The Government's Response to the Reports by Sir Peter North CBE QC and the Transport Select Committee on Drink and Drug Driving

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Priorities and actions

The Government is committed to improving road safety. It is a priority to deter driving when unfit through drugs or alcohol, and to ensure that those who persist in this dangerous behaviour are detected and punished effectively.

Considerable progress has been made in the abatement of drink-driving, but much more progress needs to be made to achieve similar results with drug-driving – while continuing the long-running work against drink-driving. We know that the use of impairing drugs is widespread, and that many of those who use them see no reason to refrain from driving under their influence. The prospect of an effective means of detecting and deterring drug-driving will – for the first time – allow a serious enforcement effort against this dangerous behaviour. That is our first priority, which we believe is shared by the police.

It is just as dangerous for people to drive impaired by alcohol or drugs, and it is quite wrong that it is easier to get away with one than the other. We are convinced that our priority must be to give the police the means to protect law-abiding road users with measures that are efficient and effective, concentrating on those who are the most danger to themselves and other road users. There needs to be a clear message that drug-drivers are as likely to be caught and punished as a drink-driver. We need to make it easier for the police to identify drug-drivers and obtain the evidence needed for successful prosecutions.

Our strategy is to focus resources and any legislative changes on measures which will have the most impact in reducing dangerous behaviours. There are therefore two main priorities to continue the successful abatement of drink-driving and achieve similar success against drug-driving:

- to give the police effective tools to identify and proceed against drug-drivers;

- to streamline the enforcement process for drink and drug driving to ensure the most efficient use of police and other enforcement resources.

We will implement the following measures

- revoke the right people have to opt for a blood test when their evidential breath test result is less than 40% over the limit (the ‘statutory option’)*;
- streamline the procedure for testing drink-drivers in hospital*;
- close a loophole used by high risk offenders to delay their medical examinations;
- require serious drink-drivers to take remedial training and a linked driving assessment – as well as a medical examination - before recovering their licence;
- re-launch the drink-drive rehabilitation scheme under which drink-drivers can obtain reduced driving disqualifications;

- approve portable evidential breath testing equipment for the police;
- provide for preliminary testing not to be required where evidential testing can be undertaken away from the police station*;
- approve preliminary drug-testing equipment initially for use in police stations – and at the roadside as soon as possible;
- delegate to custody nurses the assessment police doctors are now required to make of suspected drug-drivers*;
- seek opportunities to collect better information about the prevalence of drink and drug driving, and its implication in casualty accidents.

We have concluded that improving enforcement is likely to have more impact on the most dangerous drink-drivers, whereas it would not be value for money - or the most effective use of resources - to lower the prescribed alcohol limit for driving. The reasons are explained in detail in the attached paper.

We will progress work on a new offence relating to driving with a specified impairing drug in the body.

Primary legislation is required in relation to those items marked *, and to enable any new drug offence, and we will seek a slot for this at the earliest opportunity. Full impact assessments, including among other things the potential impacts on enforcement and the judicial system, will be prepared in the usual way when legislation is brought forward.

Introduction

1. This is the Government's response to the independent report on drink and drug driving in Great Britain commissioned by the previous Government from Sir Peter North CBE QC in December 2009. His terms of reference are at Annex A. The report was submitted in May 2010 and published on 16 June[1]. This paper responds to its 51 recommendation - 28 on drink-driving, and 23 on drug-driving.

2. This paper is also a response to the report of the Transport Select Committee, Drink and Drug Driving Law[2], which was published on 2 December 2010 following an inquiry by the Committee into Sir Peter's main recommendations. The Committee's 12 recommendations are reproduced at Annex B, with a note in each case about where they are discussed in this paper.

3. The Government has considered all the recommendations by Sir Peter and by the Select Committee, and other evidence available in relation to drink and drug driving. It has made an assessment of the resources required to provide an effective response to this dangerous behaviour, having regard to pressures on public spending. It has also considered the wider social and economic impacts of the changes proposed, especially in relation to the prescribed alcohol limit for driving.

4. It is now 80 years since road traffic law made it an offence to drive while unfit through alcohol or drugs. These are referred to in this document for convenience as 'drink-driving' and 'drug-driving' respectively. Sir Peter and the Select Committee have done the same.

5. Measures first put in place over 40 years ago have made considerable inroads into the serious problem of drink-driving. The latest figures – for 2009, published in August 2010 – are the lowest ever. After ten years which saw little improvement, there has been a 32% fall in drink-drive fatalities in the last three years. While some of the causal factors are understood we cannot fully explain these trends but the result is that drink-drive fatalities are now almost 80% lower than 40 years ago. The trend for positive breath tests has also been downwards, although testing has increased. Nevertheless, drink-driving still accounts for hundreds of deaths on our roads, and thousands of serious injuries – this is not acceptable, and further progress is crucial.

6. On the other hand, the toll from drug-driving has not been checked in recent years. Sir Peter is right that there is not enough information to track this problem adequately, but what is available points to a worrying level of illegal, recreational drugs among

[1] The North Review website has been archived and is now available from the National Archives website at: http://webarchive.nationalarchives.gov.uk/20100921035225/http://northreview.independent.gov.uk/

[2] http://www.publications.parliament.uk/pa/cm201011/cmselect/cmtran/460/46002.htm

road fatalities. North has cited evidence that the use of recreational drugs is widespread, although preferences change over time. There is clear evidence about the impairing effects of drugs in use. Research has also shown that those who use these drugs do not recognise this impairment, and are unconcerned about driving under their influence.

7. It is therefore true that the nature of both problems has changed over time – one has declined, while some drug users have developed an idea that they can drive impaired with impunity. There has been a welcome response to effective measures against drink-driving, but we have lacked equivalent measures to combat drug-driving.

8. Sir Peter's terms of reference asked him to assess the impacts of any change in the prescribed alcohol limit for driving on health outcomes, businesses and on the economy more widely. These have not been considered in detail in many previous assessments of the impacts of reducing drink-drive casualties. We have investigated the scope for a rigorous analysis of the costs and benefits likely to accrue from a change in the prescribed alcohol limit for driving. The Department's further work is presented at Annex C.

9. Many of the potential changes – such as possible impacts on the drinks sectors and rural economy - are difficult to quantify. Any assessment must be in part subjective because there is limited evidence from which to predict the changes in driving and drinking behaviour which might occur. A key consideration, however, is that most drink-drive casualties are well above the limit. It is these drinkers who need to change their behaviour radically to get major casualty savings. However it is not clear that these high-end drink-drivers - who must know they are already well above the limit - would change their behaviour simply as a result of a lower limit. Evidence suggests that the biggest deterrent is the perceived risk of the severe consequences of detection.

10. We must be concerned about the cost-effectiveness of particular measures to combat impaired driving. The police face constant difficult choices in prioritising their work. We recognise the increase in their activity in recent years against drink-driving, and their frustration with the constraints in tackling the drug-drivers they encounter all the time. It is easy to call for more priority to be given to a specific offence, but operational decisions about priorities have to be taken in the round and resources targeted at the highest risks. It is also important that they are properly informed by local considerations, which may well produce a different outcome in different areas.

11. The impact assessment in Annex C has also looked at the judicial impacts of a new offence of exceeding a lower limit. The criminal justice system is expensive. A great deal of resource is applied to road traffic offenders. Drink and drug offenders all have to be taken to court and will face disqualification. We have not followed - and, like Sir Peter and the Transport Select Committee, we do not favour - the approach in other countries of using penalty points and other administrative remedies for less serious drink-driving cases.

12. It is imperative to streamline the enforcement regime wherever possible if necessary additional measures are to be successful. The changes we propose, taken together, will make a step change to the effectiveness of the law on these two offences.

13. Sir Peter was asked to look specifically at the law, but he and the Select Committee rightly recognise that an effective strategy against driving unfit through alcohol and drugs uses other tools as well. The Department has campaigned against drink-driving for 40 years, and the positive impact has been widely recognised in helping to build the strong consensus that drink-driving is socially unacceptable and dangerous. We will aim to build on similar public attitudes to driving unfit through drugs.

14. Effective campaigns have highlighted a range of personal consequences to persuade offenders to change their behaviour before they are caught. We also recognise the need for incentives as well as deterrents. We look to develop a new direction for this work through the Driver Friendly campaign that is being developed and promoted through manufacturers and retailers.

15. We know that success depends on a range of interests working together – nationally and locally. Local authorities and voluntary bodies have an important part to play, and others can learn from what works well. Individual police forces have used innovative approaches, and we look to other forces to learn from these as well.

1. Drink-driving - Introduction

1.1 The North report makes 28 recommendations about drink-driving. It is convenient to group the response to these under the following headings

- The prescribed limit (recommendations 2, 3, 5, 8 and 9)
- Testing drivers (recommendations 11-14, 26-28)
- Penalties (recommendations 6, 15, 16, 18, 23 and 24)
- Training (recommendation 10)
- High Risk Offenders (recommendations 17 and 19-22)
- Statistics (recommendations 1 and 25)

1.2 There are also single recommendations about the role of the drinks industry (4), and possible action by transport fleet operators (7).

1.3 A number of these recommendations are about continuing current practice and require no action. Of those that require action we propose to implement the following (the sections of this report in which each is discussed are given in brackets):

1. statistics (Section 7)

10. drink-drive training (Section 5)

11. repeal of the statutory option (Section 3)

22. High Risk Offender scheme loophole (Section 6)

27. & 28. portable evidential testing devices (Section 3)

1.4 Of these, primary legislation is required for recommendation 28; and secondary legislation is required under existing powers for aspects of recommendations 10, 12 and 22. Impact assessments, including among other things the potential impacts on enforcement and the judicial system, will be prepared in the usual way when this legislation is brought forward. We do not accept the remaining recommendations for the reasons set out below.

1.5 Recommendations 4 (promotions to drivers) and 7 (interlocks) are mainly for industry. They do not require legislation.

2. The prescribed limit

2.1 The North report makes five linked recommendations about the prescribed limit:

2. The prescribed blood alcohol limit should not be reduced to 20mg of alcohol per 100ml of blood.

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

5. There should not be a lower limit of 20mg/100ml for drivers of HGVs, PSVs or taxis and private hire vehicles.

8. There should not be a lower limit of 20mg/100ml for either young or novice drivers.

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

Setting the prescribed limit at 50mg/100ml

2.2 The North report – and Recommendation 3 - supports a view widely advocated by some stakeholders that the prescribed limit should be reduced from 80mg/100ml to 50mg/100ml for all drivers. The prescribed limit applicable to all drivers throughout Great Britain can be changed by secondary legislation subject to affirmative resolution.

2.3 The Select Committee decided not to support this recommendation. However, at paragraph 38 of their report, they recommend that the Government should aim in the long term for an "effectively zero" limit of 20mg/100ml although they acknowledge that this is too great a step at this stage. They therefore concluded that for the moment the priority should be tougher enforcement.

2.4 Sir Peter reaches his conclusion for two main reasons:

- a range of forecasts predict that reducing the limit would lower casualties;
- the lower limit is less restrictive than most people think, and it is not therefore likely to have serious adverse social and economic consequences.

2.5 The forecasts used by North suggest annual fatality savings of between 43 and 168. The forecasts are taken from various sources, including from a model commissioned by the

National Centre for Health and Clinical Excellence (NICE) which has given results much greater than any earlier estimates.

