Department for Transport

Enforcement Procedures against Drink Drivers and Other Offenders – A Consultation Document

Proposed Changes in Legislation for Testing Procedures for Drink and Drug Driving and in Other Transport Sectors and for Remedial Training for Road Traffic Offenders

November 2012

Contents

Executive summary

1.1 This consultation encompasses the legislative changes the Government proposed in its response of March 2011 to the reports by Sir Peter North[1] and the Transport Select Committee[2] on drink and drug driving ("the Government's response")[3]. The changes covered in this consultation do not, however, include creating a new offence related to driving with a specified impairing drug in the body, which is also being progressed by the Government.

1.2 The proposed legislative changes relate to Great Britain (and not to Northern Ireland) and will be implemented subject to the outcome of this consultation and the securing of legislative time. The proposals are consistent with the devolution of the drink drive limit in Scotland, through the Scotland Act 2012.

1.3 The consultation seeks views about proceeding with:

a. the withdrawal of the 'statutory option';

b. changes as to when preliminary breath tests are needed;

c. changes to the testing procedures in hospital;

d. changes to who can assess whether someone is under the influence of drugs; and

e. amendments to the regimes for aviation, rail and shipping which mirror the road regime.

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[1] Report of the Review of Drink and Drug Driving Law: Sir Peter North CBE, QC (June 2010) http://webarchive.nationalarchives.gov.uk/20100921035225/http://northreview.independent.gov.uk/docs/NorthReview-Report.pdf

[2] Report of the Transport Select Committee: Drink and Drug Driving Law (November 2010) http://www.publications.parliament.uk/pa/cm201011/cmselect/cmtran/460/46002.htm

[3] The Government's Response to the Reports by Sir Peter North CBE QC and the Transport Select Committee on Drink and Drug Driving: Command Paper 8050 (March 2011) at: http://www.official-documents.gov.uk/document/cm80/8050/8050.pdf

1.4 ‘Statutory option’: This consultation seeks views about the withdrawal of the right people have to replace their breath alcohol specimens with either a specimen of blood or specimens of urine in cases where the lower of the two breath readings provided does not exceed 50 microgrammes (mcg) of alcohol per 100 millilitres (ml) of breath (i.e. the ‘statutory option’).

1.5 Preliminary breath tests: The consultation seeks views about removing the requirement for preliminary testing where evidential testing is undertaken away from a police station. This would mean that a preliminary breath test would not to have to be taken in addition to two evidential breath tests, when mobile evidential breath testing devices are used away from a police station. At the moment there are no mobile, evidential breath testing devices type approved for use by the police. However such devices may be type approved and available for use within the next two years.

1.6 Testing procedures in hospitals: The consultation also seeks views about streamlining the procedure for testing drink drivers and drug impaired drivers in hospital so that a wider range of registered healthcare professionals are allowed to take evidential blood specimens. This would make it consistent with other policing provisions.

1.7 Opinion on whether a driver may have condition due to a drug prior to evidential testing: The Department has contacted certain stakeholders about a further proposal to also allow registered healthcare professionals to form this opinion of suspected drug drivers. Currently, under the Road Traffic Act (1988) only doctors are able to do this. This consultation also invites anyone else to comment about this proposal.

1.8 Amendments to the Regimes for Rail, Maritime and Aviation: The legislative changes would apply to the Road Traffic Act 1988. This Act or other parallel legislative provisions, apply similar measures to the drink drive offence to railways, shipping and aviation. The consultation seeks views about whether any changes here should also apply to these other transport sectors.

1.9 The consultation document also outlines the possible scope for further research related to the legislation and processes for court imposed reassessments of banned dangerous drivers necessary for

them to regain their licences and for new drivers who are disqualified having reached six penalty points. The research would offer the possibility of an evidence base for longer term policy development.

1.10 This document also seeks views about the way forward on three as yet un-commenced legislative provisions in the Road Safety Act 2006 relating to the training and punishment of certain road traffic offenders.

How to respond

2.1 The consultation period began on 22 November and will run until 2 January. Please ensure that your response reaches us before the closing date. If you would like further copies of this consultation document, it can be found at https://www.gov.uk/government/publications or you can contact Nehal Thakore if you would like alternative formats (Braille, audio CD, etc).

2.2 Please send consultation responses to

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Road User Licensing Insurance and Safety
Zone 3/19
Great Minster House
33 Horseferry Road
London SW1P 4DR
020 7944 5113
Roadsafetyenforcement@dft.gsi.gov.uk

2.3 When responding, please state whether you are responding as an individual or representing the views of an organisation. If responding on behalf of a larger organisation, please make it clear who the organisation represents and, where applicable, how the views of members were assembled.

2.4 Information provided in response to this consultation, including personal information, may be subject to publication or disclosure in accordance with the Freedom of Information Act 2000 (FOIA) or the Environmental Information Regulations 2004.

2.5 If you want information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence.

2.6 In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we

receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

2.7 The Department will process your personal data in accordance with the Data Protection Act (DPA) and in the majority of circumstances this will mean that your personal data will not be disclosed to third parties.

Drink Driving in Great Britain

Summary of key statistics

3.1 In 1967[4], nearly a quarter (22.4%) of road fatalities was associated with drink driving – that is an estimated 1,640 out of a total of 7,319. In just under forty-five years the number of fatalities has fallen to 280 in 2011[5], a decrease of 26% from 2009 and 83% lower than 1979. There are still very many drink drive **casualties** – with an estimated total of virtually 10,000 in 2011. Fatalities resulting from drink driving collisions still account for 15 per cent of all road fatalities.

3.2 Drink drive injuries represent a far smaller proportion of all road injuries than the corresponding proportions of fatalities. Nevertheless, in 2011, 1,290 reported serious injuries and 8,430 slight injuries occurred when someone was driving whilst over the legal alcohol limit.

3.3 The numbers of drink drive related casualties increased by 3% from 9,700 in 2010 to 9,990. Drink drive fatalities increased by 12 per cent from 250 in 2010 to 280 in 2011. However, although the 2011 fatality figure is almost one sixth of what the equivalent 1979 figure was (1,640), it is still the case that more than 50,000 drink drive offenders are convicted each year.

Analysis of reported drink drive data

3.4 Provisional figures show that in 2011 there were 6,730 reported personal injury road collisions involving at least one driver/rider over the legal alcohol limit, of which 260 were fatal incidents. Serious injury incidents reported increased by 5 percent from 990 in 2010 to 1,040 in 2011, whilst slight injury incidents increased from 5420 to 5,430.

[4] See page 56 of the North Report.
[5] Estimates of the number of accidents and casualties involving illegal alcohol levels are available from Department for Transport at http://www.dft.gov.uk/statistics/series/road-accidents-and-safety/ . The Reported Road Casualties Great Britain annual report includes an analysis of drinking and driving.

3.5 Table RAS51001 below shows the trend in the numbers of people that are killed and seriously injured (KSI) in crashes that involve illegal alcohol levels in Great Britain. Until 2011, there had been a downward trend in the number of KSIs. The recent increases in drink drive casualties and collisions mirrors the 2011 figures for all collisions. This showed an increase of 2 per cent in KSI casualties across all road collisions; serious injuries were up by 2 per cent and fatalities by 3 per cent.

3.6 Sustained periods of very poor winter weather in 2010, both at the beginning and the end of the year, reduced vehicle travel and encouraged more cautious driving and is a likely factor in the higher levels for both all road casualties and drink drive casualties in 2011 compared to 2010. The 2011 figures still being a significant improvement on 2009.

Table RAS51001: Estimated number of reported drink drive accidents and casualties: GB 2001 - 2011

Number

	Accidents				Casualties			
Year	Fatal	Serious	Slight	Total	Killed	Serious	Slight	Total
2001	470	2020	9780	12270	530	2700	15550	18780
2002	480	2,050	10,620	13,150	550	2,790	16,760	20,100
2003	500	1,970	9,930	12,400	580	2,590	15,820	18,990
2004	520	1,790	8,900	11,210	580	2,340	14,060	16,980
2005	470	1,540	8,060	10,070	550	2,090	12,760	15,400
2006	490	1,480	7,430	9,400	560	1,970	11,840	14,370
2007	370	1,400	7,520	9,280	410	1,760	11,850	14,020
2008	350	1,280	6,980	8,620	400	1,620	10,960	12,990
2009	340	1,180	6,530	8,050	380	1,490	10,150	12,030
2010	220	990	5,420	6,630	250	1,250	8,210	9,700
2011 [p]	260	1,040	5,430	6,730	280	1,290	8,430	9,990

[P] Provisional data. The sample of fatality data from Coroners for 2010 has now been finalised but 2011 estimates are based on a reduced sample of coroners' returns and may be biased. They remain provisional until more complete information for 2010 is available.

