

**MINUTES OF THE MEETING OF  
THE SECRETARY OF STATE FOR TRANSPORT'S HONORARY  
MEDICAL ADVISORY PANEL ON ALCOHOL, DRUGS AND SUBSTANCE MISUSE  
AND DRIVING**

**Held on Wednesday, 12 October 2016 at 11.00 a.m.**

**Present:**

Professor E Gilvarry                      Chair  
Professor K Wolff  
Dr J Marshall  
Dr A Brind

**Lay Members:**

**Ex-officio:**

Professor D Cusack	National Programme Office for Traffic Medicine, Dublin
Dr Sally Bell	Maritime & Coastguard Agency
Dr M Prunty	Department of Health
Professor A Forrest	Assistant Coroner, Professor of Law
Miss N Davies	Head of Drivers Medical Group, DVLA
Mrs K Bevan	PA, Drivers Medical Group, DVLA
Mr J Donovan	Head of Driver Licensing Policy, DVLA
Mr M Davies	Driver Licensing Policy, DVLA
Mr R Morgan	Business Change and Support, DVLA
Mr D Thomas	Business Change and Support, DVLA
Dr W Parry	Senior Medical Adviser, DVLA
Dr A Brown	Panel Secretary (Drugs and Alcohol), Medical Adviser, DVLA
Dr P Rizzi	Medical Adviser, DVLA
Dr A White	Panel Secretary (Psychiatry), Medical Adviser, DVLA
Dr S Rees	Panel Secretary (Diabetes), Medical Adviser, DVLA

**1. Apologies for absence**

Apologies were received from: Professor C Gerada, Dr O Bowden-Jones, Dr P Rice, Dr N Dowdall, Ms K Kleidt-Gorton, Mr M Ellis, Mr B Jones and Mrs P Moberly.

The Chair requested that the huge thanks of the Panel were formerly expressed for the contribution from Mrs Moberly following her resignation as Lay Member of the Panel.

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## **2. Chair's remarks**

The Chair informed the Panel that the Meeting of the Panel Chairs had been cancelled for a variety of reasons and that this would be rescheduled soon.

## **3. Minutes of the meeting of 9 March 2016**

The minutes of the last Panel Meeting held on 9 March 2016 were agreed as accurate.

## **4. Matters arising**

The matters arising were all on the Agenda except for an Update on Drug Driving. A brief update was added as the first item of this Agenda, in the expectation of a more detailed update at the next Panel Meeting.

## **5. Department for Transport (DfT) Update on Drug Driving**

On behalf of DfT, the Panel was informed that a paired drink and drug driving impairment course was to be piloted. Presently, 7 bids from providers across England and Wales for a combined drink and drug driving rehabilitation course have been received. The Driving and Vehicle Standards Agency (DVSA) have approved the programme and are intending to allocate the first drivers from 24 October 2016. This will allow an assessment of the course to check that it remains effective in the combined form, before reporting back to DfT.

Following a Freedom of Information request to DVLA, 4850 driver records had been endorsed for 'drug driving' offences from 1 January 2016 to 31 August 2016. This translates into an expected rate of over 7000 convictions in 2016, compared with 879 convictions in 2014. Although this figure remains lower than that for 'drink driving' at approximately 40,000 annually, it represents a considerable increase relative to the previous level, that necessitated the requirement of a demonstration of driving impairment due to drugs. It was anticipated that a full presentation of this data at the next meeting would be of considerable interest to the Panel.

Further discussion regarding a High Risk Offender (HRO) scheme for drug driving was deferred until the next Panel Meeting. The key questions to be considered are, whether or not, such a scheme should be created and, if so, the criteria for referral. Also, the operational impact on DVLA should be considered.

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## 6. CDT amber zone audit results

Panel previously requested that information on the amber zone is presented to the Panel Meeting. In particular Panel was interested to know if those in the Amber zone who are being issued a licence reoffend as a HRO.