2.6 The Department for Transport (the Department) publishes National Statistics on reported road casualties in Great Britain and the annual report routinely includes an article on drink-driving. The most recent in this series was published on 23 September 2010[3]. Figures show that fatalities resulting from drink-drive accidents[4] fell by 5% from 400 in 2008 to 380 in 2009[5], whilst seriously injured casualties fell by 9% from 1,620 to 1,480. Slight casualties resulting from drink-drive accidents fell by 8% from 10,960 to 10,130. Total drink-drive casualties fell by 8% from 12,990 to 11,990. Fatal drink-drive accidents remained unchanged from 2008, remaining at 350 for the second year in a row. Overall drink and drive casualty accidents fell by 7% from 8,620 to 8,050.

2.7 These figures show a considerable reduction in drink-drive casualties in the last three years. There has been a reduction of more than 75% in drink-drive casualties since 1979. Deaths alone have fallen by 32% from 560 in 2006 to 380 in 2009. Changes of this kind are likely to be the product of many factors working together.

2.8 The Department has also published alongside the main road casualty statistics provisional statistics on breath alcohol screening tests in England and Wales 2009[6]. This report provides experimental statistics on the results of roadside breath alcohol screening tests, administered by police forces in 2009, using new digital breath testing devices which record each test automatically. They relate to drivers of road vehicles only. The analysis in the note is based on data supplied to the Department for Transport by 37 (out of 43) police forces, each of whom supplied at least one month of data relating to 2009 (around 535,000 tests in total). The data for 2009 are not complete and do not cover England and Wales as a whole. Therefore, in order to avoid producing potentially misleading statistics, the analysis in the note is limited to examining proportions and distributions within the data[7].

2.9 It is important to note that not all 'drink-drive casualties' are themselves 'drink-drivers': the statistics include other casualties in accidents in which a 'drink-driver' was involved – who may or may not have been a casualty themselves. The statistics in question also give figures for casualties in accidents in which somebody tested positive for alcohol but was not a 'drink-driver', as defined (see footnote 5). Once again, the

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[3] Available on line at - http://www.dft.gov.uk/pgr/statistics/datatablespublications/accidents/casualtiesgbar/rrcgb2009

[4] For these purposes, a reported "drink drive accident" is a collision on a public road reported to police in which someone is killed or injured and where one or more of the drivers or riders involved either refused to give a breath test specimen; or failed a roadside breath test; or died and was subsequently found to have more than 80 milligrams of alcohol per 100 millilitres of blood. (This paper refers to these three groups together as "drink-drivers".) "Drink drive casualties" are defined as all road users killed or injured in a "drink drive accident".

[5] All the figures quoted here for 2009 are provisional

[6] http://www.dft.gov.uk/pgr/statistics/datatablespublications/accidents/breathalcohol

[7] More comprehensive statistics on screening breath tests are published in the Home Office Statistical Bulletin *Police Powers and Procedures, England and Wales 2008/09*, which includes returns of tests recorded manually, as well as those recorded automatically.

casualty may not themselves have tested positive; and the person who did may or may not have been a casualty. It is also important that the statistics do not indicate fault or blame – it is not to be assumed, therefore, that all the accidents or casualties are attributable to alcohol impairment.

2.10 The statistics collected by the Department, however, allow the following analysis of alcohol-related road fatalities.[8]

Blood alcohol levels of reported fatalities aged 16 and over: GB 2008

	Below limit			Above limit			
mg/100ml	**0-9**	**10-50**	**51-80**	**81-100**	**101-150**	**151-200**	**over 200**
Motorcycle riders	287	38	5	6	5	10	11
Car drivers	389	54	14	5	33	48	61
Other vehicle drivers/riders	43	3	0	1	0	2	8
Passengers	81	21	4	5	13	17	16
Pedestrians	167	21	5	7	12	16	62
Cyclists	51	4	0	1	0	4	1

Source: Coroners and Procurators Fiscal only

2.11 The above table shows that the numbers of drivers and riders testing positive for alcohol at levels below the prescribed limit are greater than those exceeding the limit (80mg/100ml). Almost all of the former were also below 50mg/100ml with only 2% between 51 and 80mg/100ml. It might fairly be assumed that the more alcohol in a driver's body the more likely it is that impairment resulting from the alcohol caused – or contributed to – the accident, and its severity. On the other hand, the lower the driver's blood alcohol, the more likely it might be that some other factor contributed. It will be noted, in this connection, that the great majority of fatalities testing positive for alcohol but below the limit were actually below 9mg/100ml.

2.12 Widely accepted evidence cited in Sir Peter's report shows that drivers' relative crash liability starts to rise sharply at blood alcohol levels between 50mg/100ml and 80mg/100ml. It becomes very much higher above the present limit. In over 90% of drink-driver fatalities (where a driver was over the limit, as defined – see note to

[8] NB - Only the categories of drivers and riders in the first three lines of this table fall within the definition of 'drink-drivers' given in the note to paragraph 2.6 above.

paragraph 2.6 above) the drink-driver was over 100mg/100ml, and over 40% who were over the limit were over 200mg/100ml. There is a similar bias among those apprehended.

2.13 The lower-end forecast of casualty savings mentioned in paragraph 2.5 above derives from work by Professor Richard Allsop, which has been refined several times over the years[9]. This is an estimate based on assumptions about the way drivers in this country might modify their behaviour in response to a change in the limit. The estimate is of the potential reduction in fatalities if all drivers liable to give test results between 80 and 110mg/100ml reduced their alcohol consumption so as to become liable to test in the range 50 to 80 mg/100ml; and all those liable to give test results between 50 and 80mg/100ml reduced their alcohol consumption so as be just under 50mg/100ml. In this estimate, significant change among those most seriously above the present limit is excluded from the calculation as unlikely.

2.14 The estimates constructed on this basis give an indication of the scale of potential benefits which might be expected. Achieving them would require a wholesale change among drivers testing positive at an intermediate – but mainly illegal – level which may not fully materialise. It is generally recognised that the estimate unavoidably simplifies for modelling purposes. It is assumed that drivers can be segmented for alcohol consumption on the basis of evidence from a breath test, or a post mortem. This evidence tells us how much alcohol a driver had in the body at the point of testing, but it does not show that he or she habitually imbibes that level of alcohol, and indeed the level rises and falls through any drinking episode.

2.15 The high end forecast mentioned in paragraph 2.5 above is from the NICE model, and is based on results from research overseas. Some of this work is comparatively dated. The figure of 168 fatalities saved is based on applying experience some years ago in Australia. The drink-drive problem has changed where it has been tackled. The results are based upon studies where a lower limit was associated with other measures such as significant changes in enforcement.

2.16 There have been periods in which major reductions in drink-drive casualties have occurred in this country, and others when progress has been more difficult. This pattern is overlaid by trends in overall alcohol consumption. Following considerable progress in the last three years, this country now has the best record of any for having reduced drink-drive casualties. The remaining problem involves a different sort of audience than those against whom earlier campaigns were directed. Drink-driving was abating in this and other countries at the time of the Australian studies used by NICE. It is not clear how additional measures might be capable of making that sort of change now.

2.17 The NICE report does not show how such considerable savings as they have modelled could be achieved. If such a reduction could be achieved among the moderate drinkers (represented in the fatalities figures by those who tested well below the prescribed limit), such drivers would all need to refrain almost completely from driving after drinking. If, on the other hand, the reduction is to come from the most excessive drink-drivers (represented in the fatalities by those testing well over the prescribed

[9] See e.g. *How Much is Too Much?* - May 2005 at http://eprints.ucl.ac.uk/1379/1/Brake05_REA.pdf

limit), there will need to be a very substantial change in behaviour among such people. Research[10] has found that these people are unlikely to have measured their drinking – in some cases, deliberately. Some will have been persistent mis-users of - or clinically dependent upon – alcohol. It is a matter of judgement whether it is realistic to predict major casualty savings that would depend to such an extent on a fundamental change in this sort of behaviour.

2.18 Problem drivers are not taking chances with the limit – they seem not to measure their drinking; but with the chance of getting caught – which experience has taught them is very low on any given occasion. Such drivers will only re-consider their drinking habits if they recognise the risk of being caught. That re-assessment may not be achieved by changing a limit they are now willing to exceed routinely. So, Allsop is probably right not to assume casualty savings among such drivers. Assumptions of wholesale change among more moderate drinkers may also be optimistic but they may well indicate the order of magnitude of potential savings.

Enforcement

2.19 It is generally true that what is most likely to abate offending is the perceived risk of being caught and punished. The North report explicitly does not address the implications of a lower limit for the enforcement agencies. It does, however, argue that the offence should have more priority with the police. The Select Committee note that effective police enforcement is equally as important to deter drink-driving as the level of the legal blood alcohol limit, and recommend that it should be much more visible, frequent, sustained and well-publicised. This recommendation is partly addressed in the following paragraphs, and also in a later section about random testing, on which North and the Select Committee have made a further recommendation.

2.20 There is good evidence that more enforcement of the limit works. The evidence of benefits from changing the limit alone is less robust. A lower limit will have to be effectively enforced if benefits are to be achieved – and not at the expense of resources now applied to the very dangerous drivers who breach the present limit, or other road traffic offenders or criminals more generally. A step change in enforcement is likely to be needed to change the behaviour of problem drivers to the extent assumed in the forecasts.

2.21 Catching and processing additional offenders claims time from the police – potentially at the expense of other work, and at all subsequent stages through the prosecution process. A lower limit which widened the scope of the offence risks giving the police a tricky choice – how do they focus on the dangerous people if they have to catch lower-level drinkers too? If the focus on the more dangerous drink-drivers is lost, then the apparent benefits of widening the offence will be undermined. Indeed if resources are not changed but the limit is lowered, then the diversion of resources to catching and

[10] A Qualitative Study of Drinking and Driving: Report on the Literature Review – available online at - http://www.dft.gov.uk/pgr/roadsafety/research/rsrr/theme3/report13review.pdf

A Qualitative Study of Drinking and Driving: Report of Findings – available online at - http://www.dft.gov.uk/pgr/roadsafety/research/rsrr/theme3/report14review.pdf

processing less serious drink-drivers could reduce the likelihood of the more dangerous high-end offenders being caught.

2.22 The Select Committee recommend that individual police forces should be consulted to assess the respective cost-benefit implications of more effectively enforcing the current drink-drive limit against any proposed reduction. However, there is no real basis for such an analysis. It would be possible to measure time devoted specifically to drink-drive enforcement - as in a specific campaign, for example. How much time the police generally spend on enforcement over a particular period will, however, be affected by how many accidents occur, how many moving traffic offences are committed and how many reasonably suspected incidents of drink-driving are witnessed. We cannot predict how a lower limit would change drivers' behaviour, or affect the number of accidents the police might be required to attend. Enforcement is also more than a police resource issue. The Department's Impact Assessment also considers costs elsewhere in the judicial system of more enforcement.

2.23 The Coalition Agreement includes a commitment to authorise drug-testing equipment for driving, identifying as a priority the need to bring to justice drivers impaired by drugs, and this response describes the measures we are taking to that end. The resources available to the police are constrained and we have to ensure that they are sufficient to make a real impact on drug-driving, in order to make the sort of casualty savings that have been seen on drink-driving.