3.7 Table RAS51001 shows:

- An increase in the total number of drink driving collisions, which rose by 2 per cent from 6,630 in 2010 to 6,730 in 2011. However the 2011 figure represented a drop of 65 per cent since 1979.
- Seriously injured casualties increased by 3 per cent from 2010 to 1,290. This compares to a figure of 8,300 in 1979.

- Slightly injured casualties increased by 3 per cent from 2010, almost one third of what the 1979 was (21,490).

3.8 Whilst there has been a welcome reduction in the number of overall drink-drive related fatalities and serious injuries in the last forty years, it is still the case that over 1,500 are killed or seriously injured annually.

The People Who are Drinking[6] and Driving

3.9 People aged 60 years or over had the highest proportion of killed drivers/riders with no alcohol present in their blood[7] (89 per cent) and the lowest portion killed over the limit (6 per cent). Conversely, 25-29 year olds had the lowest proportion of killed drivers with no alcohol present (54 per cent) but the highest proportion of killed drivers/riders over the legal alcohol limit (35 per cent).

3.10 Those aged between 20 - 24 had the second highest proportion of all killed drivers who were over the legal alcohol limit (30 per cent) and the highest proportion for blood levels over twice the legal alcohol limit (24 per cent), followed by those aged 25 -29 (22 per cent). In contrast people over 60 had the lowest proportion for blood levels twice over the legal limit (4 percent).

3.11 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. They are up to fives times more likely to be at least twice over the limit.

3.12 Table RAS51010, below, shows that in both 2000 and 2010 of all car drivers, those aged under thirty had the most drink drive accidents. Young car drivers (aged 17-24) had more drink drive accidents per 100 thousand licence holders and per billion miles driven than any other age group. Car drivers aged 60 years old and over had the least. In all age groups, there was a reduction of almost a half from 2000-2010 in both the numbers and rates of drink drive accidents.

[6] http://assets.dft.gov.uk/statistics/releases/road-accidents-and-safety-annual-report-2011/rrcgb2011-03.pdf
[7] Department for Transport, Reported Road Casualties Great Britain, - see http://assets.dft.gov.uk/statistics/tables/ras51007.xls

Table RAS51010: Estimated number of car drivers in drink drive road injury accidents: accidents per licence holder and per mile driven: GB 1999 and 2010

	Car driver drink drive accidents		Drink drive accidents per 100 thousand licence holders		Drink drive accidents per billion miles driven	
	2000	2010	2000 [1]	2010	2000 [1]	2010
Under 17	80	10	..	..	..	..
17 - 19[2]	1,060	500	76	32	326	121
20 - 24	2,150	1,370	76	42	156	118
25 - 29	1,790	1,010	52	30	77	52
30 - 34	1,480	720	37	22	50	33
35 - 39	1,180	600	35	16	38	20
40 - 49	1,430	920	21	12	25	14
50 - 59	750	470	13	7	17	9
60 or over	360	300	5	3	11	6
All ages [3]	10,440	5,970	30	15	44	24

Table RAS51009: Blood alcohol levels of reported fatalities aged 16 and over: GB 2010

	Cumulative percentage over blood alcohol levels milligrammes (mg) /100ml							Percentage over 80mg/100ml time of accident	
	Below limit		Above limit				Sample	22:00-03:59	04:00-21:59
	9	50	80	100	150	200	size		
Motorcycle riders	19	10	**8**	7	7	4	270	43	6
Car drivers	29	24	**23**	21	15	6	389	58	13
Other vehicle drivers/riders	26	18	**18**	18	13	8	39	18	18
Passengers	36	32	**29**	21	10	5	97	44	19
Pedestrians	49	44	**43**	41	34	27	176	70	25
Cyclists	23	17	**13**	12	6	4	52	71	4

3.13 Table RAS51009 shows that:

- Over half of car drivers killed between 10 pm and 4 am were over the limit.

- Over two thirds of pedestrians killed between 10 pm and 4 am were over the legal limit for drivers.

- Over two thirds of cyclists killed between 10 pm and 4 pm were over the legal limit; however this equates to only 5 out of the 7 fatalities where a cyclist, aged 16 or over, was involved in a road accident between 10pm and 4am. This can be compared to the 74 pedal cyclists in total, aged 16 or over, killed in 2010.

The Prescribed Drink Drive Limit

3.14 The Department's strategy is to focus resources and any legislative changes on measures which will have the most impact in reducing dangerous behaviours. Lowering the drink-drive limit would be inconsistent with that approach and would result in some practical difficulties. These include, for example, the calibration of equipment, the time and cost of providing training and guidance to officers and the determination of appropriate penalties. Our advice is not to drink and drive, but changing the prescribed limit would raise questions and concerns about how many drinks could be consumed prior to driving.

3.15 Section 2[8] of the Government's response to the North review outlines its position about the prescribed limit for alcohol.

3.16 The prescribed drink drive limit can be measured through alcohol concentrations in blood, urine or breath. In all cases the concentration is measured in terms of a weight of alcohol per volume of blood, breath or urine. The weight units are expressed in legislation as milligrammes (mg) (one thousandths of grammes) in blood and urine and microgrammes (mcg) (one millionths of grammes) in breath. The volume units are expressed in 100 millilitres (100ml) (with a millilitre being one thousandth of a litre).

[8] The Government's Response to the Reports by Sir Peter North CBE QC and the Transport Select Committee on Drink and Drug Driving: Command Paper 8050 (March 2011) at: http://www.official-documents.gov.uk/document/cm80/8050/8050.pdf

The Statutory Option

Evidential Specimens

4.1 Evidential specimens for alcohol in relation to road traffic offences can be of breath, blood or urine. The evidential specimen required of suspects must be a specimen of breath except where one of several specific circumstances exist. These exceptions are broadly:

a. when a police officer has reasonable cause to believe a breath specimen cannot be taken for medical reasons;

b. when a reliable breath testing device is not available; and

c. when a police officer has reasonable cause to believe a breath testing device has not produced a reliable reading.

4.2 Therefore the vast majority of evidential specimens are of breath. Where breath is used, two evidential specimens are required. The evidential breath specimen with the lower proportion of alcohol is used and the other one disregarded.

4.3 No change to any of these provisions is being proposed in this consultation.

Description of the Statutory Option

4.4 The ‘statutory option’ provides people with the right to replace their breath alcohol specimens with either a specimen of blood or specimens of urine in cases where the lower of the two breath readings provided is not more than 50 mcg of alcohol per 100 ml of breath.

4.5 It is this provision which this consultation proposes to repeal. This would involve the repeal of sections 8(2), 8(2A), and 8(3) of the Road Traffic Act 1988 (RTA) and making a number of consequential amendments including to section 8(1) RTA.

Origins of the Statutory Option

4.6 Breath tests had been allowed for screening but not for evidential tests in 1967 legislation. The legislative provision to enable evidential breath testing was introduced in 1981, with devices being used soon afterwards.

4.7 At the time of the 1981 legislation, breath test machines had not been used on an evidential basis in Britain. There were concerns about their reliability and there had been challenges in court about the use of breath test machines as screening devices.

Current Operation of the Statutory Option

4.8 For around 30 years, there has been extensive use and development of evidential breath testing machines, which have been used following robust and revised type approval processes. We therefore consider that the concerns about reliability and challenges to evidential breath test results no longer justify the retention of the statutory option.

4.9 Indeed a recent survey, taken in a police force area[9] where all major custody centres have resident healthcare professionals indicated that virtually all statutory option cases resulted in a positive blood or urine specimen.