The data from the DVLA Driver Medical Record System combined with the Carbohydrate Deficient Transferrin (CDT) results provided by King's College Hospital, London, from the start of the contract in November 2013, was presented to the Panel. This involved a review of the reoffence rates for HRO scheme drivers with results in the Amber range (2.3-2.9%). In total 100,657 CDT results were available, with 2,435 results in the Amber range, of which 2,146 were HRO cases, with the rest persistent alcohol misuse cases. A total of 79 HRO drivers (3.7%) reoffended suggesting that DVLA licensing decisions for drivers in the Amber zone by DVLA were effective, in terms of reducing drink driving convictions. Most of the reoffences for alcohol occurred more than 6 months after the licensing decision (76%), with the majority (57%) after 12 months. In addition, the same group of drivers had numerous other offences on their driver records for the same period. The number causing these offences could not be determined as some had multiple non-alcohol offences.

The Panel discussed these results, suggesting that certain individuals appeared to repeatedly indulge in high risk behaviours, a finding comparable to the risk tendencies of those with drug misuse offences. Historically, approximately 40% of the drug cases were identified by DVLA from the alcohol HRO group, again highlighting this relationship.

It was considered appropriate for DVLA to set the threshold for alcohol misuse to identify those with problems in relation to driving in the range (2.3% to 2.9%), when the sensitivity and specificity for the diagnosis of problematic alcohol consumption is set above the manufacturer's CDT cut off level for alcohol misuse in the general population (1.6%). The duration of the licence issued did not appear to affect the reoffending rate: short term (3 years or less); full duration (unrestricted except by age) and no licence (revoked, refused or withdrawn) licences, having reoffending rates of: 4.4%; 6.1% and 2.5% respectively.

It was considered important to note that the demonstration of a prospective disorder (disability), either persistent alcohol misuse or alcohol dependence was required for short duration and removed licences. This process may entail the loss of C1/D1 implied entitlements. The requirement for a medical as opposed to legislative condition is important, particularly with regard to legal appeals against DVLA decisions. The medical diagnosis must be clear to the Court. It was accepted that DVLA would not have access to a full forensic history in these circumstances, although this may be helpful and should intensify the enquiry when available.

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In summary, the Panel agreed that the use of CDT as a marker of alcohol consumption appeared to be effective and useful to DVLA in managing alcohol cases and Appeals. However, it was recognised that medical professionals were generally not aware of the significance of CDT. In Amber zone cases the General Practitioners, in particular, are often sent information regarding this significance to allow a discussion of the CDT result with their patient in the interests of road safety and clinical care. Similar information may be used to inform the Courts during Appeal cases.

The Panel advised that the available information from previous Panel Minutes and websites such as that of King’s College Hospital explaining CDT should be reviewed by the Panel Members who have an interest in this field, with a view to producing a short, concise document for clinicians regarding the interpretation of CDT. This should receive formal review by the Panel at the next Meeting although it may be considered sooner for operational use through a circulation to relevant Panel Members. Once this endorsement has been provided, DVLA may consider adding the information as an Appendix to Chapter 5 of ‘Assessing Fitness to Drive – a Guide for Medical Professionals.’ The Panel approved of this suggestion.

## 7. Assessing Fitness to Drive – a Guide for Medical Professionals

The draft of the new guide on ‘Assessing Fitness to Drive’ (AFD) was available to Panel, and this allowed a comparison with the previous advice contained in the ‘At a Glance Guide to the Current Medical Standards of Fitness to Drive’ (AAG). The revision of the guidance to doctors followed the recommendations of the Fatal Accident Inquiry in Glasgow, December 2015, and was presented by DVLA in March 2016.

The Advisory Panel on Alcohol, Drugs and Substance Misuse and Driving made the following recommendations and approved the following contents of ‘Assessing Fitness to Drive – a Guide for Medical Professionals’ after a detailed discussion. Panel recommended DVLA consider appropriate legal or other advice on the contents, if necessary. General release on the internet is expected to take place within a matter of weeks.