2.24 The long-running campaign against drink-driving has established a strong social consensus that driving impaired by alcohol is unacceptable and dangerous. The evidence shows that most people take a highly precautionary view about how little they should drink if they are driving. They do not want to run the remotest risk of being caught for drink-driving, or of having an accident because they are impaired. At the same time, there would be pressure to know what a new limit allows and any suggestion that anybody could avoid prosecution while drinking more than they are willing to risk now would be very unhelpful.

Education

2.25 The Select Committee believe that any reduction in the legal drink-drive limit should only occur after an extensive Government education campaign, run in conjunction with the pub, restaurant and hospitality industries, about drink strengths and their effect on the body. They recommend (paragraph 38) that the Government should look to learn from experiences in other countries which have successfully implemented a reduction in the drink-drive limit to either 50mg/100ml or 20mg/100ml.

2.26 It is important to consider what the effect would be on different kinds of drivers of lowering the prescribed limit. Evidence suggests that the problem drivers' behaviour is entrenched, whereas the majority of drivers take a precautionary approach. The majority would not need to lower consumption to stay legal with a lower limit, but their response to the present limit suggests that they will not want to take any chance with the risk of offending. These responsible people have the choice to drink even less – and especially to drink less when they are out. If that happened, it would have a substantial impact on the businesses they patronise. But unless such people are responsible for more casualties than the figures quoted above suggest, there would be little impact on

casualties if these people drink or drive less. The result would be economic costs without the intended benefits.

2.27 Others have campaigned to increase understanding of 'units'[11] - with the result that most people are aware of the concept, but only a small minority actually use it to manage their drinking[12]. We recognise that the public have a poor understanding of how much alcohol there is in a particular drink, but a main part of our problem is that the dangerous drivers are not measuring their liquid consumption, let alone considering its alcohol content – those who drink at home typically do not use any form of measure for their drinks, and topping up is a common social practice.

Other impacts

2.28 Changes in the law against drink-driving have the potential to yield a range of costs and benefits. These have not been considered in detail in many previous assessments of the benefits of reducing drink-drive casualties. We have investigated the scope for a rigorous analysis of the costs and benefits likely to accrue from a change in the prescribed alcohol limit for driving, although many of the changes, such as the wider impact on the drinks sectors and rural economy, are difficult to quantify and it is not possible to deliver a definitive assessment.

2.29 Further work undertaken by the Department on the social and economic impacts of a lower prescribed limit is presented at Annex C. It is in part subjective because there is also little evidence from which to predict the changes in driving and drinking behaviour which might occur. The assessment therefore identifies a range of potential benefits from a reduction in the limit; and ranges for some potential costs.

2.30 It is recognised that there would be wider health benefits from any measures which resulted in reduced misuse of alcohol; however, there is little evidence to assess specific benefits of this kind associated with a change in the limit. These would depend on people reducing overall alcohol consumption, and not just on people refraining from driving after drinking.

2.31 Scenarios have been constructed which model the impact of avoiding a range of road casualties. Sir Peter reported a range of estimates for annual fatality savings between 43 and 168. These estimates are discussed in paragraphs 2.12-2.17 above.

2.32 On the costs side, there are estimates for the judicial impacts of a new offence of exceeding a limit at 50mg/100ml. The assessment also considers the impact of drivers refraining from patronising pubs and other on-licensed premises. Estimates of these impacts depend on the quality of data available about the sectors concerned. This is assessed to allow only scenarios which illustrate the potential range of the impacts. There are wider potential social and economic impacts beyond the direct consequences for sales in on-licensed premises. It is not possible, however, to quantify these from

[11] See, for example, http://www.drinkaware.co.uk/features/health/guide-to-alcohol-units-and-measures

[12] 16% said that they kept a check on the number of units they drank (although some of these checks were not likely to be accurate) - Lader, D. (2009) Drinking: Adults' Behaviour and Knowledge in 2008. Opinions (Omnibus) Survey Report No. 39. Newport: Office for National Statistics; available on-line at - http://www.statistics.gov.uk/downloads/theme_health/drink2009.pdf.

available information, given especially the uncertainties about the likely changes in drinking and driving behaviour.

Setting the prescribed limit at 20mg/100ml

2.33 The Select Committee have supported an aspiration to move to a limit of 20mg/100ml (see paragraph 38 of their report). They agree with Sir Peter that such a change could not be contemplated at this stage.

2.34 A limit of 20mg/100ml is effectively a "zero tolerance" level and operates in some other European countries. It is advocated as consistent with longstanding advice - "Don't drink and drive", and is considered to avoid mixed messages to the public. The North report rejected this limit for a lack of evidence that drivers with low blood alcohol concentrations were a problem group in terms of casualties; and it would risk alienating public support for drink-drive legislation. It was also considered that milder penalties would have to be in place at this level, which could dilute the effectiveness of the current regime.

2.35 The research cited in paragraph 2.17 above includes evidence that problem drivers say that only a complete ban on driving after drinking would change their behaviour. We have no evidence that this would prove to be so, given how entrenched their behaviour appears to be. On the other hand, it would not be right to put the responsible majority at risk of serious penalties purely for the sake of an attempt to persuade other, irresponsible drivers to change their ways. We believe that education, smarter enforcement, and deterrent sanctions are a more appropriate way of tackling these dangerous drivers.

Conclusion on prescribed limit

2.36 Our strategy is to help the police to focus on the most dangerous people – those who feature most prominently in the drink-drive offence and casualty statistics; as well as the drug-drivers who at present escape detection. We do not believe that widening the scope of the drink-drive offence by lowering the limit is consistent with this approach. It has various operational and practical difficulties; and imposes social and economic costs which we do not consider, on the present evidence, to be matched by potential benefits.

2.37 For all these reasons, the priority on drink-driving must be to make the present regime work better. We do not propose to lower the prescribed alcohol limit for driving as well.

3. Testing drivers

3.1 North has seven linked recommendations about the way in which it is determined that a driver has exceeded the prescribed limit:

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

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

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

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

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

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

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

The statutory option and blood/breath ratios

3.2 We agree with Recommendation 11, and consider that the statutory option should be removed when an opportunity to legislate arises. We will need to consult formally at that time, and prepare appropriate impact assessments in the usual way. We will seek views at that time on Recommendation 12, that the prescribed limit in breath should be calculated as 1/2000th of the limit expressed as a blood alcohol concentration. If the statutory option is removed, it will be necessary in the interest of fairness and the robustness of the regime to ensure that the breath-alcohol limit is set at a level which, in

the overwhelming majority of cases, represents a blood alcohol level above the legal threshold.

3.3 A driver is asked for two evidential breath specimens. Section 8(2) of the 1988 Act says that, if a driver's evidential breath specimen with the lower proportion of alcohol contains no more than 50mcg/100 ml of alcohol, the driver may claim that it should be replaced by a blood or urine specimen and, if he then provides such a specimen, neither specimen of breath shall be used. This is referred to as 'the statutory option'. The Secretary of State may by regulations under Section 8(3) substitute another threshold instead of the one in Section 8(2).

3.4 The origins of the statutory option are not well recorded. It has been suggested that it exists to cover beyond doubt issues about the accuracy of evidential breath-testing; but it has never been considered that the equipment is so inaccurate as to require the sort of margin Section 8(2) provides. The best explanation is linked rather to the difficulty of arriving at valid equivalents for alcohol in breath and blood. Alcohol in breath is a good measure of impairing alcohol in the blood, because it is transferred from blood vessels to breath in the lungs at the same time as oxygen is also taken up by the blood vessels. Elimination of alcohol progresses at about one unit of alcohol per hour – taking only a few hours to clear altogether from a moderately impaired person, but much longer with extreme impairment. There is, of course, no way of linking 'units' to the prescribed limit, because of the complexities of absorption and elimination of alcohol, which vary from one individual to another.

3.5 Research published by the Department[13] has shown that, among the complexities of measuring an individual's impairment by alcohol, the relationship of blood and breath alcohol is by no means the same for all drivers – or indeed for any driver at different stages of a drinking 'episode'; and the range is wide. In studies where participants' blood and breath alcohol have been compared, a 'bell-curve' distribution of results has been achieved. Since impairment is a function of blood alcohol concentrations, any chosen solution therefore risks one of two kinds of problem:

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

- 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.

It is not, of course, possible to pick out the drivers who may lose or benefit in either of these ways without doing simultaneous breath and blood tests. Drivers in the first group are already partly protected from prosecution by the prosecuting threshold agreed between the Home Office and the police (which the North report recommends removing – see his Recommendation 14 and paragraphs 3.12-3.16 below).

3.6 There is no international agreement on how to set the alcohol concentrations in blood and breath on a consistent basis and different jurisdictions have tried to settle the

[13] Available on-line at http://www.dft.gov.uk/pgr/roadsafety/research/rsrr/theme3/report15.pdf

problem in different ways. The law in this country uses a result derived from research, which gives a limit in breath which is 1/2,300th[14] of the limit expressed in blood. This is a mean figure and results in an over-statement for about 25% of subjects. (Other countries have chosen 2000:1 - without any statutory option.)

3.7 The statutory option provides a remedy for drivers who might otherwise be treated unfairly – almost no other jurisdiction has one. As explained, a driver who appears from a breath specimen to be up to 40% over the prescribed limit can opt to have that specimen set aside in favour of a blood or urine specimen. (The police officer will prefer blood as a rule.) This is a very wide margin, and it has perverse consequences.

3.8 The result in practice is that drivers who exercise the option are almost bound to gain inequitable advantages. Venous blood will be used, with less alcohol than arterial blood if the driver is still impaired. There will always be a delay in securing the blood sample, on top of the time taken to bring the driver in and undertake the evidential breath test. Given the body's progressive elimination of alcohol, delay will yield a result significantly under-stating the likely level of alcohol while driving.

3.9 So, the effect of the statutory option is to favour all drivers with a breath specimen up to 50mcg/100ml, without any consideration of whether any individual needs this advantage in the interests of fairness. The impression that it provides a safeguard against inaccuracies in the equipment is wrong - the equipment is very accurate. Besides, a 40% margin for the sake of accuracy is quite unwarranted and accuracy is dealt with separately by the process described below. There is no other reason for such an allowance, given that the object is only to discover if a driver was over the prescribed limit, and those with results below 40mcg/100ml are already eliminated. We propose to legislate to remove the 'statutory option'.

3.10 There can be no question of discontinuing blood or urine samples altogether. There are cases where – pursuant to Section 7 of the Act – blood or urine specimens are taken because a specimen of breath is unobtainable for various reasons.

3.11 Research results show that expressing the limit in breath as 1/2,000th of the limit expressed in blood practically eliminates the risk of drivers' impairment being over-estimated – with the prosecution threshold (see below) providing a further safeguard. On the other hand, a significant additional number of drivers are then more leniently treated. It may be a more consistent approach, but it can also only be adopted by slightly raising the prescribed limit expressed in breath. We will seek views on this issue when we consult formally - as we must - on future legislation to remove the 'statutory option'.

Analysis and charging thresholds

3.12 We do not agree with Recommendations 13 and 14.

3.13 The 3mg/100ml deduction described in Recommendation 13 creates an analysis threshold. This was based on a number of experiments on blood and urine samples spiked with alcohol at around the 20mg/100ml to 30mg/100ml level. These gave a

[14] 35mcg is 1/2300th of 80mg

Standard Deviation of close to 1mg/100ml. Good statistical and laboratory practice is to take three times the Standard Deviation as an estimate of the (scientific) error. Hence, 3mg/100ml was set as the normal deduction for these cases. As most of the variation of results is independent of concentration, similar results would be expected from the same experiments carried out on blood and urine samples containing 80mg/100ml and 107mg/100ml respectively.