4.10 However, where a police custody centre does not have a resident healthcare professional and therefore the specimen of blood cannot be taken at effectively the same time as breath was provided, there may be a negative statutory option result due to delays in taking the specimen. There are two phases for the behaviour of alcohol in the body: absorption (when the alcohol concentration will be increasing) and elimination (when the alcohol concentration will be decreasing). It is likely that most drivers arrested for drink driving will be in the elimination phase during any period of time between the provision of breath and (in instances where there is a not a resident healthcare professional) the arrival of a doctor to take any blood specimen.

4.11 During that time, some of the suspects who have provided breath specimens where the lower reading does not exceed 50 mcg of alcohol /100ml of breath and are therefore eligible for the ‘statutory

[9] 2012 survey courtesy of Devon and Cornwall Police

option' will have sufficient alcohol eliminated naturally from their bodies to pass the further evidential test. Indeed research prior to the North review (and done prior to the routine establishment of resident healthcare professionals) indicated that about a quarter of statutory option tests[10] resulted in blood or urine specimens below the prescribed limit. Almost invariably these tests relate to people who would also have been in excess of the prescribed limit had a blood (or urine) specimen been taken at the time of their evidential breath test.

Costs and Benefits

4.12 The statutory option is also increasing costs for the police in investigations whether or not suspects then fail their subsequent blood or urine test. A recent survey[11] indicated that whilst only about a half of those eligible opted for a statutory option test, this nonetheless amounted to about 8% of people arrested for drink-driving opting for it. This results in significant extra policing costs.

4.13 Removing the statutory option would mean a number of offences would be committed in future, with proceedings and punishments following. This is because positive evidential breath tests would not be replaced by negative blood or urine tests. The volume of these offences will be small where resident healthcare professionals at police custody centres are already available, but they will nonetheless have some effects on court, probation and legal aid costs.

4.14 The impact assessment (which will be published shortly) summarises some of the effects of withdrawing the statutory option, including to the costs borne by the police and the criminal justice system. It includes a range of forecasts about future activity rates. Enforcement may for example remain at 2011 levels long term, or it is possible that it may decrease at a rate consistent with the projected reduction in road deaths and serious injuries (including attributable to drink driving).

4.15 The impact assessment also includes central, low and high scenarios which assume different proportions of statutory options returning negative results. This has been done to account for the fact that there is no national database from which to determine

[10] North Review paragraph 4.56
[11] 2012 survey courtesy of Devon and Cornwall Police

precisely the use of resident healthcare professionals in police stations nationwish and therefore accurately estimate the possibility for delays in obtaining blood tests.

4.16 Without resident healthcare professionals, figures suggest that the statutory option removes up to 25% of those tested (and who are within the boundary of the statutory option) from court proceedings[12], whereas it would be very few cases with resident healthcare professionals. A range of 2% to 25%, with a central point of 10% of statutory option tests leading to negative blood or urine specimen, has therefore been used in the analysis.

Roadside Evidential Breath Tests

4.17 The police cost savings associated with the withdrawal of the statutory option have been estimated on the basis that all evidential breath tests will continue to be done in police stations. However the legislation is already in place to allow evidential breath testing (as well as screening breath tests) to be done outside police stations, including at the roadside. In these instances the savings achieved by the removal of the statutory option would be even greater.

4.18 A Home Office type approval process for mobile evidential breath testing equipment is planned to conclude in 2014. If devices achieve type approval, mobile evidential breath testing will offer significant opportunities for improving the manner, timeliness and the efficiency with which police deal with offenders in some circumstances.

4.19 These benefits would be significantly undermined and compromised by the continuation of the statutory option. Statutory option tests would require some offenders to be taken to police stations and then tested, when they could otherwise have been dealt with at the roadside. Mobile evidential breath tests may be particularly useful at hospitals and in localities remote from major custody centres. The retention of the statutory option would compromise efficiency gains in these circumstances in particular.

4.20 This larger difference in police costs between retaining and withdrawing the statutory option, when there is mobile evidential breath testing equipment available compared to now, has not been

[12] Comparison of figures in North review paragraph 4.56 and MoJ 2009 crime and justice statistics

quantified in the impact assessment. However the extra costs would be significant where mobile evidential breath testing equipment is deployed and they may also reduce the uptake of such equipment.

Conclusion

4.21 The Department therefore proposes to withdraw the statutory option in order:

a. to make the application of the drink driving law fairer to suspects, regardless of how they are tested and their knowledge of the law;

b. to ensure that people who are driving above the prescribed limits for drink are prosecuted successfully;

c. to increase the efficiency and effectiveness of enforcement activity using current equipment;

d. to increase the efficiency and effectiveness of enforcement activity using mobile evidential breath testing equipment; and

e. to contribute towards more credible and effective drink driving law.

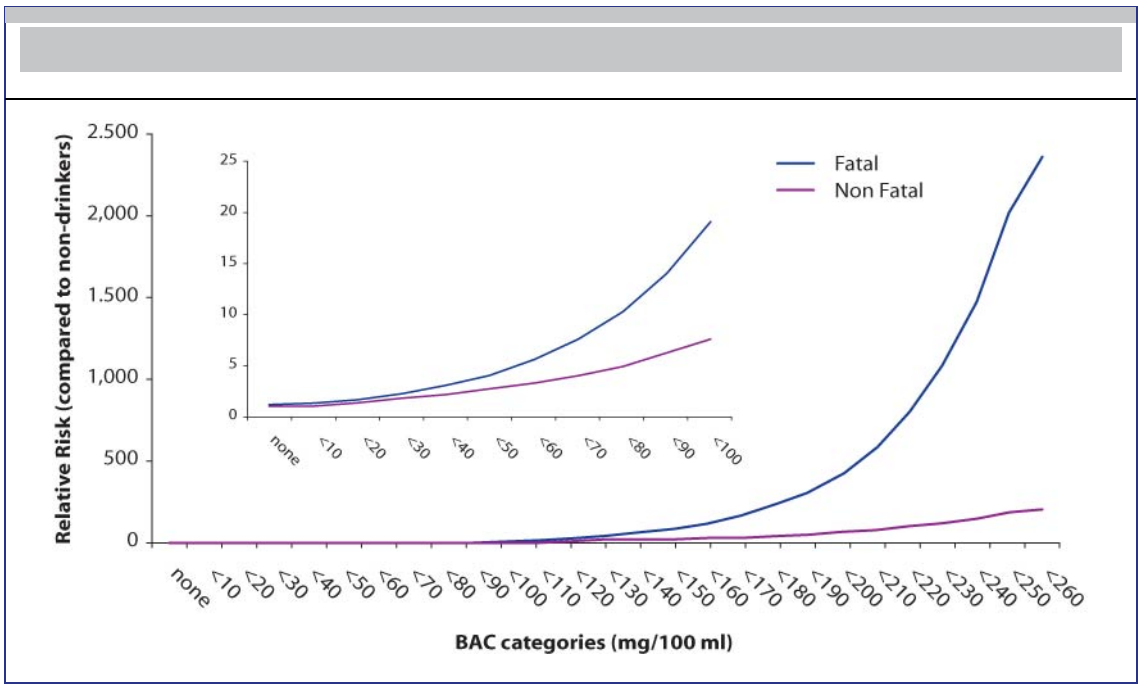
Q1. ***Should the statutory option be withdrawn or not?***

Breath and Blood Alcohol Concentrations

Driver Impairment due to Drink

5.1 The prescribed drink driving limit does not require impairment to be proven. Instead it is based on the principle that drivers can be deemed to be impaired when their bodies have in excess of a certain proportion of alcohol. In general drivers are at greater risk of being involved in collisions, having slower reaction times, impaired multi-tasking and having their driving impaired in other ways, as alcohol concentrations increase. The chart below illustrates how the risk of involvement in a crash varies by a driver's blood alcohol concentration (North Review).

Chart: Relative risk of being involved in a fatal or non-fatal incident in England and Wales



5.2 Alcohol proportions can be tested from specimens of breath, blood (from veins) and urine. However there is not a single, universal and fixed ratio between these concentrations. For example variations in physiology between people will result in people with identical blood alcohol concentrations having different breath alcohol concentrations[13].