### Alcohol misuse

	<b>Group 1 car and motorcycle</b>	<b>Group 2 bus and lorry</b>
<b>Persistent alcohol misuse</b> confirmed by medical enquiry and/or evidence of otherwise unexplained abnormal blood markers	Must not drive and must notify the DVLA. Licence will be refused or revoked until after: a minimum of 6 months of controlled drinking or abstinence, and normalisation of blood parameters, if relevant.	Must not drive and must notify the DVLA. Licence will be refused or revoked until after: a minimum of 1 year of controlled drinking or abstinence, and normalisation of blood parameters, if relevant.

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## Alcohol dependence

	<b>Group 1 car and motorcycle</b>	<b>Group 2 bus and lorry</b>
<b>Dependence confirmed by medical enquiry</b> Also refer to alcohol related seizure below	Must not drive and must notify the DVLA.  Licence will be refused or revoked until after a minimum of 1 year free of alcohol problems.  Abstinence is usually required, with normalised blood parameters, if relevant.	Must not drive and must notify the DVLA.  Licence will be refused or revoked in all cases of any alcohol dependence within the past 3 years.
	<b>For both driving groups:</b> <ul style="list-style-type: none"> <li>licensing will require satisfactory medical reports from a doctor</li> <li>the DVLA may need to arrange independent medical examination and blood tests</li> <li>referral to and the support of a consultant specialist may be necessary.</li> </ul>	

## Alcohol-related disorders

	<b>Group 1 car and motorcycle</b>	<b>Group 2 bus and lorry</b>
<b>Examples</b> <ul style="list-style-type: none"> <li>hepatic cirrhosis with chronic encephalopathy</li> <li>alcohol induced psychosis</li> <li>cognitive impairment</li> </ul>	Must not drive and must notify the DVLA.  Licence will be refused or revoked until: recovery is satisfactory any other relevant medical standards for fitness to drive are satisfied (for example, Chapter 4, psychiatric disorders, page 70).	Must not drive and must notify the DVLA.  Licence will be refused or revoked.

## Alcohol-related seizure

**Seizures associated with alcohol use are not considered provoked in terms of licensing.**  
 If there is **more than one seizure**, the regulations governing epilepsy will apply to drivers in both groups (see Appendix B, page 103).

	<b>Group 1 car and motorcycle</b>	<b>Group 2 bus and lorry</b>
<b>Solitary seizure</b>	Must not drive and must notify the DVLA.  Licence will be refused or revoked for a minimum of 6 months from the date of the solitary alcohol-related seizure (for details see, Chapter 1, neurological disorders, pages 14, 15 and Appendix B).  Subsequent licensing requires satisfaction of the fitness standards elsewhere in this chapter whenever there is a background of alcohol to the seizure, and will include requirements for:  an appropriate period free from persistent alcohol misuse and/or dependence independent medical assessment. Blood analysis and consultant specialist reports usually necessary.	Must not drive and must notify the DVLA.  Licence will be refused or revoked for a minimum of 5 years from the date of the solitary alcohol related seizure, (for details see, Chapter 1, neurological disorders, pages 14, 15 and Appendix B).  Subsequent licensing requires: no underlying cerebral structural abnormality no epilepsy medication for at least 5 years maintained abstinence from alcohol if previously dependent review by a specialist in addiction and a specialist in neurology.

## Drug misuse or dependence

	<b>Group 1 car and motorcycle</b>	<b>Group 2 bus and lorry</b>
<b>Drug group</b> <ul style="list-style-type: none"> <li>cannabis</li> <li>amphetamines (but see methamphetamine drug group Y below)</li> <li>'ecstasy' (MDMA)</li> <li>ketamine</li> <li>other psychoactive substances, including LSD and hallucinogens</li> </ul>	Must not drive and must notify the DVLA with persistent misuse or dependence. Medical enquiry confirming the problem will result in licence being refused or revoked: for a minimum of 6 months, which must be free of misuse or dependence. <b>Except</b> in the case of ketamine: for a minimum of 6 months drug-free after misuse, or for a minimum of 12 months that must be free of dependence and may require an independent consultant or specialist assessment and urine screen arranged by the DVLA.	Must not drive and must notify the DVLA with persistent misuse or dependence. Medical enquiry confirming the problem will result in licence being refused or revoked: for a minimum of 1 year, which must be free of misuse or dependence. Relicensing will usually require an independent medical assessment and urine screen arranged by the DVLA.
<b>Note on methadone</b> Full compliance with an oral methadone maintenance programme supervised by a consultant, specialist or appropriate registered health care practitioner, may allow licensing subject to favourable assessment and, usually, annual medical review. Similar criteria may apply for an oral buprenorphine programme. There should be no evidence of continued use of other substances, including cannabis.		