3.14 Home Office and ACPO policy since 1983 has been to ensure that all those prosecuted for drink-driving are certainly over the limit[15]. The charging threshold that currently applies – to which Recommendation 14 refers - serves this purpose. This arrangement may also serve to give reassurance, because of the imprecise nature of the correlation between breath and blood alcohol. However, the need for a threshold is not because the breath test device used might have been inaccurate. The type approval process guarantees that devices are consistently accurate and precise[16].

3.15 Under the current type approval specification, instruments have to 'self-check' themselves against a 35mcg gas standard and are allowed a tolerance of 32–37mcg, a variation of 5mcg. In addition, the gas standard is allowed a 1mcg variation at manufacture. Unless the type approval specification and gas and instrument design changes, there will always be a potential uncertainly of up to 6 micrograms. On this basis, the long-established charging threshold is indispensable. It is there to take account of the tolerance in such a way that we do not have contested cases where lawyers are challenging the result in an attempt to persuade the court that their client was under the limit.

3.16 If there is no charging threshold, the need it serves would have to be addressed elsewhere in the process, to remove any challenge that the result was lower than the actual limit. Otherwise, if officers have to attend a lot of not guilty trials, they will simply set their own tolerance and arrest only at a level of their choice rather then the legal limit.

Random testing

3.17 We do not accept Recommendation 26.

3.18 Primary legislation is required if it is necessary to provide expressly for unrestricted powers to require screening breath tests.

3.19 The case for change rests on a perception that the public are aware that police do not have an unrestricted power and that drink-drivers realise they are unlikely to be tested provided they do their best to drive carefully and avoid an accident or any other offence. This perception is linked to the restrictions under which the existing power is exercised. The police can, for example, check tyres at any time of the day or night with

[15] enshrined in Home Office Circular 1983/43 (there is a similar arrangement in Scotland enshrined in a letter of 14 July 1983 from the Crown Agent to the Law Society of Scotland)

[16] Type approval is a process by which equipment used by the police for law enforcement is measured against a published specification to ensure that it meets the required standard and is practical in use. Specifications are prepared with the benefit of expert advice and are subject to public consultation. Submitted equipment is subject to field and laboratory testing, by police forces and an approved laboratory (see also paragraph 10.33 below).

no reason, but the law only allows alcohol levels to be tested if certain criteria are satisfied.

3.20 The Select Committee recommend (paragraph 54 of their report) that the Government should give police an additional power to enable preliminary breath tests to be required and administered in the course of a designated drink-drive enforcement operation. They are concerned that the proposal for a general and unrestricted power is too wide and arbitrary. They have concerns about the public acceptability of such a power, and are not convinced that the introduction of this power is necessary to send a strong message to the public. They therefore seek the more specific power recommended.

3.21 The police already have an unrestricted power to stop vehicles; and a power to require a breath test if they suspect drink-driving, or if there has been a moving traffic offence, or after a road traffic collision. This power to stop for any reason and test if there is reasonable suspicion that a person has alcohol in his body - even if not over the limit - is already fairly sweeping. A power to conduct random tests could be seen as oppressive.

3.22 The object of random testing – as practised in other countries – is to create an expectation throughout the year among all drivers that they might be tested without reason, even if it is clear to the police officer that they are sober. If random breath testing raised levels of perceived risk of detection among drink-drivers, and so deterred them, it could make an important contribution to enforcement and reduction in deaths and injuries from drink-driving. However, it is possible that the level of testing activity would have to be multiplied to achieve any effect. An EC recommendation[17] that such procedures should aim to test all drivers once in three years would require more than ten million tests per year in this country – less than one million are conducted now. This would not be cost-effective, or a justified diversion of police resource. It would be better to develop smarter ways of using the existing power so that drink-drivers – rather than drivers in general – become at higher risk of testing and detection.

3.23 We recognise that specific campaigns, run by different forces, have potential to deliver a significant impact. Some, for example, run short exercises in which roadblocks are used and all passing drivers are tested, or given that opportunity. Other forces have done intelligence work to identify locations where intensive testing would have a particular impact – including deterrence.

Blood samples

3.24 Section 7(1) of the Road Traffic Act 1988 provides that a constable may, subject to the provisions of this Section and Section 9, In the course of an investigation into whether a person has committed an offence under Sections 3A, 4 or 5 of this Act, require him to provide two specimens of breath for analysis, or to provide a specimen of blood or urine for a laboratory test. These provisions relate to offences of drink or drug-driving. Section 7(3) regulates the provision of evidential blood specimens – which may only be taken at a police station or in a hospital. Section 11(4)(b) of the Act provides for a

[17] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2001:043:0031:0036:EN:PDF

blood sample to be taken by a medical practitioner or a health care professional – but the latter may only take specimens in a police station.

3.25 Section 7A provides for taking blood samples from a person incapable of consenting. Section 7A (2) says that a request under this Section 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 shall not be made to a medical practitioner other than a police medical practitioner unless (i) it is not reasonably practicable for the request to be made to a police medical practitioner; or (ii) it is not reasonably practicable for such a medical practitioner (assuming him to be willing to do so) to take the specimen. There is no provision for any other health professional to take the specimen in these cases. It follows, therefore, that a case will fall unless an appropriate medical practitioner is available. The North report has demonstrated that this is a general difficulty, but makes no recommendation on this aspect of the problem.

3.26 Sections S62(9) and (9A)[18] of the Police and Criminal Evidence Act 1984 ("PACE")[19,] provide that an intimate sample, except a sample of urine, may be taken from a person by a registered medical practitioner; or a registered health care professional. Section 65 of PACE[20] says that "registered health care professional" means a person (other than a medical practitioner) who is:

- a registered nurse; or
- 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.

3.27 Thus, the law already provides for custody nurses to take blood samples; and the Road Traffic Act permits them to do so at a police station. It would be an advantage to allow them to take blood specimens in drink-driving cases away from a police station. This would be mainly used to permit tests in hospitals. It will avoid letting offenders off when a police doctor is not available to do the test. At present the police must ask a medical practitioner, not anyone else, to take a specimen where consent is withheld. This restriction to medical practitioners was deliberate, in view of the sensitivities involved in taking a specimen without consent. Not allowing nurses to take a specimen in a hospital even with consent was also deliberate, to avoid arguments over whether consent had been properly given or not. It would, however, be practically easier to allow nurses to take samples and might generally be welcomed, but there could be an issue about the appropriate role of nurses and medical practitioners. We will consider further whether to widen the role of custody nurses.

Portable evidential testing devices

3.28 We agree with Recommendations 27 and in principle with 28.

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[18] Inserted by Section 54(1) of the Police Reform Act 2002 (c. 30)

[19] c. 60

[20] Inserted by Section 54(2) of the Police Reform Act 2002 (c. 30)

3.29 Section 6 of the Act provides that – in given circumstances – a police officer has the power to require a driver to co-operate with a preliminary breath test. The nature of this test is described in Section 6A[21] of the Act.

3.30 The test may be conducted – as it usually is – at the roadside, or elsewhere (for example in a hospital). The equipment now used to conduct such tests – which must be approved by the Secretary of State (the Home Secretary in this instance) - includes a screen to display the result of the test, which can then be judged against the prescribed limit for breath in Section 11(2) of the Act by a police officer deciding whether to proceed to arrest a drink-driver.

3.31 Section 6D(1)[22] of the 1988 Act provides for a driver to be arrested where, following a preliminary breath test, an officer has reasonable suspicion that the proportion of alcohol in the driver's breath exceeds the 'prescribed limit'. The officer then has power under Section 7(1) of the Act to require the provision of two specimens of breath for analysis on a device type-approved by the Home Secretary, or the provision of a specimen of blood or urine for laboratory analysis. These tests are all conducted at a police station, as the equipment involved is only type-approved for such use. The results of these tests – whether of breath, blood or urine - are evidential should it be decided to charge the driver with exceeding the prescribed limit. The two specimens of breath are tested separately and a decision on whether or not to charge the driver with an offence under Section 5 of the Act is taken on the basis of the lower result from the two tests (see Section 8(1) of the Act).

3.32 The Home Office is working on a specification for an approved portable evidential breath testing device. This should be published in final form within three months. The specification is challenging because, unlike the facilities at a police station, the roadside and other places where an evidential test might be conducted offer more demanding environmental conditions and, in particular, are not protected from potential sources of electronic interference; and devices submitted for approval will have to be tested to ensure that they are not subject to such interference.

3.33 Having portable evidential devices allows procedures to be streamlined. However, it will mean that a driver would only be arrested if the officer was satisfied that he or she might otherwise continue to drive unfit.

3.34 There are a number of consequential changes which we will address:

- the requirement for a screening test - primary legislation would be required to allow the police – as proposed in Recommendation 28 - to dispense with screening tests when they have evidential equipment at the roadside;

- the requirement for two evidential tests – decisions to prosecute for exceeding the prescribed limit are based on the lower of two evidential breath samples; two such tests will therefore be needed at the roadside;

[21] inserted by the Railways and Transport Safety Act 2003 (c. 20)

[22] inserted by the Railways and Transport Safety Act 2003 (c. 20)

- provision of blood or urine specimens – drivers who are unable to provide evidential breath samples at the roadside will have to be taken to a police station to provide blood or urine specimens;

- the statutory option - it would be necessary to have secured removal of the statutory option before moving to evidential testing away from the police station.

Removal of screening breath tests

3.35 A screening breath test may be required where there has been a moving traffic offence, a suspicion of alcohol, or involvement in a road traffic accident. An evidential test may be required at a police station or hospital in the course of an investigation into an offence contrary to Section 3A, 4 or 5 of the Act. There does not need to have been a screening breath test to arrive at this point. It would be an advantage to conduct evidential tests at the roadside on these terms, but currently (under Section 6 (2)(c)) this can only happen if a preliminary breath test has been required. This means there would have to be three roadside tests under the law as it stands.

3.36 Primary legislation would be needed to allow evidential testing at the roadside on the same basis as it is now permitted in a police station or hospital - that is, without a screening test. There will then need to be a power of arrest for failing a roadside evidential test – for which the law does not at present allow.

3.37 We will seek an opportunity to take enabling powers so that these changes can be achieved once the portable evidential equipment is in use, and we are in a position to remove the statutory option.

4. Penalties and sentencing

4.1 There are six recommendations relating to penalties for drink-driving:

6. Drink-driving offences in breach of the lower blood alcohol limit of 50mg/100ml Id when driving any vehicle of this type should continue to be an aggravating factor in the Magistrates' Court Sentencing Guidelines and in any future Scottish sentencing guidelines.

15. The excess alcohol offence under Section 5(1)(a) of the Road Traffic Act 1988 of driving or attempting to drive over the prescribed limit of 50mg/100ml should carry a period of disqualification of not less than 12 months and a band C fine.

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

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

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

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

4.2 Recommendations 6, 15, 16 and 18 depend on Recommendation 3. We do not agree with Recommendations 23 and 24.

4.3 The present penalty regime for drink and drug-drive offenders includes a minimum one year disqualification for the main offences. This has been regarded as an important element of the deterrent against these offences, which might be lost if offenders perceived a chance of less severe penalties. The Select Committee believe (paragraph 41) that the success of Great Britain's drink-driving policy has been largely attributable to the deterrent effect of the current 12-month mandatory disqualification penalty and believe that it should remain even after a reduction in the legal BAC limit. We agree.