5.3 The same quantity of alcohol affects and impairs people differently and the effects of a specific concentration on a particular individual can also vary. However the studied and documented impairment effects on people are more closely connected with alcohol proportions in blood, rather than with alcohol in breath or urine.

5.4 The current drink drive limit in Great Britain was set in the light of evidence, including primarily from the USA, about impairment related to blood alcohol concentrations. The evidence established that drivers collectively would be impaired, and therefore more hazardous, when they had concentrations in their bloodstreams in excess of 80 milligrammes (mg) of alcohol in 100 ml of blood.

5.5 On average the ratio between blood alcohol concentrations and urine alcohol concentrations was established as averaging about 3:4. Hence a urine alcohol concentration of 107 mg per 100 ml was established in the prescribed limit.

5.6 Likewise research[14] suggested that a ratio between blood and breath of alcohol concentrations of 2,300:1 was appropriate and hence the breath alcohol limit of 35 mcg per 100 ml was established in the prescribed limit[15].

5.7 There is a prescribed limit in law for each of breath, blood and urine; as such no priority is given to one particular bodily fluid's concentration for individual cases. It is therefore not a defence for an individual to attempt to establish that an evidential test in one

[13] Jones AW. The relationship between blood alcohol concentration (BAC) : a review of the evidence. Commissioned by DfT 2010. (As yet unpublished.) http://assets.dft.gov.uk/publications/research-and-statistical-reports/report15.pdf

[14] North review ref 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.

15 North review ref 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.

medium, for example breath, that is legitimately presented to court in excess of the prescribed limit, might have been equivalent to a lower concentration in another medium, such as blood.

Blood: Breath Ratios

5.8 However the 2,300:1 ratio is not the average ratio between blood and breath alcohol concentrations. The average ratio of drink drivers is about 2,400:1[16]. The ratio of 2,300:1 was set in Britain for the prescribed limit. Research indicates that about a quarter of drink drive offenders would have been disadvantaged by using breath as opposed to blood with the 2,300:1 ratio[17].

5.9 Other countries use ratios of 2,100:1 and 2,000:1, possibly in some cases because the average blood to breath ratio was considered to be lower than 2,400:1 when they legislated. The ratios may also be used to virtually avoid the possibility of anyone being disadvantaged by a blood specimen. A 2,000:1 ratio would for example disadvantage only 0.5% of people.

5.10 The ratio of 2000:1 is used in Austria, France and Spain (where the corresponding alcohol concentrations are 25 mcg/100 ml for breath and 50 mg/100 ml for blood). A ratio of 2100:1 is used in Germany, Sweden, Norway, Australia, Canada and the USA.

[16] North review ref 99. Jones AW. The relationship between blood alcohol concentration (BAC) and breath alcohol concentration (BrAC): a review of the evidence. Commissioned by DfT and published 2010: http://assets.dft.gov.uk/publications/research-and-statistical-reports/report15.pdf

[17] North review paragraph 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[17] 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 [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] 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.

Statutory Blood Alcohol Concentration (BAC), Breath Alcohol Concentration (BrAC) and Blood Breath Ratio used in various countries[18].

Country	Statutory BAC	Statutory BrAC	Blood Breath Ratio
Australia	0.05 g/100 ml	0.25 mg/l	2,100
Austria	0.50 g/l	0.25 mg/l	2,000
Belgium	0.50 g/l	0.22 mg/l	2,272
Canada	80 mg/100 ml	0.08 g/210 l	2,100
Denmark	0.50 mg/g	0.25 mg/l	2,100
Finland	0.50 mg/g	0.22 mg/l	2,400
France	0.50 g/l	0.25 mg/l	2,000
Germany	0.50 mg/g	0.25 mg/l	2,100
Greece	0.50 g/l	0.25 mg/l	2,000
Italy	0.50 g/l	0.25 mg/l	2,000
New Zealand	80 mg/100 ml	40 µg/100 ml	2,300
Norway	0.20 mg/g	0.10 mg/l	2,100
Poland	0.20 g/l	0.10 mg/l	2,000
Portugal	0.50 g/l	0.25 mg/l	2,300
Republic of Ireland	50 mg/100 ml	35 µg/100 ml	2,300
Spain	0.50 g/l	0.25 mg/l	2,000
Sweden	0.20 mg/g	0.10 mg/l	2,100
Netherlands	0.50 mg/ml	220 µg/l	2,300
United Kingdom	80 mg/100 ml	35 µg/100 ml	2,300
USA	0.08 g/100 ml	0.08 g/210 l	2,100

5.11 A ratio risks one of two kinds of problem (as discussed by in the Government's response of March 2011 to the reports by Sir Peter North and the Transport Select Committee on drink and drug driving):

a. some drivers risk being convicted unfairly because a breath test will over-estimate their blood alcohol level (compared to the result of a timely blood test properly conducted);

[18] Jones AW. The relationship between blood alcohol concentration (BAC) : a review of the evidence. Commissioned by DfT 2010. (As yet unpublished.) http://assets.dft.gov.uk/publications/research-and-statistical-reports/report15.pdf

b. if the limit is set high to avoid this problem, then many drivers are likely to be treated too leniently – and will avoid prosecution even though a timely blood test (if conducted properly) would have found them in excess of the prescribed limit

5.12 The police and CPS operate a charging threshold (independent of the statutory option) at 40 mcg of alcohol in 100 ml of breath. This is designed to eliminate any unfairness or inaccuracy due to instrument testing standard variability. It follows therefore that cases will not be subject to the statutory option, where the lower of the two breath specimens does not exceed 40 - except for few rare and most serious cases where police intend to rely on back calculations to prove that the driver was above the limit at the time of driving. The North review (sections 4.45 to 4.49 included in annex A of this document) has considered charging thresholds and laboratory margins (for breath, blood and urine results) further.

5.13 A 2,000:1 ratio ensures that for 99.5% of offenders there is at least equivalence for a breath test compared to a timely blood test, so they are not disadvantaged by a breath test over a blood test. Someone who is charged on the basis of a breath test is therefore very likely to have also exceeded the prescribed blood alcohol concentration at the time of the breath test.

5.14 So there will be very limited risks of drivers being categorised as offenders because they provided an evidential breath specimen rather than a blood specimen. Anyway, drivers just below the prescribed level have levels of alcohol in their bodies which research shows impair them significantly. Therefore we propose to retain the prescribed limit at its current levels in blood, breath and urine, upon the withdrawal of the statutory option. This retains the use of the 2,300:1 ratio.

5.15 A theoretical alternative of retaining the current blood alcohol level, but increasing the breath alcohol limit to 40 mcg per 100 ml (with a consequential charging threshold of 45) would represent an excessively lenient approach to the enforcement. It would effectively increase the drink drive limit, by increasing the prescribed limit in breath, the most commonly used type of evidential specimen.

5.16 NICE research[19] suggests that the risks of a driver being involved in a fatal crash are at least six times higher for drivers with a blood alcohol concentration of between 50 and 80 mg per 100 ml, when compared to a driver with no alcohol in their blood. This risk increases to eleven fold for blood alcohol concentrations of 80 to 100 mg per 100 ml.

5.17 Increasing the breath alcohol limit could have the effect of condoning this highly risky behaviour and would be excessively lenient.

5.18 A further theoretical alternative of slightly lowering the current prescribed limit in blood (and urine), whilst leaving the breath limit unchanged, would also ensure nearly all suspects just above the prescribed breath limit would also fail a timely blood test.

Q2. Do you agree with the retention of the implied blood to breath alcohol concentration ratio of 2,300:1 for the prescribed limit upon the withdrawal of the statutory option? If not should a ratio of 2,000:1 (or what other ratio) be used with a higher prescribed breath alcohol concentration or with lower prescribed blood and urine alcohol concentrations?

Scotland, the Statutory Option and Blood: Breath Ratios

5.19 The subject matter of the RTA and the Road Traffic Offenders Act 1988 are reserved to Westminster (see paragraph (d) of the road transport reservations listed in section E1 of Schedule 5 to the Scotland Act 1998. Under the Scotland Act 2012 the regulation making powers relating to the prescribed drink driving limit was devolved to Scottish Ministers (see section 20). This means that the Scottish Government and Parliament can make decisions about the prescribed limit in Scotland. The Scottish Government has indicated its intention to lower the prescribed limit in Scotland to 50 mg per 100 ml of blood.