	<b>Group 1 car and motorcycle</b>	<b>Group 2 bus and lorry</b>
<b>Drug group</b> <ul style="list-style-type: none"> <li>heroin</li> <li>morphine</li> <li>methadone (note on compliance, page 80)</li> <li>cocaine</li> <li>methamphetamine</li> </ul> <b>Benzodiazepines</b> Note on therapy versus persistent misuse below.	Must not drive and must notify the DVLA with persistent misuse or dependence. Medical enquiry confirming the problem will result in licence being refused or revoked for a minimum of 1 year, which must be free of misuse or dependence. Relicensing may require an independent medical assessment and urine screen arranged by the DVLA. *Applicants or drivers <b>complying fully with a</b> consultant supervised oral Methadone maintenance programme may be licensed subject to favourable assessment and normally annual medical review. Applicants or drivers on an oral <b>buprenorphine</b> programme may be considered applying the same criteria. There should be no evidence of continuing use of other substances, including cannabis.	Must not drive and must notify the DVLA with persistent misuse or dependence. Medical enquiry confirming the problem will result in licence being refused or revoked for a minimum of 3 years, which must be free of misuse or dependence. Relicensing will usually require an independent medical assessment and urine screen arranged by the DVLA. *Applicants or drivers <b>complying fully with a</b> consultant supervised oral Methadone maintenance programme may be considered for an annual medical review licence once a minimum <b>3 year</b> period of stability on the maintenance programme has been established with favourable random urine tests and assessment. Expert Panel advice will be required in each case.
<b>Note on benzodiazepines</b> The non-prescribed use of these agents and/or the use of a suprathreshold dosage outside BNF guidelines constitutes persistent misuse or dependence for licensing purposes – whether in a programme of substance withdrawal or maintenance, or otherwise. The prescribed use of these drugs at the therapeutic doses listed in the BNF, without evidence of impairment, does not amount to persistent misuse or dependence for licensing purposes (albeit, clinical dependence may exist).		

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## Seizure associated with drug use

**Seizures associated with drug use are not considered provoked in terms of licensing.**

If there is more than one seizure, the regulations governing epilepsy will apply to drivers in both groups (see Appendix B, page 103).

	<b>Group 1 car and motorcycle</b>	<b>Group 2 bus and lorry</b>
<b>Solitary seizure</b>	Must not drive and must notify the DVLA. Licence will be refused or revoked for a minimum of 6 months after the solitary drug-related seizure (for details see, Chapter 1, neurological disorders, pages 14, 15 and Appendix B). Subsequent licensing requires satisfaction of the fitness standards elsewhere in this chapter whenever there is a background of substance misuse or dependence to the seizure, and will include requirements for: an appropriate period free from persistent alcohol misuse and/or dependence independent medical assessment usually, urine analysis and consultant specialist reports.	Must not drive and must notify the DVLA. Licence will be refused or revoked for a minimum of 5 years after the solitary drug-related seizure (for details see, Chapter 1, neurological disorders, pages 14, 15 and Appendix B). Subsequent licensing requires: no underlying cerebral structural abnormality no epilepsy medication for at least 5 years maintained abstinence from alcohol if previously dependent review by a specialist in addiction and a specialist in neurology.

## Notes on the Guidelines

As a result of the Panel discussion regarding the supervision of methadone maintenance programmes, full compliance supervised by a consultant, specialist or appropriate registered health care practitioner was considered acceptable with reference to the delivery of the programme. However, DVLA will still require formal endorsement by ‘a registered medical practitioner nominated by the Secretary of State’ as described in the Road Traffic Act (Section 94). The same considerations apply to a benzodiazepine management programme.