4.4 The EC 6th Framework Programme supported a project, Police Enforcement Policy and Programmes on European Roads (PEPPER), which included, as Deliverable 6, a report produced in 2008 entitled 'Comparison and analysis of traffic enforcement chains across EU Member States and in relation to EU policies[23]. This report has a table comparing the prescribed limits in various EC countries, and the associated penalties. This shows a number of examples where penalty points and modest fines are used for offences below the UK prescribed limit. In some cases – for example, Spain and Portugal, the limit above which a criminal offence is committed is reported to be higher than the UK limit. In Canada, the federal limit is the same as in the UK, although the Provinces impose short-term licence suspensions for exceeding a lower limit.

4.5 The Department has not researched the reasons for these graduated regimes; nor is it aware of research into the impact of reducing penalties in this way. The Government agrees with Sir Peter that this is not the right approach. It may be that this approach is intended among other things to reduce the burden on criminal justice systems of processing additional offenders.

4.6 Even those countries which have penalties that are arguably tougher than Great Britain (such as Sweden – who have a lower limit and very tough sanctions) do not have a better drink-driving casualty rate. Where countries have made recent progress, this has been by improving enforcement – or raising the perceived risk of detection.

4.7 The 1988 Act is constructed so that the penalties for exceeding the prescribed limit are retained even if the prescribed limit is changed. The Government considers that the present penalties are proportionate to the seriousness of the present offence.

4.8 There are two references in these recommendations to Sentencing Guidelines. Recommendation 18 might be read as suggesting that courts are not following the current guideline now. No such concern is raised in the North report itself.

Forfeiture of vehicles

4.9 The Scottish provision referred to in Recommendation 23 is in Section 33A of the Road Traffic Offenders Act 1988, and relates to a power to order the forfeiture of a vehicle on conviction for certain road traffic offences. Primary legislation would be required to extend this provision to England and Wales. It largely replicates the provisions of Sections 143(6) and (7) of the Powers of Criminal Courts (Sentencing) Act 2000[24], which do not apply to Scotland. The main difference between the two is that the Scottish provision also allows the court to authorise the police to seize a vehicle if proceedings have been or are likely to be brought for a relevant offence, and it seems reasonable that on conviction a forfeiture order might be made.

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[23] http://www.pepper-eu.org/docs/pepper_documents/PEPPER_D6_WP1_20080821.pdf

[24] These apply (*inter alia*) where a person commits an offence under the Road Traffic Act 1988 which is punishable with imprisonment, and in cases of (failure to provide an evidential specimen in the course of a drink-drive investigation. The vehicle in question shall be regarded as used for the purpose of committing the offence, and the court may make an order to deprive the offender of his rights, if any, in the vehicle.

4.10 The crux of this recommendation is therefore the extension of powers to seize vehicles before conviction. There are already circumstances in which the police can seize vehicles before conviction (e.g. for reasonably suspected driving without insurance), but these powers are restricted; and the vehicle has to be released if the owner/driver satisfies relevant requirements, e.g. producing insurance and paying charges for removal and storage. Police are reluctant to seize vehicles in advance of a hearing – at which all sorts of relevant issues might be contested: the drink-drive offence itself and ownership of the vehicle, for example. Extending the Scottish power to England and Wales would be subject to a Human Rights Act assessment. Article 6 requires guilt to be established by due process. Article 1, Protocol 1 relates to the right to enjoyment of property, and Article 8 covers respect for private and family life. People other than the owner of the vehicle might be affected. Also, the person might be acquitted, in which case there might be a claim for compensation even if the vehicle had been retained and could now be returned. It would also have resource implications, with the police having to seek court orders and then search premises for the vehicle and seize it. Practical issues of providing for removal, storage and disposal of the seized vehicles would have to be considered.

4.11 It cannot be assumed that a vehicle is owned by the person driving it on any occasion. If the law enabled any vehicle to be seized no matter who owns it, there would be problems with vehicles owned by another person, as well as with company car, hire cars, leased cars, etc.

4.12 We will monitor Scottish practice on this issue with interest, but we do not consider that it is appropriate to amend the law for England and Wales at this time. We will consider whether more use can be made of the loss of a vehicle as a penalty to be used by the courts. This may be particularly useful where there is a high risk of disqualified drivers continuing to drive. We will explore whether sentencing guidelines should be strengthened.

Permanent disqualification

4.13 The proposal in Recommendation 24 that, in cases of repeat drink-drive convictions for offences involving mandatory disqualification - and particularly of those convicted of such offences whilst disqualified, permanent disqualification from driving should be routinely considered by the magistrates and sheriff courts raises serious concerns. This would tend to encourage lay courts to hand out the very serious penalty of permanent disqualification. Court of Appeal case law has said that very long terms of disqualification – even for very serious crimes – should be avoided as they are not conducive to rehabilitation.

4.14 The Sentencing Council for England and Wales is independent. It is for the Council to decide whether or not to revise the guidelines as suggested. For England and Wales we therefore propose to leave Recommendation 23 to the Sentencing Council for England and Wales to consider as it may see fit. The Council will be provided with a copy of this response.

5. Remedial training

5.1 There is one recommendation about remedial training for drink-drivers:

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

5.2 We agree with Recommendation 10 and have additional proposals relating to the training of drink-drive offenders.

5.3 The Driving Standards Agency's foundation course on safe road use[25] and the new 'Learning to Drive' syllabus[26] both include coverage of driver impairment.

5.4 There is provision in the Road Traffic Offenders Act 1988 for drink-drivers to win a discount on their disqualification from driving if they successfully complete an approved drink-driver rehabilitation course. The Road Safety Act 2006 includes powers for this scheme to be re-launched, and the first step is to complete secondary legislation which will provide for approvals to be re-issued by April 2012.

5.5 The present scheme has a variety of providers working to variations on a core syllabus. The aim is to work with the newly approved providers to develop a more robust syllabus consistent with the DSA's competence framework on safe and responsible road use and other appropriate standards. Elements of this syllabus will be available for other driver trainer initiatives, such as Pass Plus, and Drivers Continuous Professional Development.

5.6 The Courts have powers to require drivers who have committed certain offences to be re-tested – by disqualifying them from holding a (full) licence until test passed[27]. The offences include causing death by careless driving when under the influence of drink or drugs. Drivers who are disqualified on these terms must pass "an appropriate driving test" in order to recover a full licence. At present, the choice is between the normal theory and practical tests that must be passed for initial licence acquisition, or an "extended test" which is defined in regulations to mean the current theory test (including the Hazard Perception Test) to be passed for initial licence acquisition and a double-length practical test based on the test to be passed for initial licence acquisition.

5.7 The Secretary of State may designate other offences involving obligatory endorsement to which mandatory re-testing would apply[28]. We intend to use these powers to require

[25] http://www.sqa.org.uk/sqa/35045.html

[26] http://www.dft.gov.uk/dsa/category.asp?cat=723

[27] under Section 36 of the Road Traffic Offenders Act 1988 (as amended)

[28] Section 36(2) Road Traffic Offenders Act 1988

drink and drug driving offenders attracting a substantial disqualification to re-test, but we need to change the test they would take first. Drivers who have to be re-tested are not currently required to do any remedial training first. The Secretary of State has powers[29] to determine in regulations the detailed nature of particular kinds of test used for offenders. We will therefore examine whether we should effectively require those who are disqualified until re-testing to undergo remedial training, by developing a special test which will assess whether they have done so. This re-assessment would follow any medical assessment required by the High Risk Offender (HRO) scheme (see Section 6 below). This work can be linked to development of the current rehabilitation scheme, for which an assessment element would need to be developed.

[29] Section 89 of the Road Traffic Act 1988

6. High Risk Offenders

6.1 Sir Peter made five recommendations about the High Risk Offender (HRO) scheme:

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

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

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

21. The High Risk Offenders scheme should continue to operate in respect of repeat offenders.

22. The Government should move swiftly to bring into force those provisions of the Road Safety Act 2006 which will ensure that High Risk Offenders do not regain their licence without first being assessed by a DVLA doctor.

6.2 We agree with Recommendations 17, 19, 21 and 22. We do not agree with Recommendation 20.

6.3 Section 94(5) of the 1988 Act, and regulations made thereunder[30] establish what is known as the High Risk Offenders' scheme ("the HRO scheme").The purpose of this scheme is to identify drink-drivers whose dependence upon, or persistent misuse of alcohol constitutes a relevant disability requiring a decision to be made whether or not to revoke their driving licence.

6.4 There are three categories of disqualified offender who are consigned to this scheme:

- those disqualified by reason that the proportion of alcohol in their blood equalled or exceeded 200mg/100ml;
- those who failed to provide an evidential specimen;
- those who have committed more than one specified drink-drive offence within ten years.

6.5 (The full description of the first group includes corresponding figures for breath and urine.) The same blood/breath ratio adopted by Section 11(2) has been used to set the

[30] Regulation 74(1) of the Motor Vehicle (Driving Licence) Regulations 1989 (SI 1989 No 2684)

thresholds for this scheme. The HRO scheme thresholds can be changed by secondary legislation.

6.6 Three recommendations (17, 19 and 21) propose to retain the status quo. Recommendation 20 is to the effect that the thresholds should stay where they are relative to the limit, even if the limit is reduced. This is mistaken: the object of the thresholds is to identify levels of impairment likely to be associated with drivers with a dependence upon - or persistent misuse of - alcohol who are considered likely to be found among drivers with very high alcohol concentrations; the scheme is not an additional punishment. There is no evidence that a lower threshold is justified for the purposes of the scheme.

6.7 As to Recommendation 22, drivers categorised as High Risk Offenders are required, at the end of their disqualification, to undergo a medical examination before their licence can be re-instated. However, under the current rules a loophole allows them to resume driving as soon as they submit an application to get their licence back, whether or not the mandatory assessment of their fitness has been completed or not. Commencing Section 13 of the Road Safety Act 2006 will close the loophole. The relevant Instrument will now be laid and brought into force.

7. Statistics

7.1 Sir Peter has made two recommendations about the collection of statistics about drink-driving.

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

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

7.2 The following response also covers recommendations 1 and 6 in the Section of the North report on drug-driving, because they are the same.

7.3 Recommendations 1 and 25 are not accepted.

Coroners' data

7.4 The Ministry of Justice intends to implement as soon as practicable a number of provisions contained within Part I of the Coroners and Justice Act 2009. These provisions will bring significant changes to the coroner service in England and Wales. The Government will not, however, be introducing a Chief Coroner. Instead, the Lord Chancellor, or an alternative person, will take on some of the Chief Coroner's functions as set out in the 2009 Act.

7.5 In 2010 the Ministry of Justice carried out a public consultation on policy for secondary legislation that is intended to underpin the coroner provisions of the 2009 Act. There will need to be further public consultation on the draft regulations ahead of any implementation. Further work will need to be done to consider whether to issue national guidance for coroners on testing for drink and drugs in road traffic fatalities; and whether coroners should be required to report alcohol and drug results from road traffic fatalities as part of the Annual Coroners Statistics on Deaths Reported. These statistics show deaths reported to coroners, including inquests and post-mortem examinations held, inquest verdicts returned and finds reported to coroners under treasure legislation.

