casualties resulting from drinking and driving the two sources above are combined and scaled up to allow for those accidents where no information is available. The method takes into account the fact that relatively more of the drivers and riders involved in fatal and serious accidents are breath-tested than in slight accidents. These estimates are published annually in RRCGB (see article 3 Table 3a).

However, it should be noted that even these estimates will under represent the number of drink drive accidents since they are based entirely on data reported to the police using the STATS19 form and therefore do not cover those casualties in accidents which are not reported to the police. Damage only accidents are not included.

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<sup>254</sup> Department for Transport Statisticians. 2010.

Producing more detailed breakdowns (than published in article 3 of RRCGB) of the overall drink drive estimates is time consuming but more importantly the figures may be unreliable. This is because the scaling factors used to allow for missing data may not be relevant to subsets of the data e.g. young drivers.

However, it is possible to undertake more detailed analysis of the “raw” data in the STATS 19 database (i.e. accidents and casualties where the actual blood/breath test result is known) Although the raw figures underestimate the actual number of casualties involved in drink drive accidents the general trends and patterns are likely to be reasonably robust.

# Annex L: Breath testing for alcohol by country

**Table 1: Proportion of drivers who have been breath tested for alcohol by country over a one year period (2005–2007)**

Country	Legal BAC limit (mg/100 ml)	Population (2008)	Drivers (2008)	Alcohol-related deaths* as percentage of all road deaths (%)	Year	Checks	Offences	Ratio (%)	Checks per driver per annum (%)	Offences per driver per annum (%)
Belgium	50	10,584,534	6,350,720	10.5	2006	625,000			9.8	
Cyprus	50	778,684	467,210	17.4	2006	71,149	1,470	2.1	15.2	0.3
Czech Republic	0	10,287,189	6,172,313	3.4	2007	410,000	15,077	3.7	6.6	0.2
Denmark	50	5,447,084	3,268,250	16.0	2005	389,000			11.9	
Finland	50	5,276,955	3,166,173	26.2	2006	696,064	27,901	4.0	22.0	0.9
France	50	63,392,140	38,035,284	27.3	2006	11,387,829	359,229	3.2	29.9	0.9
Germany	50	82,217,800	49,330,680	11.4	2006		196,000			0.4
Greece	50	11,171,740	6,703,044	8.0	2006	1,300,000	46,938	3.6	19.4	0.7
Hungary	0	10,066,158	6,039,695	8.7	2005	1,101,010	34,213	3.1	18.2	0.6
Italy	50	59,131,287	35,478,772			188,540	35,703	18.9	0.5	0.1
Netherlands	50	16,357,992	9,800,000	6.2	2005	2,000,000	33,000	1.7	20.4	0.3
Norway	20	4,681,134	2,808,680	11.1	2006	1,600,000			57.0	
Portugal	50	10,110,271	6,066,163	10.2	2007	1,000,000	32,000	3.2	16.5	0.5
Spain	50	44,474,631	26,684,779	20.5	2006	3,602,000	106,086	2.9	13.5	0.4
Sweden	20	9,113,257	5,600,000	16.1	2007	2,534,236	17,499	0.7	45.3	0.3
UK	80	60,852,828	33,000,000	17.0	2006	577,000	103,000	17.9	1.7	0.3

Sources:  
 DGETREN – EU Directorate-General for Energy and Transport  
 ETSC – European Transport Safety Council  
 ERSO – European Road Safety Observatory  
 TISPOL – European Traffic Police Network

\* Alcohol-related deaths: The percentage of fatalities resulting from accidents involving at least one driver impaired by alcohol.

## **Annex M: Code of Practice for preliminary test**

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(Reproduced from original booklet – 2004)

*Department for*  
**Transport**

**CODE OF PRACTICE**

**FOR**

**PRELIMINARY IMPAIRMENT**

**TESTS**

## **A Code of Practice**

Issued by the Secretary of State for Transport under the power contained in Section 6B(2) Road Traffic Act 1988 (as amended by the Railways and Transport Safety Act 2003), and for the use of police officers trained and authorised to carry out Preliminary Impairment Tests.

December 2004

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## CODE OF PRACTICE

### ROAD TRAFFIC ACT 1988

#### Sections 3A, 4 and Section 6B as amended by the Railways and Transport Safety Act 2003

#### **1 Introduction**

1.1 The Road Traffic Act 1988 as amended by the Railways & Transport Safety Act 2003 requires the Secretary of State to issue a Code of Practice, (the Code) in respect of Preliminary Impairment Tests.