Panel discussed the prescription of medicinal cannabis, recognising that although this could potentially become a drug of abuse, the present national prescribing guidelines (British National Formulary) remained pertinent and should be used as a reference by the prescriber.

The Panel commented that the term ‘multiple substance misuse’ is a very broad concept and would like the opportunity to review the relevant standards following a consideration of the definition of persistent. The question of persistence is likely to be relevant to a future discussion in relation to fitness to drive.

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## **8. Medical standards review:**

### **Alcohol and Drug dependence: a comparison of national criteria**

The Panel is aware that the requirements for fitness to drive relating to several of the mental health conditions had been reviewed recently, with a reduction in the period of recovery required before licensing could be considered.

Panel agreed to review the relevant information formally as a paper at the next Panel Meeting to ensure that the standards applied by DVLA are consistent with those elsewhere, including, the EU, North American and Antipodean jurisdictions. Panel accepted that clinical intuition, received wisdom, the durability of the guidelines in practice and their historical origins from the Epilepsy Standards, may represent important contributions to appropriate licensing decisions in different parts of the world. The review is expected to consider the context of the licensing decisions, as well as, the available medical evidence for the standards applied.

## **9. Drug Misuse and Dependence Guidelines update**

Panel was informed that, ‘The Orange Guidelines’ (Clinical management of drug dependence) have recently undergone their 5<sup>th</sup> review since 1981. Although, the emphasis is on clinical management of patients with drug use problems, there is a section on Drugs and Driving. The consultation period is over and publication expected within months.

In general, the guidelines are high level and consistent with the existing DVLA advice in practice. AFD is referenced in the document, in addition to, the ‘Psychoactive Substances Act,’ (2016), and GMC guidance on confidentiality, (2009). A review by the DfT Officials was recommended.

## **10. The definition of persistent misuse**

Alcohol or drug misuse is a prescribed disability according to the Road Traffic Act 1988, Section 92(2)(a). Prescribed disabilities are defined in the Motor Vehicles (Driving Licences) Regulations 1999, Section 71(1)(e). The law defines those medical conditions which are considered to be “relevant” and “prospective” disabilities for driver licensing purposes. Section 92(2) of the Road Traffic Act 1988 defines a “disability” as “...and the persistent misuse of drugs or alcohol, whether or not such misuse. However, the law does not provide a definition for “persistent”.

The Panel was asked to review the definition of ‘persistent misuse’ of drugs and/or alcohol after an Independent Complaints Assessor review of a case, in order to provide a clearer understanding of the interpretation.

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The DVLA offers definitions of alcohol or drug ‘misuse’ and ‘dependence’ based on ICD-10 medical criteria in ‘Assessing Fitness to Drive.’ Panel is aware of other definitions, such as ‘substance abuse’ and ‘use disorder,’ derived from DSM4 and DSM5. The discussion of this matter over many years, including the adoption of the ICD-10 medical definition of ‘misuse’ in 2004, as previously minuted, was considered by the Panel at this Meeting. In addition, Panel reviewed the archived minutes in relation to persistent misuse from 2000 to 2016 to assist the discussion.

The present consideration includes a need to consider, whether or not, ‘persistent misuse’ involves the process of harm to oneself and/or others, or a definition in terms of frequency and quantity of the drug and/or alcohol levels consumed, or both of these considerations.

Sometimes this Panel has reviewed individual cases in these terms, and provided advice dependent on the frequency, quantity and type of substance used, and this appears appropriate. The illicit nature of drug use and licit use of alcohol has caused some difficulties with a consistent definition of persistent misuse in the past. This is a representation of Annex 3 of the 2<sup>nd</sup> EC Directive and the Panel has previously discussed the complexity with the application of this Directive (Minutes of January and October 2004). Persistent misuse of drugs or alcohol whether or not such misuse amounts to dependency is prescribed in respect of Group 1 and Group 2 licences.