7.6 The Department for Transport has been working with the Coroners' Society, and individual coroners, on the provision of additional toxicology data from road traffic

accident fatalities to a national database. A survey[31] has found that alcohol is more routinely tested for by coroners than drugs, across all road user groups, but many responding coroners always or often test drivers/motorcyclists for drugs. Most are willing to contribute to a national database; and the preference is to use additional questions on the existing blood alcohol concentration (BAC) data collection form (form L407) used by the Department's contractor to obtain information about alcohol-related road fatalities. The Department has a programme of work to follow up this survey, and to establish how far it is possible to collect robust nationally applicable figures on the involvement of drugs in road fatalities. This will begin with a re-design of the L407 form.

Offences Brought to Justice

7.7 There is a statistics series on offences brought to justice (OBTJ). The term covers only 'notifiable offences', that is those which Parliament has decided should be - or may be - triable in the Crown Court. These include some of the most serious driving offences, such as causing death by dangerous driving, causing death by careless driving when under the influence of drink or drugs and dangerous driving. A number of other motoring offences – drink and drug driving, for example – are not included. It is not proved that the police concentrate on notifiable offences to the exclusion of others.

7.8 The Government attaches importance to local accountability of the police. The Government's recent consultation paper - Policing in the 21st Century: Reconnecting Police and the People[32] - proposes less Government intervention and bureaucracy. It aims to free the police from central control by removing government targets, excessive centralised performance management, and by reviewing the data burden that is placed on forces – while ensuring that data is still available to local people. The Government will continue to have a role in setting the national strategic direction for the police, but it will have no role in telling the police how to do their job –or in holding them to account for how well they have done it.

7.9 The Chief Statistician recently launched a consultation on improving Criminal Justice Statistics, which included proposals for OBTJ as a statistical measure. These proposals look at reducing the burden on the police from central collections and there are no proposals to expand the range of offences counted. In line with the Government's priorities of freeing up the police to focus on catching criminals, there is no longer a centrally-imposed OBTJ target.

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[31] Report available on-line at - http://www.dft.gov.uk/pgr/roadsafety/research/rsrr/theme3/roadfatalities/pdf/rscp2152.pdf

[32] http://www.homeoffice.gov.uk/publications/consultations/policing-21st-century

8. Other recommendations

8.1 Sir Peter has made two other recommendations about drink-driving. These are for the relevant industry sectors.

Drinks industry

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

8.2 The Department has been working with these industries to promote a Driver Friendly scheme which rewards drivers – and their companions – if the driver abstains from alcohol. The initiative aims to make it easier for drivers to choose soft drinks over alcoholic drinks by making them more attractive via price promotions and other added value offers. Campaign partners have included Coca-Cola GB, Greene King, and pub companies such as: Punch Taverns, Enterprise Inns, Admiral Taverns, Everards and Scottish & Newcastle. Coca Cola has provided 'buy one get one free' offers for nearly 10,000 venues to pass on to customers. Other options include free offers of other items for drivers agreeing to stick to soft drinks. This campaign ran throughout 2010 and will continue in 2011[33].

Best practice

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

8.3 Good practice is well-established on the management of impairment among those who drive for work. Employers already have a legal duty under health and safety management regulations to assess and manage risks among those who drive for work. The adoption of good practice is therefore a matter for employers and fleet operators; it does not require a further regulatory intervention by the Department. Alcohol ignition interlocks are used in some fleets to provide risk assurance. The Department has

[33] See the Department's online coverage of this scheme at - http://www.dft.gov.uk/think/focusareas/driving/drinkdriving?page=Partners&whoareyou_id=

undertaken research into the practicalities of a judicial interlock programme[34]. The conclusion was that the costs of implementing and enforcing a scheme are likely to be disproportionate.

[34] Beirness, D.J., Clayton, A. and Vanlaar, W. (2008) An Investigation of the Usefulness, the Acceptability and Impact on Lifestyle of Alcohol Ignition Interlocks in Drink-Driving Offenders. Road Safety Research Report 88. Department for Transport: London

9. Drug-driving: Introduction

9.1 We all rely from time to time on medicine of some kind for our health and well-being. Some drugs – including some that are mis-used – impair ability to drive.. We agree with the Select Committee that drug driving while impaired by drugs, whether illegal drugs, or legal prescription medicines, is as important an issue as drink-driving, given the risks involved to other road users, the relative lack of public awareness and the difficulties impeding adequate police enforcement. It is not right that it is now relatively easy to enforce the law against drink-driving, while equally serious driving impaired by drugs is not effectively dealt with.

9.2 The Committee recommend that the Government should develop a five-year strategy for tackling this behaviour. We aim to make substantial progress well within that time frame, and the following sections in this response set out the measures we are taking to that end.

9.3 The Government published a new Drugs Strategy in December 2010. It sets out a clear ambition to reduce demand, restrict supply and support and achieve recovery. By reducing drug use in the population we can reduce the toll caused by drug-impaired driving. The specific measures which we are taking against drug-impaired driving will reinforce the wider action that we are taking to prevent the misery and pain that mis-use of drugs causes to individuals, families and communities.

9.4 The North report made 23 recommendations about drug-driving. We agree in principle with the main thrust of these proposals, which envisage a step-by-step programme of new measures aimed at creating a more effective regime than at present. These steps are:

- to approve preliminary testing equipment which can be procured by police forces for use initially in police stations, and later at the roadside;

- to implement other measures to make the law against drug-driving work more effectively;

- to continue research into equipment which could be approved for the police to test for these substances;

- on the basis of this work, to examine the case for a new specific offence - alongside the existing one - which would relieve the need for the police to prove impairment case-by-case where a specified drug had been detected.

9.5 The response to Sir Peter's recommendations are grouped as follows:

- Making the present law more effective (4, 5, 7, 8, 9, 10, 11 and 16)

- Penalties (23)
- A new offence (13, 14 and 15)
- Medicine (21 and 22)
- Research (2, 12, 17 and 18)
- Statistics (1, 3 and 6)
- The High Risk Offenders Scheme (19)
- Remedial training (20)

9.6 We propose to implement at this time recommendations 7, 8, 9 and 11 (all are discussed in Section 10 of this response). Work is continuing on recommendations 13 to 15, 21 and 22. Recommendation 23, on penalties, is a matter for the Sentencing Council. Where legislation is required, an impact assessment, including among other things the potential impacts on enforcement and the judicial system, will be prepared in the usual way.

10.Making the present law more effective

10.1 The North report makes seven recommendations about improving the effectiveness of the present regime against drug-driving.

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

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

7. 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'.

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

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

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

11. Steps should be taken for the earliest practicable type approval and supply to police stations of preliminary drug screening devices to be used in accordance with Section 6C of the Road Traffic Act 1988. This should be achieved within two years.

Type approval ought in the first instance to focus on devices capable, in aggregate, of detection of those drugs or categories of drugs which are the most prevalent, including amongst drivers, namely:

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

FIT tests

10.2 We do not accept the main proposal in Recommendation 4.

10.3 The police have the power to require a driver to undertake a preliminary test (such as what is commonly referred to as a 'field impairment test', or 'FIT test') to ascertain if the person might be impaired by a drug or by alcohol. It is an offence to fail to comply. One object of this power is to enable the police to require a driver to get out of the vehicle, which allows an officer to test, as part of an assessment of impairment, whether they can stand unsupported and walk normally. A FIT test must be undertaken by an officer with appropriate training, and in accordance with a Code of Practice issued by the Secretary of State. Once trained, officers need to carry out tests regularly to ensure they remain effective.

10.4 Training officers to conduct FIT tests is an operational matter for the police and depends on decisions as to best use of resources. It should not be mandatory. The decision will depend – among other things – on how officers are deployed. For example, the case for training dedicated traffic officers is not the same as for officers on general duties who may nevertheless encounter drug-drivers. Conducting a FIT test is time-consuming and may be of limited value. If a driver is obviously impaired the officer's evidence of this impairment is suitable and may be sufficient. A FIT test might also be redundant if a driver has admitted drug use.

10.5 A test may suggest impairment that is not due to a drug and may not affect driving ability - a driver might be unable to walk steadily for a physical reason that does not affect their driving ability at all. An officer may well be able to establish this sort of evidence without doing a test.

10.6 To make a rule as proposed would create difficulty if the police cannot get a trained officer to the scene. There is a parallel with testing for alcohol: a driver too impaired to co-operate with a breath test will be arrested under Section 4 of the 1988 Act and no

screening breath test will be administered first, even though there is general guidance to do so.

Submission of evidence

10.7 We do not accept Recommendation 5 and no further action is now needed on Recommendation 10.

10.8 The police will as a matter of practice provide all the evidence of impairment seen in any given case, and it is this evidence that must be considered. Collecting more evidence for its own sake is not supported as it would be an unnecessary burden and could be counter-productive.

10.9 We do not accept that the courts can or should be directed to give greater weight than they do now to evidence of general impairment other than while actually driving. It is not clear whether the proposal is directed to the Courts' decisions on guilt or on sentencing – the latter has to be inferred as it is only that which the Sentencing Council for England and Wales can guide. However, evidence is collected for the purpose of securing a conviction, and the police do not wish to collect unnecessary data. The Courts will have regard to all relevant proven evidence in decisions on sentencing, but the police cannot be expected to present routinely evidence that is not required to secure a conviction.

10.10 The police have recognised the issue raised in Recommendation 10, of samples submitted to laboratories for analysis without the relevant form or other details of the circumstances of the case which can aid laboratory analysis. It is a matter of supervision. One solution would be for the laboratory to keep the sample and return the papers for the form to be supplied. This is being addressed in regional meetings with forces, where the number of samples received without forms is highlighted.

Custody nurses

10.11 We accept recommendation 7.

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 health care professionals such as custody nurses as well as from a medical practitioner.

Health professional training

10.16 We agree with recommendations 8 and 9.

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[35]. 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 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.

Preliminary testing devices

10.24 On Recommendation 11, Sir Peter proposes that priority should be given to type approval for, and supply to police stations of, preliminary drug testing devices. He suggests that type approval ought in the first instance to focus on devices capable of detection of those drugs or categories of drugs which are the most prevalent, including amongst drivers, recognising that more than one device may be needed to cover the whole range.

10.25 We are taking steps, as Sir Peter proposes, for the earliest possible type approval of preliminary drug testing devices for use in police stations. It will then be for manufacturers to supply, and police forces to obtain, approved devices and put them to use. We are also finalising the additional requirements for type approving such devices for use at the roadside.

10.26 Securing a conviction for driving unfit through drugs requires it to be proved that:

i) the offender was driving or in charge of a vehicle;
ii) the offender was impaired so as to be unfit to drive; and
iii) the impairment was caused by drugs.

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

10.27 The police may arrest where there is evidence of driving that was unfit (i) and (ii); and the officer has reasonable grounds (not necessarily a test result) to suspect that the impairment was caused by drugs (iii)). In the case of driving whilst over the prescribed alcohol limit, the breath test replaces the need to prove impairment, and of course no other evidence is needed for this offence. So the drink-driving procedure has been simplified - with very beneficial effect.

10.28 But all three proofs remain for drug-driving. The North report has set out the problems the police face with getting the evidence that the impairment is caused by drugs. Invasive samples are required, and getting these depends on uncertain procedures involving forensic medical examiners. Preliminary drug testing devices solve this problem – because drivers who fail preliminary tests will be required to give the blood samples required. The results of the preliminary test may allow a more targeted analysis of the evidential sample, potentially reducing laboratory costs.