1.2 Section 6B(2) specifies that the Code deals with;

- the kind of task that may be specified for the purpose of a Preliminary Impairment Test;
- the kind of observation of physical state that may be made in the course of a Preliminary Impairment Test;
- the manner in which a Preliminary Impairment Test should be administered;  
and
- the inferences that may be drawn from the observations made in the course of a Preliminary Impairment Test.

In issuing or revising this Code the Secretary of State shall aim to ensure that a Preliminary Impairment Test is designed to indicate;

- whether a person is unfit to drive;  
and
- if he is, whether or not the unfitness is likely to be due to drink or drugs.

- 1.3 The Code includes provision about;
- approval by a Chief Officer and
  - training & qualification of police officers.

## 2 Approval by Chief Officer

- 2.1 A police officer administering a Preliminary Impairment Test under this Code must be approved for the purpose by the chief officer of the police force to which he belongs.  
(Section 6B (6) Road Traffic Act 1988)

## 3 Training and Qualification

- 3.1 Before being approved by his chief officer to administer preliminary impairment tests under this Code, a constable shall be qualified for the purpose by training and assessment in the use of Field Impairment Tests in accordance with the standard set in:

- BS EN ISO 9001: 2000 and
- The Quality Manual held by the Association of Chief Police Officers (ACPO) and the Association of Chief Police Officers Scotland (ACPOS).

- 3.2 In addition to being trained to administer the Field Impairment Tests, constables authorized to administer the tests will also be trained to a standard set down in the above BS EN ISO, to identify the signs and symptoms of drug influence.

- 3.3 Constables will be trained for the purpose only by instructors who have been approved for that purpose, in England and Wales by the Association of Chief Police Officers (ACPO) and, in Scotland by the Association of Chief Police Officers (Scotland) (ACPO(S)).

- 3.4 Chief officers will keep a record of officers trained and the date of approval and should issue to each officer a certificate of approval. The certificate will refer to Section 6B(6) Road Traffic Act 1988.

## 4 Administration of Preliminary Impairment Tests

- 4.1 A Constable administering a Preliminary Impairment Test shall have regard to this Code.

- 4.2 A Preliminary Impairment Test may be administered:

- at or near the place where the requirement to cooperate with the test is imposed, or
- if the constable who imposes the requirement thinks it expedient, at a police station specified by him.

## 5 Definition

A Preliminary Impairment Test may be a test of any type provided that it meets the requirements and objectives of the Act and is administered in accordance with a Code of Practice issued by the Secretary of State for the purpose. This Code of Practice deals solely with the use of Pupillary Examinations and Field Impairment Tests together as a Preliminary Impairment Test.

## 6 The Test Procedure

The Field Impairment Tests administered and the observations made shall be recorded on an appropriate form.

## 7 Pupillary Examination

7.1 Before a pupillary examination the constable shall instruct the subject to;

- look straight ahead
  - keep their eyes open
- and ascertain that:
- the person understands the instruction, and
  - whether contact lenses are being worn

7.2 The examination will be conducted using a gauge. The gauge will be held adjacent to the appropriate side of the subject's face to enable the constable, by a process of comparison, to estimate the sizes of the subject's pupils.

7.3 The constable may also record if the subject's eyes are 'watery' and/or whether the subject's eyes display 'reddening'.

## 8 The Modified Romberg Balance Test

8.1 The Modified Romberg Balance Test is an indicator of a person's internal clock and ability to balance.

8.2 Before a Modified Romberg Balance Test, a constable shall instruct the subject;

- to stand up straight with heels and toes together and with arms down by the side
- to maintain the position while the remaining instructions are given, and
- not to begin until told and

when further instructed;

- to tilt the head back slightly and then close their eyes (The constable may demonstrate the position required but without closing his/her eyes)
- to bring the head forward, open their eyes and say 'stop' when they think that 30 seconds have passed.

and ascertain;

- that the subject understands the instructions, and
- whether the subject has any disability or medical condition which he thinks might prevent participation in the test.

8.3 The constable will record whether the subject was able to balance while being instructed, whether the subject steps, sways and or raises their arms during the test and whether the subject's eyes were opened or head was lowered. The constable will also record the number of seconds that had elapsed when the subject said 'stop', and whether the subject was able to complete the test.

## 9 Walk and Turn Test

9.1 The walk and turn test is an exercise that enables assessment of whether a person is able to divide attention between walking, balancing and processing instructions.