5.20 In setting that prescribed limit the Scottish Government could also employ a different implied ratio to 2,300:1 between the breath and blood alcohol concentrations. The Scottish Governement is currently consulting on proposals to reduce the drink drive limit.

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

Paragraph 2.15 of the consultation paper[20] suggests the Scottish Government have no plans at this time to alter the existing ratios used to calculate drink drive limits.

5.21 The North review recommended both reducing the prescribed drink driving limit (from 80mg/100ml of blood to 50mg/100ml) and changing the blood to breath ratio used to derive the limit expressed in breath to 2,000:1. This would have resulted in a limit of 20 mcg per 100 ml of breath as opposed to 35.

5.22 It is for the Scottish Government and Parliament to consider and make decisions about how the prescribed limit in Scotland might be changed. However the UK Government's response of March 2011 to the reports by Sir Peter North and the Transport Select Committee on drink and drug driving did not accept the change to a 2,000:1 ratio in the context of Sir Peter North's recommendation for a lower prescribed limit for Great Britain.

5.23 As stated above, the subject matter of the RTA, including provisions about the statutory option, remain in the competence of the UK Parliament and Government. The UK Government and Parliament could make different legislative provisions for different parts of Great Britain if justified. However we consider that the provision for the statutory option is redundant across Great Britain. This consultation therefore proposes its withdrawal across Great Britain.

Q3. Are there any issues related to the statutory option which you consider might justify a different position about whether to withdraw it or not in different parts of Great Britain?

Note: Annex A is a set of extracts from the North report relevant to the statutory option and breath alcohol/ blood alcohol ratios.

<u>Railways, Shipping and Aviation</u>

5.24 The statutory option is also currently included in the legislation related to railways, shipping and aviation. In the aviation sector a lower drink limit than for road traffic applies to most activities.

5.25 The Transport and Works Act 1992 covering rail (including light rail and guided bus ways) includes a provision (section 32) for the statutory option. This closely parallels section 8 of the RTA.

[20] http://www.scotland.gov.uk/Publications/2012/09/3556/downloads#res401340

5.26 For shipping, the Railways and Transport Safety Act 2003 includes provisions related to drink and drugs by having a limit for professional (and recreational – not currently enabled) mariners and fishermen. The alcohol limit and the testing regime largely mirror the RTA and associated road traffic provisions. The statutory option is applied through section 83 of the Railways and Transport Safety Act, through a reference there to section 8 of the RTA. These provisions cover these people in UK territorial waters and also the crew of craft registered in the UK around the world.

5.27 For aviation, the Railways and Transport Safety Act 2003 includes provisions related to drink and drugs for aircraft flight and cabin crew, air traffic controllers and licensed UK aircraft maintenance engineers. These provisions cover these people in the UK and also the crew of an aircraft registered in the UK around the world.

5.28 The alcohol and drug testing regime largely mirror the RTA and associated road traffic provisions. The statutory option is applied through section 96 of the Railways and Transport Safety Act, through a reference there to section 8 of the RTA. However the prescribed alcohol limit for aviation (except for licensed aircraft maintenance engineers) is lower, being:

a. 9 mcg of alcohol per 100 ml of breath;

b. 20 mg of alcohol in 100 ml of blood; and

c. 27 mg of alcohol in 100 ml of urine.

5.29 We are evaluating the case for withdrawing the statutory option from the legislative provisions for the rail, shipping and aviation sectors to avoid the risk of procedural mistakes and the consequential risk to proceedings failing in cases in these sectors.

Q4. Should the statutory option be withdrawn in the rail, shipping and aviation sectors? If not in which sectors should it be kept?

Other Legal Changes to Drink and Drug Driving Procedures

Requirements for Preliminary Breath Testing

6.1 A preliminary (screening) breath test may be required in a number of circumstances – where there is a suspicion of alcohol, involvement in a road traffic accident or a moving traffic offence. However, it is not a necessary pre-requisite for an evidential test made at a police station or hospital in relation to an offence covered by sections 3A, 4 or 5 of the RTA.

6.2 If an evidential test is a breath test, two breath specimens must be taken with the evidential specimen with the lower proportion of alcohol being used and the other one disregarded. The preliminary breath test reading is not used for evidential purposes.

6.3 However under section 7 (2) (c) of the RTA an evidential breath test can only be required at places other than a police station or hospital following a positive screening test. The instrumentation used for the two purposes is different.

6.4 Currently approved evidential breath testing equipment is only available for use at a police station. However, Home Office type approval trials of portable evidential breath testing equipment are scheduled to start with decisions due in early 2014. The roadside deployment and portability of this equipment may offer significant operational advantages to the police in some circumstances.

6.5 We propose to assist the use of portable evidential equipment by amending section 7 (2) (c) of the RTA. This would mean that an officers in the course of an investigation into a suspected drink driving offence can conduct an evidential breath test in places other than at a police station or hospital (including at the roadside) without the need for a preliminary screening test.

6.6 The change will avoid three breath specimens being sought at the roadside and reduce this requirement to two. It will avoid an extra test in what can be difficult operational situations for the police. The procedural change would have no effect now, because portable evidential breath testing equipment is not yet type approved. However it is likely to be available in the near future and we therefore propose to make this legislative change.

Q5. Should the requirement for a preliminary breath test prior to the requirement for an evidential breath test outside a police station or hospital be removed?

6.7 We are also considering the modification of the section 6D RTA powers of arrest to include a power to arrest for failing a roadside evidential test, related to an investigation of an offence under section 3A, 4 or 5 of the RTA. The section 6D power of arrest without warrant currently relates to the results of a preliminary breath test and would be amended slightly to include when a roadside evidential breath test has been failed.

Changes to Testing Procedures in Hospitals

6.8 A medical practitioner or a registered healthcare professional in a police station can take evidential blood specimens for drink and drug driving investigations (ie into offences under sections 3A, 4 and 5 of the RTA). Section 11 (4) (b) of the RTA restricts the taking of blood specimens to medical practitioners in hospitals. (Blood specimens cannot be taken outside police stations or hospitals).

6.9 For drink and drug driving proceedings specimens may be taken from suspects who give their consent or who are incapable of giving consent for medical reasons.

6.10 The proposal is to change the RTA (section 11 (4) (b)) to allow a blood specimen to be taken by a medical practitioner or a registered healthcare professional in hospitals. There would be related changes to RTA section 7A (2) and (3).

6.11 The proposed change to the RTA would allow registered healthcare professionals, in the absence of any objections, to take blood specimens for drink and drug driving investigations, as they can do for many other police investigations and in other medical contexts.

6.12 The main use of the change would be to allow nurses and paramedics to take evidential blood and urine specimens in hospitals.

6.13 This is not the case of limiting the change to hospitals but the proposal is to extend the current provision of legal taking of blood specimen from 'police stations' only to 'police stations and hospitals'.

6.14 A registered healthcare professional is defined in section 11 of the RTA and section 65 of the Police and Criminal Evidence Act 1984 'PACE' as someone other than a medical practitioner who either is a registered nurse or a registered member of a healthcare profession (designated for the purpose of the section by the Secretary of State).

6.15 Custody nurses already advise on the fitness of individuals to be detained, interviewed and transferred or released from police custody. They also conduct intimate body searches, physical examinations and obtain forensic samples. In fact nurses are continuously expanding their roles to meet the needs of patients, service users and communities and are already working in custody areas across the country providing high quality healthcare for detainees. Many of the functions that were traditionally undertaken by the Forensic Physicians (otherwise known as Forensic Medical Examiners), including assessing whether detainees are fit for detention or interview, are performed by nurses. They can treat injuries and administer certain medications, reducing the need for hospital care.

6.16 The Royal College of Nursing 2008[226] 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."

6.17 There are some further implications related to the taking of specimens of blood for drink drive cases at hospitals. Section 9 of RTA includes provisions for the notification of the medical practitioner in charge of a patient's case to be notified before

specimens are requested to be taken. This requirement protects the patient who can and those who cannot consent (for valid reasons). Such a medical practitioner can object to requests being made for specimens or specimens taken on the grounds of them prejudicing proper patient treatment and care. There is no intention that this protection should be other than in the hands of a Registered Medical Practitioner.