10.29 Our aim is to make available for police purchase the equipment they need to enforce against drug-driving effectively. Their work against drink-driving demonstrates the effectiveness of simple testing procedures. We aim to replicate this for drug-driving with procedures that are easy to use and give police officers the confidence to require further tests from suspect drivers. Our goal is to have reliable, preliminary drug testing equipment type approved as soon as possible.

10.30 The Railways and Transport Safety Act 2003 amended Section 6 of the Road Traffic Act to provide that an evidential drug test can be required where a driver has failed a preliminary drug test, without the need to obtain a doctor's advice. It is therefore agreed that it would be a big step forward to have devices capable of being used in a police station. Our goal is to have available devices that could be used to good effect in the more demanding roadside environment. The Home Office is continuing to work on the specification for such a device

10.31 The specification for a station-based device has now been approved by Ministers and manufacturers have submitted devices for type approval. We hope there may be devices available for police purchase towards the end of 2011.

10.32 As is the long-established case with other devices used in traffic law enforcement (breath alcohol test devices, speed meters, etc), the Secretary of State will approve only those devices which comply with a specification drawn up by expert advisers. It is important that devices are not open to challenge – we cannot afford to lose cases because offenders argue that blood was improperly taken. That is why it is vital that any type approval specification is sufficiently rigorous. In order to facilitate the earliest use of devices, however, it will be possible to approve devices to test for just one or more of the substances listed in the specification – it will not be necessary for a device to be capable of detecting all potential substances.

10.33 The specification is for a device that is suitable for enforcement of the criminal law on drug driving in this country. Devices already used for other purposes, such as testing if someone should be referred for drug treatment, and in other jurisdictions with different environmental and operational conditions, different legal frameworks and different socio-political expectations as to police enforcement, legal process, etc, are therefore not necessarily suitable for approval.

11. Penalties

11.1 The North report has one recommendation about drug-driving penalties.

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

11.2 As noted already, the Sentencing Council for England and Wales is independent. It is for the Council to decide whether or not to revise the guidelines as suggested. For England and Wales we therefore propose to leave Recommendation 23 to the Sentencing Council for England and Wales to consider as it may see fit.

11.3 The North report finds that the problem of driving having taken drugs and alcohol in combination is a serious one because relatively low levels of drugs combined with relatively low levels of alcohol can be very impairing, and are not uncommon among drivers. In fact, some drivers may hope to escape conviction by drinking insufficient alcohol to fail a breath test, in combination with drugs that they do not believe the police can detect.

11.4 The police do not routinely collect evidence to show a combination of drugs, or of drugs and alcohol in a particular driver; nor would they need to prove such evidence to secure a conviction for the relevant offences. It is necessary only to establish sufficient evidence to prove an offence. There is a good reason why the police investigate first whether a driver has exceeded the prescribed limit for alcohol. This can be done easily, and sufficient evidence is readily available from breath tests. In the case of drug-driving, it is sufficient to prove the involvement of one impairing drug, and not necessary, for example, to demonstrate 'polydrug' use. The North report expresses concern that this approach fails to gather better evidence and identifying those who are doubly reckless; although it is a reasonable and practical response by the police, given that the consequences of conviction will be similar, if not the same. However, it is noted that the Sentencing Guidelines for England and Wales do not cite the combination of drugs and alcohol as an aggravating factor in cases of drink or drug driving; nor is there provision in Scotland to consider this issue.

11.5 The police are free to use any relevant evidence of impairment – which may be very apparent where drugs have been mixed with each other, or with alcohol. They are not prevented from proceeding where an impaired driver has satisfied a breath test for alcohol. A Court may be in possession of proved evidence relating only to the prescribed alcohol limit, or to a single drug; but it might also have more general evidence of impairment, including proof of 'polydrug' use, or the mixing of drugs and alcohol. There is no maximum disqualification for the offence of driving unfit through

drugs or alcohol, and the Court would be free to take such evidence into account in setting the penalty imposed.

11.6 It is open to the Sentencing Council to consider whether that is enough to address this concern; and, if not, whether to propose guidance on the matter. As already noted, the Council will be provided with a copy of this response.

12. An additional drug-driving offence

12.1 The North report makes three recommendations about a potential new offence relating to drug-driving:

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

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

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

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

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

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

12.2 The Select Committee has supported the principle of a new offence where evidence based impairing thresholds for specified substances have been exceeded. We agree with Sir Peter that this merits further work, and that it would greatly assist in the enforcement of drug-driving if - for some substances at least - the offence could be tackled without the police having to prove evidence of impairment case by case. Simplifying the process for drink-driving in this way has been one of the keys to success against this offence.

12.3 We agree with Sir Peter and the Select Committee, however, that the existing offence would need to be retained, even when an additional offence is available.

12.4 The police – and some other interests - have long called for a new offence of having a specified drug in the body while driving, on the grounds that they would not then be obliged to collect or prove evidence that a person's ability to drive has been impaired. Some other countries have the benefit of such an offence, and it is similar to our law on the prescribed alcohol limit. We agree that an objective measure of whether a drug driving offence has been committed should deliver a significant improvement in the enforcement of drug driving.

12.5 Sir Peter is right to recognise, however, that this is a complex issue and so we will continue the research and other work he has suggested. We cannot pre-empt that work by describing any additional offence at this stage, or give a firm date for its potential introduction. Any proposals will be subject to further consultation, and the clearance of regulatory and other impact assessments in the usual way.

12.6 In the meantime, it is possible to summarise some of the issues which we have to resolve:

- which drugs to proscribe, and how to manage displacement to other substances and combinations;
- whether testing should be against analytically detectable thresholds, or whether impairing thresholds can be set – and, if so, what they should be;
- how to handle polydrug use – and mixture of drugs and alcohol;
- how to handle impairing legal medicine – including the misuse of such substances.

These questions all overlap each other in practice.

12.7 Any thresholds to be included in an additional offence will have to be properly defined. Levels in any particular person are highly variable over time, as is an individual's tolerance. It cannot be certain in advance that an offence based on impairing thresholds is practical for every, or indeed for any, drug.

12.8 If there is evidence that a drug impairs a person's ability to drive, then clearly those taking it should not drive. Recommendation 14 proposes a defence where the impairing drug has been taken in accordance with medical advice. This proposed defence might be unnecessary and undesirable: in such a case, proper advice should be not to drive while impaired. Some drugs prescribed for medicinal purposes may be classed as illegal drugs if taken otherwise. It may not be possible to deal with every drug within the scope of an additional offence, and some will still have to be dealt with as now - with due evidence of impairment in each case.

12.9 Sir Peter proposes using an absolute offence if an offence based on impairing thresholds proves to be impractical. This is an issue to return to in the light of the further work he has proposed. The Select Committee have also concluded (paragraph 98), on balance, in favour of a "zero-tolerance" offence for illegal drugs which are known to impair driving, which are widely misused, including among drivers, and which represent a substantial part of the drug driving problem. However, they consider that, as with alcohol, "zero-tolerance" would not necessarily be based simply upon the detection of drugs in the bloodstream. An appropriate quantity would need to be detected in order to rule out, for example, passive inhalation. In contrast to alcohol, which is legal, illegal drugs which are known to affect behaviour and make it dangerous to drive after use, do appear to warrant a more stringent approach to thresholds. We wish to explore this recommendation further with key interest groups, including the Commission on Human Medicines.

13.Medicine

13.1 The North report makes two recommendations about the management of patients taking medicine which might impair driving:

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

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

13.2 Recommendations 21 and 22 reflect work already in progress.

Medical training

13.3 The Medicines and Healthcare Products Regulatory Agency (MHRA) are examining ways to focus educational activities to different target audiences including medicine takers and healthcare professionals. The MHRA website contains information for patients, healthcare professionals and the pharmaceutical industry on various drug safety aspects. The MHRA already produce regular Drug Safety Update bulletins for healthcare professionals on emerging safety issues when they arise. This is principally available electronically from the MHRA website although paper copies are also available. Further safety notifications on specific safety issues are also issued in the form of letters to doctors, or electronically through drug safety alerts. However, the MHRA are also constantly striving to improve educational activities by taking advice from experts on the front line through the Commission for Human Medicines (CHM) in order to cater for any specific need.

13.4 The Driving and Vehicle Licensing Agency (DVLA) have introduced a number of measures to raise public and professional awareness about fitness to drive:

- an A-Z Medical Notifications Guide was placed on the DirectGov website[36] in June 2010 to provide advice on how medical conditions may affect an individual's ability to drive safely and how and when to inform DVLA;

- hyperlinks from the Guide are being created to external websites such as Diabetes UK, British Heart Foundation, etc.;

[36] http://www.direct.gov.uk/en/Motoring/DriverLicensing/MedicalRulesForDrivers/MedicalA-Z/index.htm.

- the 'Driving With A Medical Condition' pages on the DirectGov website have been restructured to make them easier to navigate and understand;

- information has been publicised on DirectGov and within DVLA offices to raise awareness of medical conditions that may affect fitness to drive;

- maintaining engagement with customers and representative groups - e.g. haulage industry associations, the British Medical Association and the General Medical Council, to publicise the requirement to notify a medical condition and how to do so, and to help identify further improvements;

- the DVLA "At A Glance guide to the current medical standards of fitness to drive" will in future give guidance to doctors on impairment.

  This will remind doctors that it is an offence to drive or attempt to drive whilst unfit through drugs; and that the law does not distinguish between illegal drugs and medicines. Health professionals prescribing or dispensing medication will be reminded to consider the risk associated with that medicine, or combination of medicines, and driving, and take the opportunity to discuss with the driver how to take that medicine safely.

13.5 Measures have also been taken to provide better advice and support to drivers who should notify DVLA but who fear the consequences of losing their licence if they do so. These include measures to raise public and professional awareness on switching to public transport and eligibility for mobility allowances, reduced fares and travel discounts, and advice to friends/ relatives concerned about someone's fitness to drive:

- inclusion of benefits information in licence revocation notifications to drivers;

- inclusion of public transport website information in revocation notifications is under consideration.

Education

13.7 The Select Committee believe that improving public awareness about the likelihood of being caught by the police is essential in order to deter people from driving under the influence of drugs. They recommend a high profile drug driving advertising and information campaign to highlight the consequences of being caught and convicted for this crime, as well as the significant safety risks that a driver impaired by drugs poses to themselves and others.

13.8 The Department ran a THINK! campaign on these lines in 2009, and material from the campaign remains available on our website[37]. Government advertising and marketing spend was frozen in June 2010 to help deliver efficiency savings which the Government pledged to deliver this year. Only the most essential campaigns – including the THINK! Christmas 'Don't Drink-drive' campaign – are going ahead. A main issue with the 2009 campaign was that, although the consequences for drug-driving are severe – and were highlighted as the same for drink-driving, they are rarely

[37] http://drugdrive.direct.gov.uk/

incurred because of the difficulty for the police in bringing drug-drivers to account. The priority is to fix this problem – as we propose. The scope of any supporting education and publicity can be addressed once we have done so.

13.9 As set out in the Drug Strategy, we will continue to use the FRANK service to ensure that people have accurate and reliable information about the effects and harms of drugs. FRANK discourages drug-impaired driving and we will ensure that its material is regularly updated to reflect new information and evidence, and that FRANK is linked into any specific communications activity on drug-impaired driving.