9.2 Before a walk and turn test, a constable shall identify a line, avoiding the use of a kerb or anywhere the subject may fall, and shall instruct the subject;

- to place the left foot on the line
  - to place the right foot on the line in front of the left foot touching heel to toe (The constable may demonstrate the position)
  - to put the arms down by the side and keep them there throughout the test, and
  - to maintain the position while remaining instructions are given and ascertain;
  - whether the subject understands the instructions so far given
- The constable shall further instruct the subject that when he/she says 'start';
- to take nine heel to toe steps along the line
  - to ensure that on each step the heel of the front foot is placed against the toe of the other foot (The constable may demonstrate the instructions so far given)
  - after nine steps have been taken, to leave the front foot on the line and turn around using a series of small steps with the other foot
  - after turning, to take another nine heel to toe steps back along the line
  - to watch the feet at all times during the test
  - to count each step out loud
  - having once started, not to stop until the test is complete
- (The constable should demonstrate the complete test)
- and ascertain;
- whether the subject has understood the remaining instructions,

and

- whether the subject has any disability or medical condition which he thinks might prevent participation in the test.
- 9.3 The constable will record whether the subject was able to stand still while being instructed, whether the subject started too soon, whether the subject turned correctly, any occasions when the subject stopped walking, missed heel to toe connection, stepped off line, or raised their arms. The constable will also record whether the steps were correctly counted. The point of any deviation from the straight line during the course of the test will additionally be marked on a diagram on the appropriate form.

## **10** **One Leg Stand**

- 10.1 The one leg stand test is a task including balance and counting out loud.
- 10.2 Before a one leg stand test, a constable shall instruct the person;
- to stand with their heels and toes together and their arms down by their sides
  - to maintain the position while receiving the remaining instructions, and
  - not to begin until told to
- and ascertain;
- whether the subject understands the instructions so far given
- The constable shall further instruct the subject that when he/she says 'start';
- to raise the right foot 6 to 8 inches or 15 to 20 centimetres off the ground

- to keep the elevated leg straight with the toes pointing forward and the foot parallel with the ground
  - to keep the arms down by the side, and
  - to keep looking at the elevated foot throughout the test and whilst doing so, to count out aloud 'one thousand and one, one thousand and two, one thousand and three' and so on progressively until told to stop
  - and ascertain;
  - whether the subject has understood the remaining instructions
  - whether the subject has any disability or medical condition which he thinks might prevent participation in the test.
- 10.3 The officer will instruct the subject to undertake the test using each foot in turn. The instructions need not be repeated for the second foot but they may be.
- 10.4 The constable will record over a timed period of 30 seconds, for each foot, any instances where the subject sways, hops, puts a foot down or raises the arms, together with the point of the test at which it occurred.

## **11** Finger to Nose Test

- 11.1 The finger to nose test is a test of depth perception and balance.
- 11.2 Before a finger to nose test, a constable shall instruct the subject;
- to stand with feet together and whilst doing so
  - to extend both arms out in front, palms side uppermost, with the fist closed and the index finger of each hand extended (The constable should demonstrate the position)

- to maintain the position while the remaining instructions are given
- not to begin until told to
- when told to start, to tilt the head back slightly and then close the eyes (The constable may demonstrate the position)
- when told which hand to move, to touch the tip of the nose with the tip of the index finger of that hand and then having done so,
- to lower the hand (The constable may demonstrate the required action)
- and ascertain;
- that the subject understands the instructions so far given, and
- whether the subject has any disability or medical condition which he thinks might prevent participation in the test.

11.3 The constable shall call out the order of the hands to be used as follows, Left, Right, Left, Right, Right, Left.

11.4 The constable will record any instance during the test when the subject steps, sways or raises an arm, and whether the correct hand was used. The constable will record any occasions when the subject touched a part of the face other than the tip of the nose, and whereabouts.

## **12** **Additional Notes**

12.1 A constable administering Field Impairment Tests will record any additional notes about a subject's behaviour, physical or mental state, or other relevant observations.