6.18 The legislation already allows patients who have been unable to consent for valid medical reasons later not to permit the laboratory testing of such a specimen. The patient would then be committing an offence under section 7A (6) of the RTA if they failed to give permission for a laboratory test without reasonable excuse.

Q6. ***Should legislation be amended to allow registered health care professionals to take evidential blood specimens for drink and drug driving proceedings elsewhere than at a police station?***

Changes to who determines whether the condition of a drug driving suspect is possibly due to a drug

6.19 The North review recommended that section 7 (3) (c) of RTA should be amended to allow registered healthcare professionals to also take on the role fulfilled by the Forensic Physician in advising police about whether a drug driving suspect has "a condition which might be due to a drug". The review recommended the change should be made quickly (within a year), with the Government response committing to early action subject to a legislative slot.

6.20 If a suspect has tested positive in a preliminary drug test, the law already allows for an evidential specimen (of blood or urine) to be required without such a Forensic Physician's opinion. There is currently no equipment type-approved for preliminary drug tests, but a type approval process for such equipment is due to completed in late 2012.

6.21 Nevertheless changes to who can form an opinion as to whether a suspect has "a condition which might be due to a drug" remain important to implement. This is because screening machines are unlikely to be available in all police stations in the foreseeable future and they will not screen for all drugs.

6.22 Paragraphs 10.11 to 10.23 of the Government's response are included at annex B. It discusses in more detail why it wishes to

proceed with this proposal and agrees with two connected recommendations by the North review about the training of registered healthcare professionals.

6.23 The Department has written to key stakeholders about implementing this legislative change and will be meeting with representative bodies for the medical practitioner and registered healthcare professional sectors.

Q7. Do you have any comments on the proposal to allow registered healthcare professionals as well as doctors to answer the question about whether the condition of a drug driving suspect might be due to a drug?

Application of Proposals to Rail, Shipping and Aviation

6.24 All three proposed legislative changes (related to preliminary breath tests, testing procedures in hospitals and the question of whether a condition is due to drugs) could be applied to road traffic only. However to avoid the possibility of procedural confusion and mistakes leading to illegal testing and also to meet the fairness issues explained in paragraph 4.20a to apply to all modes of transport, the Department is considering whether to make equivalent legislative changes for the rail, shipping and aviation sectors.

6.25 In the case of shipping and aviation the relevant provisions of the RTA related to all three proposed changes are applied to the sectors by sections 83 and 96 (respectively) of the Railways and Transport Safety Act 2003.

6.26 For railways the Transport and Works Act 1992 (TWA) includes provisions related to testing procedures in hospital and the question of whether a condition is due to drugs. In these respects sections 31, 31A, 33 and 38 of TWA are broadly equivalent to sections 7, 7A, 9 and 11 of RTA and could be amended in a very similar way.

6.27 However section 31 (2) of the TWA restricts where evidential breath specimens can be taken to a police station. The TWA does not include any condition that evidential breath tests are dependent on a preliminary test (such as a preliminary breath test). The TWA does however allow for a non-evidential breath test.

6.28 The Department considering harmonising the legislative provisions for road and rail by amending section 31 to allow evidential breath testing to also take place outside police stations. Under the TWA powers evidential breath testing outside police stations would not have to be preceded by a preliminary breath test.

Q8. Do you consider whether any changes (related to preliminary breath tests, testing procedures in hospitals and the question of whether a condition is due to drugs) made to the Road Traffic Act should be extended to:

a. the Railways and Transport Safety Act for aviation;

b. the Railways and Transport Safety Act for shipping;

c. the Transport and Works Act for rail (including the power to conduct evidential breath tests outside police stations)?

Vehicle Forfeiture and Seizure in England and Wales

6.29 Courts can impose bail conditions, including to prevent further offences being committed. For suspected drink or drug impaired driving it is possible to impose a bail condition not to drive – which may then involve a vehicle seizure - to stop a defendant from driving. However because defendants are presumed innocent courts are likely to impose conditions sparingly and only where there is evidence that a defendant was continuing to carry on driving whilst under the influence of drink (or drugs).

6.30 The North review recommended the implementation of section 33A in England and Wales of the Road Traffic Offenders Act 1988, which applies to Scotland and allows for the seizure and forfeiture of vehicles used by repeat drink driving offenders.

6.31 The Government response to the review was not to accept this recommendation. There is already legislation (in PACE) in England and Wales providing for many of the powers. The main additional provision in Scotland is that courts can authorise the police to seize a vehicle prior to conviction if it seems reasonable that on conviction a forfeiture order would be made.

6.32 In the light of the Government response, the potential is being examined for courts to include vehicle seizure and forfeiture as part of the penalties for drink and drug drivers. The Crown Prosecution Service (CPS) has recently consulted about new guidance for prosecutors about motoring cases. Courts can also impose bail conditions without a request from the prosecution.

6.33 Bail conditions preventing driving need to be applied in an appropriate and proportionate way. A balance has to be struck between the rights of a defendant, not yet convicted, and potential benefits to public safety from reducing the risk of further offences. Bail conditions banning driving may well be proportionate for many cases where there has been a fatality or severe injury and where a defendant has previous convictions for a drink or drug driving offence or the offence occurred whilst a defendant was on bail for a similar offence.

Proposals for Statutory Training and Assessment for Offenders

Drink-Drive Rehabilitation Scheme

7.1 The Government response to the North review indicated that it would re-launch the drink-drive rehabilitation scheme (DDRS) under which drink-drivers can obtain reduced driving disqualifications.

7.2 Courts can offer reductions of up to a quarter in the length of driving disqualifications of 12 months or more on the satisfactory completion of the courses. Historically about 90,000 offenders a year have been convicted of a relevant offence. About 60,000 of these have been referred onto DDRS courses, with about 30,000 completing them.

7.3 The Driving Standards Agency consulted between November 2011 and January 2012 about modernising the existing scheme. The changes it consulted about aimed to deliver a higher quality course, improve course consistency, ensure administration costs are fully borne by users and increase the take-up rate, with the overall aim of improving road safety.

7.4 It proposes to implement changes in the light of the consultation in 2013. The implementation of the changes will involve the commencement of section 35 of the Road Safety Act 2006.

Extension of Rehabilitation Scheme to Other Offences

7.5 Section 35 of the Road Safety Act 2006 also allows the lengths of driving bans for a range of offences beyond drink driving to be reduced if offenders take training. The offences could include for speeding (including on motorways), careless driving or breaking signed prohibitions, provided these had resulted in a disqualification of at least twelve months.

7.6 About 40% of disqualified drivers do not attempt to recover their licences subsequently but increasing the availability of training may

aid subsequent rehabilitation and improve the attitudes and behaviour of those drivers who return from disqualifications.

7.7 However in 2011 there were only about 5,000 offenders who would have been eligible for the offer of a course. If the ratio between course offers and courses taken up followed the pattern for drink-driving, only about 2,000 offenders would complete these courses per year. This relatively low number of offenders involved may compromise having viable and local training.

7.8 Section 34 of the Road Safety Act 2006 has not yet been commenced. If in place it would enable Courts to make an Order, in the case of an offender who already has 7 to 11 penalty points on their licence and who is convicted of a specified penalty point offence (including speeding and careless driving), that if the person undertakes approved training within 10 months of the date of the Order, up to 3 of the extra penalty points that were attributed to that person upon conviction will cease to be taken into consideration 12 months after the date of the Order (section 34 of the Act).

7.9 An Order cannot be made unless the offender agrees to it. DfT-sponsored, published research[21] has indicated that relatively few offenders would meet these criteria and that courses may be refused by many of the worst offenders or may not be appropriate (for example because of illiteracy or criminality).

7.10 The National Driver Offender Retraining Scheme (NDORS) has been expanded substantially since the passage of the 2006 Road Safety Act. It offers remedial training as an alternative to prosecution for some lower level speeding and careless driving offenders.

7.11 The volume of speed awareness courses under NDORS has more than doubled during the last three years to close to a million per year. Additional types of course targeted towards careless drivers and speeding drivers on motorways have or are being developed.