This legislative position requires a definition of the term ‘persistent misuse’ in the context of the problem of clinical alcohol or drug misuse on a continuum towards clinical dependence. On the other hand, it is recognised that the potential for substance misuse and/or dependence is dependent on the clinical concerns relevant to the particular drug; cocaine is distinct from cannabis, for example, and cannabis use 4 or more times a week is more concerning than one or twice a week when considering persistence.

The Panel agreed that a dictionary definition of persistent, as defined: continuing obstinately; enduring; constantly repeated, was unhelpful in the context of persistent misuse of drugs or alcohol due to the clinical context. Whereas, the Panel accepted that the definition provided in ICD-10 for clinical misuse may not necessarily relate to fitness to drive.

The Panel intends to provide a working solution to this problem of definition, in order to allow DVLA a practical application. To this end it was agreed that in relation to alcohol misuse, **‘persistent is defined as repeated and/or continually recurring alcohol consumption despite the likely risk of harm to the individual or others, and with regard to the standard for physical and mental fitness for driving.’** Persistent is defined similarly in relation to the misuse of drugs where, **‘persistent is defined as repeated and/or continually recurring drug use despite the likely risk of harm to the individual or others, and with regard to the standard for physical and mental fitness for driving.’** This corresponds to the minimum standard for safe driving described in (EU Directive 2006/126/EC).

The Panel advised that the Medical Advisers should consider the practical applications of these definitions, although it was recognised the ultimate test would be in a Court of Law, where a Judge has discretion regarding the interpretation of meaning and its purpose in legislation.

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## **11. Case discussion: urine cannabis testing**

Panel discussed a case involving a declaration of persistent misuse/dependence on cannabis. Expert toxicology opinions on behalf of the customer and DVLA were considered by the Panel as well as their journal references.

The Panel unanimously agreed that the inability to abstain from cannabis despite an awareness that a medical examination with a urine drug screen was arranged some weeks ahead, combined with a significantly elevated urine cannabis metabolite level, indicated persistent misuse of cannabis 4 days after the last declared consumption. The Panel agreed with both Toxicology Specialists, that the absolute level of urine cannabis metabolite is insufficient of itself to substantiate a medical diagnosis of 'persistent drug misuse' without regard to the clinical context of the investigation.

## **12. Case discussion: intravenous opioid administration**

A case was presented involving the prescribed injection within a drug substitution programme. Previously the Panel has advised DVLA that parenteral routes for opioid substitution are not compatible with safe driving due to unpredictable absorption. No maximum therapeutic dose has been determined, although very high levels of prescribed opioid have been regarded as incompatible with safe vehicle licensing.

The Panel advised that a Specialist assessment or a Panel decision is advised in these unusual cases to allow a full evaluation of the clinical details.

The existing requirement for a Group 1 licence is a minimum period of 12 months stability on methadone and other opioid drug addiction programmes.

## **13. Case discussion: elevated CDT in haemodialysis**

A HRO driver on intravenous fistula haemodialysis with a restricted fluid intake was presented to the Panel for advice on the interpretation of the CDT results.

The Panel advised the referral of this case to a Panel Member with expertise in CDT analysis.

## **14. GMC guidelines on confidentiality**

Panel discussed the consultation (now closed) by the GMC guidelines on confidentiality. As the latest version has yet to be published, Panel will review these published guidelines at the next meeting.

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## **15. Lay Membership**

Following the recent resignation of the Lay Member, the DVLA Governance Group is considering the support for Panels in general. The aim is to provide further details to the Panel Chairs Meeting as this work is in progress. Once the review is complete, it is expected that new Lay Members will be appointed.

No membership changes to this Panel are anticipated before the retirement dates in 2017 apply.

## **16. Any Other Business**

The Chair requested that Professor R Forrest is invited to attend future Panel meetings because of his knowledge and expertise, until a suitable replacement has been appointed.

## **17. Date of next meeting**

The next meeting of the Panel is scheduled to take place on 15 March 2017.

**Dr A M Brown**  
**Panel Secretary**

14 October 2016

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