### 13 Safety and Site Conditions

- 13.1 The constable administering Field Impairment Tests must consider the safety of the subject at all times.
- 13.2 The location chosen for the tests should, whenever possible, have a hard, level, non-slippery surface, and be in a well lit, unobstructed area, away from public gaze and in appropriate weather conditions. Whenever it is not possible to achieve all or any of these, the constable conducting the tests should consider, either requiring the test to be conducted at another nearby location or at a police station, or make appropriate allowances in interpreting the observation of the tests.
- 13.3 If the subject is wearing footwear that may affect performance of the tests, the subject should be given the opportunity to remove that footwear.
- 13.4 The constable should not close his/her eyes when demonstrating any test in which the subject is required to close the eyes. The constable should also stand away from the subject and remain stationary while the test is being undertaken as movement may be a distraction for the subject.

### 14 Disabilities, Injuries and Illness

- 14.1 Constables administering Field Impairment Tests must be aware of and record any disability, injury or illness, whether physical or mental, which may affect performance of a test. Being obese or elderly may also affect performance of the tests and must be recorded.
- 14.2 A constable administering Field Impairment Tests whenever any of the above is evident or claimed may nevertheless, if they wish, continue with the requirement to cooperate with the test. However, in such circumstances, the constable must be particularly mindful of the possible effect on performance of the tests when interpreting the

observations made. In such circumstances, a constable may consider Field Impairment Tests as a Preliminary Impairment Test inappropriate or impractical.

*A Preliminary Impairment Test is not a prerequisite of any arrest or an essential element in any prosecution.*

### 15 Inferences

- 15.1 It is not possible to 'pass' or 'fail' all or any one of the tests. There is no benchmark for pass or failure, nor is there any scoring system to indicate relative success.
- 15.2 The constable shall record their observations of the pupillary examination and of the subject's performance during each test.
- 15.3 It is the intention that, at the conclusion of the tests, the constable shall be able to form an overall opinion, considering together what they know of the subject's driving, their demeanour and anything learned in general conversation or observation, together with the subject's performance during the tests and the observation of the pupillary examination, whether the person is impaired to drive a motor vehicle through drink or drugs. The constable may decide, from all of this information, whether there is sufficient evidence to arrest the subject for an offence contrary to sections 3A or 4 Road Traffic Act 1988.
- 15.4 The pupillary examination and the series of tests will be considered a useful indicator whether a person is impaired to drive and whether that impairment might be due to drink or drugs.
- 15.5 Prior to requiring a Preliminary Impairment Test, it is vital that there must be suspicion that the suspect is impaired to drive. Such suspicion will be obtained in various ways, including the manner of driving, and/or signs and symptoms of drug use observed by witnesses. The observations of the signs and symptoms are of paramount importance in the absence of evidence of a suspect's manner of driving.

- 15.6 If driving is witnessed, by whoever, the manner and nature of that driving is vitally important and should always be taken into account. In cases of 'attempting to drive' or 'being in charge' or following a collision where evidence of driving may be minimal, if available at all, the greatest care must be exercised to ensure that there is sufficient evidence that a person was 'unfit to drive' at the time of the offence. Such evidence should include observations of a suspect's physical state prior to and during participation in Field Impairment Tests.
- 15.7 The evidence obtained from Field Impairment Tests will enhance the information available to a court about the physical state of a suspect at the time of testing.

# Annex N: Police forms MG DD/E and MG DD/F

## MG DD/E form

E	<b>DRUG SAMPLE INFORMATION FORM</b>	<b>Form MG DD/E Version 3.1/Aug 2002</b>
<b>E3</b>	<b><u>LABORATORY INFORMATION</u></b>	
	<b>Case Submission Details for the FSS in lieu of Form MGFSS</b>	
	All submissions must be authorised for payment: Signature <span style="float: right;">Position</span>	
	This submission is:    URGENT <input type="checkbox"/> CRITICAL <input type="checkbox"/> STANDARD <input type="checkbox"/>	
	<b>Please inform the laboratory of any change in status</b> In addition to the authority above, every URGENT and CRITICAL submission must be authorised by an Inspector or above and a reason given	
	Authorising Signature	Print Name
	Reason	
	Method of delivery to laboratory – By Hand / Registered Post / Recorded Delivery / Courier	
	Security Seal No.	Registered Post/Recorded Delivery No
	Delivered by: Signature Print Name If there have been previous submissions give Lab Ref:	Received at laboratory by: Signature Print Name Date
	Date statement required in Urgent and Critical cases only	
<b>E4</b>	<b><u>INFORMATION REQUIRED IN DRUGS DRIVING CASES</u></b>	
	Before the specimen was requested, did a doctor give a clear oral statement that he believed drugs might have contributed to the subject's condition?	
		*YES/NO
	Was a screening breath test given?	
		*YES/NO
	Time:..... hours    Result: * PASS / WARN / FAIL / REFUSED	
	Was an evidential breath test undertaken?	
		*YES/NO
	Time:..... hours    Result: .....	
<b>E5</b>	<b><u>FURTHER INFORMATION REQUIRED</u></b>	
	What evidence is there that the subject might have been impaired by drugs?	
	.....	
	.....	
	Are drugs or medicines being taken as part of any medical or dental treatment?	
		*YES/NO
	If YES please give details .....	
	.....	
	.....	
	* Delete as Applicable	
	2	