7.12 In the light of the relatively low number of offenders who would be involved, the doubts about effectiveness in some cases and the increased use of NDORS, the Department does not propose to

[21] Road safety research report 118 'Offenders and Post Court Disposals' (DfT, September 2010) http://www.dft.gov.uk/publications/rsrr-theme2-report118

commence sections 34 and 35 of the Road Safety Act (other than for the drink-drive rehabilitation scheme).

7.13 Further consideration is being given to the rehabilitation of drug driving offenders in the context of the proposed new drug driving offence. However the Department is not bringing forward specific proposals at the moment.

Q9. Do you agree that post-court rehabilitation schemes for drivers disqualified due to speeding, careless driving and other offences and for offenders with 7-11 penalty points should not be implemented for the foreseeable future?

Extended Driving Tests and Assessments for Dangerous Drivers

7.14 Courts have powers under section 36 of the Road Traffic Offenders Act 1988 to require drivers who have committed some offence to be disqualified until they have passed an extended driving test. The extended driving test currently includes the hazard perception test and a double the standard duration of practical test.

7.15 For example convicted dangerous driving offenders who have been disqualified must take an extended driving test. Courts can also require an extended driving test for other offences (such as drink-driving) involving obligatory disqualification, when disqualifications last for more than 56 days.

7.16 Section 37 of the Road Safety Act 2006 has not yet been commenced. When commenced it would provide more powers for legal orders to be made about the nature of what tests of competence to drive should be available for which offences, where the end of a disqualification is depending on passing an extended driving test or other test of competence to drive.

7.17 The Department proposes to evaluate the operation of the current extended driving test and to develop proposals for consultation about the implementation of section 37 (including the nature of tests of competence to drive other than the extended driving test).

7.18 This work could include to:

a. establish the current use, uptake when available, and pass rates for extended driving tests;

b. consider the reasons for failures and the effects on drivers' attitudes;

c. analyse post-test offending behaviour;

d. identify possible other tests of competency (relevant to section 37 of the Road Safety Act 2006);

e. consider the applicability of such other tests of competence, to some or all of the relevant offences, including related to causing death or serious injury, dangerous driving, drink driving, drug impaired driving and severe examples of speeding and careless driving;

f. forecast the potential effects of other tests of competence on offenders' attitudes and behaviours; and

g. model the potential uptake of other tests of competence.

7.19 The Department proposes to commission preparatory work to start in early 2013.

Q10. Do you agree that in principle the use of extended driving tests and other competence tests should be evaluated with a view to considering their use more widely offences involving disqualification in excess of 56 days?

<u>New Drivers Act</u>

7.20 The New Drivers Act 1995 applies a probationary period of two years to all drivers when they pass a first qualifying driving test. If a driver reaches six or more penalty points within two years of that date their licence will be revoked and they will need to apply for a provisional driving licence and then re-sit their driving test. The Department proposes to evaluate the operation of the New Drivers Act and consider whether changes should be made to it.

7.21 This work could include to:

a. analyse the offences contributing to the withdrawal of full licences under the New Drivers Act;

b. consider the subsequent return rate to fully licensed driving and offending characteristics;

c. assess the effects on attitudes to driving due to the presence of the New Drivers Act's penalty point threshold on novice drivers and also on those who cross the threshold;

d. examine the likely prevalence of uninsured/ unlicensed driving amongst drivers affected by New Drivers Act licence withdrawals and consider linking actual licensing and third party insurance more closely;

e. consider the effects of the National Driver Offender Retraining Scheme training on novice drivers and the operation of the New Drivers Act;

f. examine for differences in the effects of the New Drivers Act by age of driver and depending whether or not they had previous driving licence entitlements (for example from another country or for certain types of vehicle);

g. assess the effects of insurance charges on the motivations of drivers covered by the New Drivers Act;

h. develop options for change, for example related to statutory remedial training as an alternative to licence withdrawal and the greater use of short period driving suspensions as opposed to licence revocation; and

i. assess the potential effects of options for change.

Q11. If you wish to submit suggestions about what should be considered in the evaluations of extended driving tests and the New Drivers Act send them to **Roadsafetyenforcement@dft.gsi.gov.uk**

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Consultation questions

Q1. *Should the statutory option be withdrawn or not?*

Q2. *Do you agree with the retention of the implied blood to breath alcohol concentration ratio of 2,300:1 for the prescribed limit upon the withdrawal of the statutory option? If not should a ratio of 2,000:1 (or what other ratio) be used with a higher prescribed breath alcohol concentration or with lower prescribed blood and urine alcohol concentrations?*

Q3. *Are there any issues related to the statutory option which you consider might justify a different position about whether to withdraw it or not in different parts of Great Britain?*

Q4. *Should the statutory option be withdrawn in the rail, shipping and aviation sectors? If not in which sectors should it be kept?*

Q5. *Should the requirement for a preliminary breath test prior to the requirement for an evidential breath test outside a police station or hospital be removed?*

Q6. *Should legislation be amended to allow registered health care professionals to take evidential blood specimens for drink and drug driving proceedings elsewhere than at a police station?*

Q7. *Do you have any comments on the proposal to allow registered healthcare professionals as well as doctors to answer the question about whether the condition of a drug driving suspect might be due to a drug?*

Q8. *Do you consider whether any changes (related to preliminary breath tests, testing procedures in hospitals and the question of whether a condition is due to drugs) made to the Road Traffic Act should be extended to:*

a. the Railways and Transport Safety Act for aviation;

b. the Railways and Transport Safety Act for shipping;

c. *the Transport and Works Act for rail (including the power to conduct evidential breath tests outside police stations)?*

Q9. *Do you agree that post-court rehabilitation schemes for drivers disqualified due to speeding, careless driving and other offences and for offenders with 7-11 penalty points should not be implemented for the foreseeable future?*

Q10. *Do you agree that in principle the use of extended driving tests and other competence tests should be evaluated with a view to considering their use more widely offences involving disqualification in excess of 56 days?*

If you wish to submit suggestions about what should be considered in the evaluations of extended driving tests and the New Drivers Act send them to Roadsafetyenforcement@dft.gsi.gov.uk

What will happen next

A summary of responses, including the next steps, will be published within three months of the consultation closing. Paper copies will be available on request.

Annex A: Statutory option & Breath/Blood Alcohol Ratios

The following extractions are taken from the North Report:

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'.

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.***[22]

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.

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[23] 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

22 1985 S.L.T. 549

23 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.)

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® was approved for use in the USA and Canada to give readings in terms of estimated BAC.[24] 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.[25]

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[26] 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

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

25 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.

26 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.

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.[27]

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.[28] 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.

<u>The statutory option and margins of error</u>

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:

- 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.

27 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.)

28 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.)

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)[29] 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,

29 Crown Prosecution Guidance. Road Traffic Offences: Drink Driving. Available at: http://www.cps.gov.uk/legal/p_to_r/road_traffic_offences_drink_driving/ and Home Office Circular 1983/46

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 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[30] 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

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

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.[31] 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,[32] 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 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.

31 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.

32 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.

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.

Annex B: Government Response to the North Review: Custody Nurses

Custody Nurses

10.11 We accept recommendation 7 [of the North review. This is:

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'.]

10.12 Primary legislation is required to allow nurses to take on the role currently fulfilled by the forensic medical examiner (FME) in determining whether the drug driving suspect has 'a condition which might be due to a drug'.

10.13 The change proposed would help the police by avoiding the problems currently caused by having to wait for a FME to attend. It would also save the cost. Waiting for a FME takes police time from patrolling. Custody nurses are more readily available and already undertake other tasks such as taking blood specimens. There is a road safety issue as drivers are being allowed to return to the driving seat still impaired when a doctor cannot be brought to the station.

10.14 Nurses are continuously expanding their roles to meet the needs of patients, service users and communities. Nurses are already working in custody areas across the country providing high quality healthcare for detainees. They perform many functions traditionally undertaken by the FME, including assessing whether detainees are fit for detention or interview. They can treat injuries and administer certain medications, reducing the need for hospital care. As explained in paragraph 3.27 above on drink-driving, they are permitted to take invasive samples from people in custody.