**E**

**DRUG SAMPLE  
INFORMATION FORM**

**Form MG DD/E  
Version 3.1/Aug 2002**

Has the subject taken any drugs or alcohol in the last 24 hours? **\*YES/NO**

If **YES** please give details .....

.....

Has the subject taken any drugs or alcohol AFTER the incident? **\*YES/NO**

If **YES** please give details .....

.....

Were any drugs found in the subject's possession (or in his/her vehicle)?

**\*YES/NO**

If **YES** please give details .....

.....

Is the subject (i) a known drugs user or solvent sniffer? **\*YES/NO**

(ii) a registered drug addict? **\*YES/NO**

If **YES** please give details .....

.....

Please circle any of the following symptoms that apply:

- |                       |                                   |                |
|-----------------------|-----------------------------------|----------------|
| Diarrhoea             | Convulsions                       | Hallucinations |
| Eye Pupils Contracted | Vomiting                          | Shivering      |
| Delirium              | Eye Pupils Dilated                | Constipation   |
| Jaundice              | Drowsiness                        | Bloodshot Eyes |
| Thirst                | Sweating                          | Violence       |
| Hyperactivity         | Blue Tinge to the Skin (Cyanosis) |                |

(This information may help the search for drugs in the submitted samples.)

Any other observations .....

.....

.....

**E6 DRUG SUSPECTED**

Is any particular drug suspected? **\*YES/NO**

If **YES** - what drug? .....

.....

**E7 PERSON COMPLETING FORM**

Full name (BLOCK Capitals): .....

\* Delete as Applicable



# F

## F4 PUPILLARY EXAMINATION

"I am going to examine the size of your pupils, comparing them to this gauge, which I will hold up to the side of your face. All I require you to do is look straight ahead and keep your eyes open wide".

"Do you understand?" ..... \*YES / NO      "Are you wearing Contact Lenses?" ..... \*YES / NO  
**PUPIL SIZE LEFT**       mm      **WATERY** ..... \*YES / NO  
**PUPIL SIZE RIGHT**       mm      **REDDENING** ..... \*YES / NO

A pupil size: 1.0 – 2.5 (inclusive) normally indicates *constriction*. 7.0 – 9.0 (inclusive) normally indicates *dilation*

**Additional Comments** .....

## F5 MODIFIED ROMBERG BALANCE TEST

"Stand up straight with your heels and toes together and your arms down by your sides. Maintain that position while I give you the remaining instructions. Do not begin until I tell you. When I tell you, tilt your head back slightly, close your eyes (*demonstrate but do not close your eyes*). When you think 30 seconds has passed, bring your head forward, open your eyes and say 'Stop'".

"Do you understand?" ..... \*YES / NO

"Do you have any disability or medical condition that prevents you from participating in this test?"

**REPLY** .....

**ABLE TO BALANCE DURING INSTRUCTIONS** ..... \*YES / NO

**IF NO** ..... **STEPS**  **SWAYS**  **RAISES ARMS**

**COMPLIES WITH INSTRUCTIONS** ..... \*YES / NO

IF NO, record time in seconds	EYES OPEN	HEAD RAISED	STEPS	SWAYS	RAISED ARMS
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**ESTIMATES 30 SECONDS AT**  **SECONDS**      "How long was that?" **REPLY** .....

## F6 WALK AND TURN TEST (Identify a real or imaginary line. Do not use a kerb or anywhere the subject may fall)

"Place your left foot on the line. Place your right foot on the line in front of your left touching heel to toe (*demonstrate*) Put your arms down at your sides and keep them there throughout the test. Maintain that position while I give you the remaining instructions".