10.15 Paragraph 10.21 below explains the opinion that is required to allow an evidential specimen to be taken from a driver arrested for suspected drug-driving. It is a straightforward opinion, not an exhaustive diagnosis of presenting symptoms. We agree for all these reasons that the Act should be amended so that this opinion

may be obtained from registered healthcare professionals as well as from a medical practitioner.

Health professional training

10.16 We agree with recommendations 8 and 9 [of the North review. These are:

8. Appropriate training should be provided to all registered healthcare 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.

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 registered health care professionals and the police officers involved in the case, as the observations of the officers might well assist registered health care 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.]

10.17 The North report has found that doctors and nurses do not have training or experience in the identification of a condition due to a drug or impairment (evidenced by the officer); and concluded that training is necessary for all. It has also found that doctors have historically misinterpreted their role and tried to find evidence of impairment.

10.18 It is agreed that any expansion of the custody nurses' role must be supported by appropriate training and education to ensure that nurses are competent in the duties required of them. This applies to any work that is done for the police. Clinical staff may be engaged by the police in a variety of ways. Some are direct employees; others are employees of organisations contracted to provide services; and some may be self-employed. The police will ensure – as they do now, through contracts of, and for, services - that appropriate training is provided for their employees; and that contracts require and deliver appropriately trained professional people.

10.19 Additionally, nurses are accountable to their professional regulator, the Nursing and Midwifery Council. Practitioners will need to satisfy

themselves that any extension to their scope of practice is fully consistent with the requirements of registration and the professional code. This is not expected to present difficulty, given the scope of custody nurses' existing role.

10.20 Recommendations 8 and 9 are prompted by Sir Peter's concern that practice in cases has elaborated what the Road Traffic Act 1988 requires of the doctor whose agreement is required before evidential samples are demanded from a drug driver. There is concern that due weight is not given to the evidence of impairment which has prompted the driver's arrest; and that doctors may be reluctant to agree that a condition may be due to a drug unless they can eliminate other explanations.

10.21 Section 7(3)(c) is clear that the question asked is a straightforward one – might the condition of the person required to provide the specimen be due to some drug? Put another way – is there a prima facie case for requiring an evidential sample for the purpose of investigating an offence of drug-driving? The Act does not require a diagnosis; or for some or all other conditions to be positively eliminated. However, it would not be appropriate to say the condition might be due to a drug if there is clear evidence that it is attributable to something else. The question must address the evidence at the time the person was driving – and when they were investigated at the roadside. There are cases where the rapid disappearance of signs that were apparent at the roadside might itself be evidence of drugs.

10.22 The issue has recently been addressed by the Court of Appeal – Angel v Chief Constable of South Yorkshire[33]. The Court said that:

The purpose of the medical advice is to provide a protection against the invasive requirement of a blood test when there is a clear medical explanation of the person's condition which excludes the influence of drugs.

… the condition referred to in Section 7(3)(c) of the 1988 Act is the person's condition at the time he was driving. It is that for which he has been arrested and is under investigation and it is to that condition that the specimen of blood will be relevant. Insofar as it

[33] See judgement on-line at - http://www.bailii.org/ew/cases/EWHC/Admin/2010/883.html

might be different, his condition later at the police station is not that to which the investigation is directed.

It is common sense, therefore, that the doctor is entitled to take into account all relevant information relating to the person's earlier condition. In some cases, of course, the person's condition at the police station may alone be sufficient to enable the doctor to give the necessary advice, but the doctor is not limited to the finding of his or her own police station examination. … the issue to be addressed by the medical practitioner under Section 73(c) is the suspect's condition at the time of the alleged offence.

10.23 It is for the police to ensure that those who are involved in these cases know and follow the requirements of the Act. ACPO have issued guidance to police forces, drawing attention to this judgement. This will be disseminated in turn to the doctors giving advice in these cases. It will need to be clear in any guidance to custody nurses, should they become involved as the North report recommends.

Annex C: Road Traffic Act 1988: Sections 3A to 11

3A Causing death by careless driving when under influence of drink or drugs.

(1)If a person causes the death of another person by driving a mechanically propelled vehicle on a road or other public place without due care and attention, or without reasonable consideration for other persons using the road or place, and—

(a) he is, at the time when he is driving, unfit to drive through drink or drugs, or

(b) he has consumed so much alcohol that the proportion of it in his breath, blood or urine at that time exceeds the prescribed limit, or

(c) he is, within 18 hours after that time, required to provide a specimen in pursuance of section 7 of this Act, but without reasonable excuse fails to provide it, or

(d) he is required by a constable to give his permission for a laboratory test of a specimen of blood taken from him under section 7A of this Act, but without reasonable excuse fails to do so,]

he is guilty of an offence.

(2) For the purposes of this section a person shall be taken to be unfit to drive at any time when his ability to drive properly is impaired.

(3) Subsection (1)(b) (c) and (d)] above shall not apply in relation to a person driving a mechanically propelled vehicle other than a motor vehicle.]

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.

(6) A constable may arrest a person without warrant if he has reasonable cause to suspect that that person is or has been committing an offence under this section.]

(7) For the purpose of arresting a person under the power conferred by subsection (6) above, a constable may enter (if need be by force) any place where that person is or where the constable, with reasonable cause, suspects him to be.]

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 testsE+W+N.I.

(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.

6APreliminary breath test

(1) A preliminary breath test is a procedure whereby the person to whom the test is administered provides a specimen of breath to be used 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 the person’s breath or blood is likely to exceed the prescribed limit.

(2) A preliminary breath test administered in reliance on section 6(2) to (4) may be administered only at or near the place where the requirement to co-operate with the test is imposed.

(3) A preliminary breath test administered in reliance on section 6(5) 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.

6BPreliminary 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.

6CPreliminary 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.

6DArrest

(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 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.

10 Detention of persons affected by alcohol or a drug.

(1) Subject to subsections (2) and (3) below, a person required under section 7 or 7A to provide a specimen of breath, blood or urine may afterwards be detained at a police station (or, if the specimen was provided otherwise than at a police station, arrested and taken to and detained at a police station) if a constable has reasonable grounds for believing] that, were that person then driving or attempting to drive a [mechanically propelled vehicle] on a road, he would commit an offence under section 4 or 5 of this Act.

(2) Subsection (1) above does not apply to the person if it ought reasonably to appear to the constable that there is no likelihood of his driving or attempting to drive a mechanically propelled vehicle whilst his ability to drive properly is impaired or whilst the proportion of alcohol in his breath, blood or urine exceeds the prescribed limit.

(2A) A person who is at a hospital as a patient shall not be arrested and taken from there to a police station in pursuance of this section if it would be prejudicial to his proper care and treatment as a patient.

(3) A constable must consult a medical practitioner on any question arising under this section whether a person's ability to drive properly is or might be impaired through drugs and must act on the medical practitioner's advice.

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.

Annex D Impact assessment

The impact assessment is still being finalised and should be published shortly.

Annex E Consultation criteria

The consultation is being conducted in line with the Government's key consultation principles which are listed below. Further information is available on the Cabinet Office website at https://update.cabinetoffice.gov.uk/resource-library/consultation-principles-guidance

Our consultation approach is to have a formal written consultation. This is because many of those who are likely to be interested are professional organisations who will respond in their organisational capacity, for example those representing medical and healthcare sectors and those sectors responsible for operational policing.

Many of those involved, especially the healthcare sectors have been notified by letter in advance of the consultation. In addition a meeting is being convened with those sectors affected. For this reason the consultation period is relatively short, running from 22 November to 2 January.

If you have any comments about the consultation process please contact:

Consultation Co-ordinator
Department for Transport
Zone 1/14 Great Minster House
London SW1P 4DR
Email consultation@dft.gsi.gov.uk

Annex F List of those consulted

Association of Chief Police Officers

British Medical Association

Department for Health

DVLA

Faculty of Forensics and Legal Medicine (Royal College of Physicians)

General Medical Council

Government of Northern Ireland

Health Profession Council (Paramedics)

Home Office

HM Health Inspection

Ministry of Justice

Nursing and Midwifery Council

Royal College of Nursing

Scottish Government

Welsh Government

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