"Do you understand?" ..... \*YES / NO

"When I say start, you must take nine heel to toe steps along the line. On each step the heel of the foot must be placed against the toe of the other foot (*demonstrate*). When the ninth step has been taken, you must leave the front foot on the line and turn around using a series of small steps with the other foot. After turning you must take another nine heel to toe steps along the line. During the test you must watch your feet at all times and count each step out loud. Once you start walking do not stop until you have completed the test". (*demonstrate complete test*)

"Do you understand?" ..... \*YES / NO

"Do you have any disability or medical condition that prevents you from participating in this test?"

**REPLY** .....

\* Delete as applicable

# F

Form MG DD/F  
Version 5.2 Dec 2004

ABLE TO BALANCE DURING INSTRUCTIONS ..... \*YES / NO

IF NO: ..... STEPS  SWAYS  RAISES ARMS  STARTS TOO SOON

COMPLIED WITH INSTRUCTIONS ..... \*YES / NO

IF NO: .....

Any deviation from the instructions should be indicated as below and on the diagram above

STOPS WALKING  1 MISS HEEL/TOE  2 RAISES ARMS  3 STEPS OFF LINE  4

CORRECT TURN ..... \*YES / NO

IF NO: STATE REASON .....

COUNTS OUT LOUD ..... \*YES / NO CORRECT STEP COUNT ..... \*YES / NO

IF NO: ..... TO TURN  FROM TURN

Additional Comments:  
.....  
.....  
.....

## F7 ONE LEG STAND TEST

"Stand with your feet together and your arms down by your sides (*demonstrate*). Maintain that position while I give you the remaining instructions. Do not begin until I tell you."

"Do you understand?" ..... \*YES/NO

"When I tell you to you must raise your right foot 6 to 8 inches (or 15 to 20 cms) off the ground, keeping your leg straight and your toes pointing forward, with your foot parallel to the ground (*demonstrate*). You must keep your arms down by your sides and keep looking at your raised foot while counting out loud in the following manner, 'one thousand and one, one thousand and two' and so on until I tell you to stop."


"Do you understand?" ..... \*YES/NO

"Do you have any disability or medical condition that prevents you from participating in this test?"

REPLY .....

Repeat procedure with each foot

\* Delete as applicable

F	Form MG DD/F Version 5.2 Dec 2004																								
<b>ABLE TO BALANCE DURING INSTRUCTIONS</b> ..... *YES / NO IF NO: .....    STEPS <input type="checkbox"/> SWAYS <input type="checkbox"/> RAISES ARMS <input type="checkbox"/>																									
<b>COMPLIES WITH INSTRUCTIONS</b> ..... *YES / NO IF NO: ....																									
<b>LEFT LEG</b> TIME (secs)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">SWAYS</td> <td style="width: 25%; text-align: center;">HOPS</td> <td style="width: 25%; text-align: center;">PUTS FOOT DOWN</td> <td style="width: 25%; text-align: center;">RAISES ARMS</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> </tr> </table>	SWAYS	HOPS	PUTS FOOT DOWN	RAISES ARMS																				
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<b>RIGHT LEG</b> TIME (secs)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">SWAYS</td> <td style="width: 25%; text-align: center;">HOPS</td> <td style="width: 25%; text-align: center;">PUTS FOOT DOWN</td> <td style="width: 25%; text-align: center;">RAISES ARMS</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> </tr> </table>	SWAYS	HOPS	PUTS FOOT DOWN	RAISES ARMS																				
SWAYS	HOPS	PUTS FOOT DOWN	RAISES ARMS																						
<b>COUNTED CORRECTLY</b> ..... *YES / NO																									
<b>Additional Comments:</b> ..... ..... .....																									
<b>F8    <u>FINGER AND NOSE TEST</u></b>																									
<i>"Stand with your feet together and your arms in this position. (demonstrate extending both hands out in front, palms side up and closed with the index finger of both hands extended). Maintain that position while I give you the remaining instructions. Do not begin until I tell you. When I tell you, you must tilt your head back slightly and close your eyes. (demonstrate) When I tell you which hand to move, you must touch the tip of your nose with the tip of that finger and lower your hand once you have done so (demonstrate).</i>																									
"Do you understand?" ..... *YES/NO "Do you have any disability or medical condition that prevents you from participating in this test?"																									
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Call out the hands in the following order, left, right, left, right, right, left.																									
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<b>F9    SIGNATURES</b> ..... Authorised Officer Conducting Test ..... Officer Completing Form (If different)																									
<b>F10    OVERALL ASSESSMENT:</b> SUBJECT - *IMPAIRED / NOT IMPAIRED * Delete as applicable																									