Patient information

13.10 Provision for warnings in patient information with medicines is already catered for in the current national and European regulatory framework. This sets out the minimum information required for all labels and leaflets, for all medicines regardless of availability through prescription or over the counter. Patients are more informed about their medicines today than they once were. All medicines are required to be accompanied with a Patient Information Leaflet (PIL). Research undertaken by the University of Leeds indicates that a large proportion of patients read the PIL which accompany medicines[38]. Since amendments to the European legislation in 2005, PILs are subject to "user testing" to ensure that patients are able to read and understand the written information to ensure that it meets their needs. PILs are therefore key risk minimisation tools in communicating messages about the impact of medicines on driving.

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

13.12 The use of pictograms on the product packing to communicate a message about a medicine has been subject to intense discussion. There is a lack of robust evidence about the effectiveness of pictograms in communicating information, and resulting in appropriate action being taken. An Expert Working Group of the Committee on Safety of Medicines (now the CHM) advised that warning symbols were open to misinterpretation. However, a recent publication noted that simple warning symbols could be effective if used with simple accompanying text[39]. Hence, if warning symbols were introduced, the meaning of any such symbol would need to be clear; and patients, the public, and healthcare professionals would need to be able to take appropriate action. This would require a process of user testing.

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[38] Raynor DK, Silcock, J.; Knapp, P.; Edmondson, H. How do patients use medicine information leaflets in the UK? *International Journal of Pharmacy Practice*, Volume 15, Number 3, September 2007, pp209-218(10)

[39] Wolf MS, Davis TC, Bass PF, Curtis LM, Lindquist LA, Webb JA, Bocchini MV, Batley SC, Parker RM. Improving Prescription Drug Warnings to Promote Patient Comprehension. *Arch Intern Med*, Volume 170, number 1, January 2010, pp 50 - 56

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

13.14 The DRUID project has also examined risk and labelling systems currently being used in some EU countries for medicines which may impair ability to drive. There is no consistent approach in Europe on the use of pictograms on medicines packaging, and several different systems have been put in place over time[40].

13.15 Since the publication of the North report, the MHRA has been working to secure agreement within Europe to develop a single, simple labelling system for medicines, based on the risk of impairment to a patients' ability to drive. This approach was recommended by CHM as the most pragmatic and proportionate approach to risk minimisation. The labelling system will then form the basis for clear and consistent information to be given to patients in the UK and across Europe.

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

14. Research

14.1 The North report makes four recommendations about research relating to drug-driving:

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

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

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

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

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

14.2 Recommendation 2 is accepted in principle; the Home Office also have a research programme in hand, concentrating at present on the development of improved testing

techniques. They are also prioritising the type-approval of preliminary testing devices, as proposed in Recommendations 12, 17 and 18.

14.3 On Recommendation 2, Sir Peter's report refers to research undertaken for his inquiry by Clockwork Research Ltd[41]. They were contracted to submit a review drawing together and synthesising evidence on a variety of issues relating to drug driving. The Department considers that this report represents the best available assessment of what is currently known. It is agreed in principle that further work may be needed in the future to assess trends and the effectiveness of changes in the enforcement of drug-driving laws.

14.4 The Home Office already have a research programme on the lines proposed in Recommendations 12, 17 and 18. This is exploring technologies which might have an application in providing reliable roadside preliminary drug tests. DRUID is also addressing the issues identified, and its work is well-advanced. We will consider the research findings carefully as they are published.

14.5 Further investigation of the list of drugs identified as impairing drivers will need to cover whether oral fluid sampling is appropriate in all cases, given the widely varying and complex routes of drug administration, metabolism and eventual expulsion.

14.6 In considering overseas experience with testing devices, it is necessary to take account of different legislation, criminal justice processes, enforcement practices, and operational conditions. Apart from the need for strict type approval requirements, it is also necessary to take into account the value at the roadside of a device that does not test for all drugs. Currently, if a constable has reasonable grounds for suspecting that a person he stops is drug impaired, he can justifiably require him, subject to medical practitioner authorisation, to give a blood specimen at a police station. A preliminary test is not necessary. The police are concerned about a risk that, if a preliminary test is conducted at the roadside, a person who tests negative for the drugs covered by the testing device will be allowed to continue driving despite in fact being impaired by some other drug.

[41] http://webarchive.nationalarchives.gov.uk/20100921035225/http://northreview.independent.gov.uk/report

15. Statistics

15.1 The North report makes three recommendations about statistics relating to drug-driving:

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

3. The Government should improve the clarity of its information on drug driving by:

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

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

15.2 A response to recommendations 1 and 6 is in Section 7 above of this response relating to drink-driving. The Government will not be appointing a Chief Coroner. Instead, the Lord Chancellor, or an alternative person, will take on some of the Chief Coroner's functions as set out in the 2009 Act.

Clarity of information

15.3 Recommendation 3 is not accepted.

15.4 The first two elements of this recommendation are linked to the proposal (in Recommendation 4) that FIT tests should be a general practice; and that the number of trained officers should be increased for this purpose. This recommendation is not accepted for reasons given in Section 10 above. We do not therefore consider that it would be appropriate to burden police forces with collecting additional statistics on this matter.

15.5 A distinction of the kind sought between drug and drink-driving offences is difficult as the current primary legislation does not distinguish between them. It would only be possible to differentiate between Section 4 cases of alcohol and drug impairment if

they became separate offences. Drivers who are suspected of being impaired will usually – and quite properly - be tested for alcohol first. If the test for alcohol is positive, there is then no need to test for drugs as well, although the person might well have taken drugs. A proportion of convictions are for failing to provide preliminary and evidential specimens – in these cases, nothing else has been proved.

15.6 If there were more effective means of enforcing the current law against drug-driving, there will be an opportunity for research into the numbers of drivers who pass through the drug-testing process.

16. High risk offenders and remedial training

16.1 The North report recommends extending the High Risk Offender scheme to drug-driving:

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

16.2 We do not agree with Recommendation 19.

16.3 The object of the High Risk Offender (HRO) scheme is explained in the response above to related recommendations on drink-driving. The scheme is an adjunct to DVLA's medical licensing regime, which is used to regulate drivers who have – or may have – a relevant disability. The HRO scheme makes special provision for the relevant disability of dependence on, or persistent misuse of alcohol. It does so by setting rules which select particular categories of convicted drink-driver for medical assessment. It would not be appropriate or proportionate to process all drink-drivers in this way.

16.4 There is no need for a similar selection process with convicted drug-drivers, or for the proposed amendment to the 1999 Regulations. It is wrong to think that drug-drivers are overlooked by DVLA because they are not covered by the HRO scheme, the function of which is simply to define which drink-drivers should be considered by the medical licensing regime. Dependency on impairing drugs is a relevant disability for driver licensing purposes. It is therefore already covered by DVLA's medical licensing regime with published guidance for medical practitioners in the "At A Glance guide to the current medical standards of fitness to drive". This regime reacts to a range of evidence on drug dependency, and it is not necessary to legislate to enable it to take specific account of drug-driving convictions. Someone caught driving under the influence of drugs twice in ten years could well be regarded as high risk.

Remedial training

16.5 The North report recommends extending remedial training now available for drink-drivers to drug-drivers as well:

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

16.6 We agree in principle with Recommendation 20, but any implementation is for the future.

16.7 The drink-drive rehabilitation scheme is discussed above in connection with Recommendation 10 on drink-driving. The existing scheme is not open to drug-drivers, because no drug-driving courses have been approved. The main reason for this is that there is insufficient demand to make a national scheme of this sort a practical proposition. It is worth noting that approaching 60,000 drivers each year are referred to approved courses under this scheme, of whom half attend. Drug-driving is also a more complex challenge, with a range of substances and associated social problems. If there was proved to be sufficient demand for a similar national scheme for drug-drivers, a syllabus suitable for all those likely to attend would have to be designed, with links into drug treatment services so that individuals get the help and support they need to get off drugs.

16.8 The Department will return to this recommendation when there is evidence that sufficient numbers are available to sustain a national scheme.

Annex A – Sir Peter North's Terms of Reference

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

On drugs

- the evidence that a new offence is needed, taking into account the evidence base on the involvement of drugs in road fatalities/accidents, data on cases brought to justice etc;
- how any new offence should be framed – for example, whether it should be based on an absolute ban, or as with alcohol and driving, a certain level of drugs within the driver's system;
- which drugs should be covered by any new offence (including the status of prescribed medications);
- the consistency of any new offence with wider government strategies for tacking the adverse health and social impacts of drugs;
- the practicability of identifying impairing substances in a legally robust way (including the availability of testing equipment);
- whether, and if so how, administrative procedures (including the role of the Forensic Medical Examiner) could be improved;
- evidence of any such offences in other countries, the associated penalty regimes and the success of policies in those nations.

On alcohol

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

Annex B – Transport Select Committee's recommendations on Sir Peter North's Report

(Cross-references to the discussion of these recommendations in this paper are given in brackets after each one.)

1. We recommend that individual police forces should be consulted to assess the respective cost-benefit implications of more effectively enforcing the current drink-drive limit against any proposed reduction.
(Response at paragraph 2.22)

2. In the long term, the Government should aim for an "effectively zero" limit of 20mg/100ml but we acknowledge that this is too great a step at this stage.(Response at paragraphs 2.33-2.35)

3. We believe that any reduction in the legal drink-drive limit should only occur after an extensive Government education campaign, run in conjunction with the pub, restaurant and hospitality industries, about drink strengths and their effect on the body. In doing so, the Government should look to learn from experiences in other countries which have successfully implemented a reduction in the drink-drive limit to either 50mg/100ml or 20mg/100ml.
(Response at paragraphs 2.25-2.27)

4. The success of Great Britain's drink-driving policy has been largely attributable to the deterrent effect of the current 12-month mandatory disqualification penalty and we believe that it should remain even after a reduction in the legal BAC limit.
(Response at paragraph 4.3)

5. Effective police enforcement is equally as important to deter drink-driving as the level of the legal blood alcohol limit. Enforcement of drink-drive law in Great Britain must be much more visible, frequent, sustained and well-publicised.
(Response at paragraphs 2.19-2.24)

6. The Government should amend the Road Traffic Act 1988 to give police an additional power to enable preliminary breath tests to be required and administered in the course of a designated drink-drive enforcement operation.
(Response at paragraphs 3.17-3.23)

7. Drug driving is as important an issue as drink-driving, given the risks involved to other road users, the relative lack of public awareness and the current lack of adequate police enforcement. The Government should aim to improve the detection of drug-driving so that it

is as important a road safety priority as combating drink-driving. We recommend that the Government develop a five-year strategy for tackling drug driving.
(This general recommendation is addressed throughout sections 9 to 16 of this response)

8. Improving public awareness about the likelihood of being caught by the police is essential in order to deter people from driving under the influence of drugs. A high profile drug driving advertising and information campaign should be central to a five-year strategy. This should highlight the consequences of being caught and convicted for this crime. The campaign should also inform the public about the significant safety risks that a driver impaired on drugs poses to themselves and others.
(Response at paragraph 13.6-13.8)

9. It is unfortunate that a drug screening device has not been type-approved seven years after police were granted the legal power to use them. However, we welcome the Government's commitment to install drug screening devices in every police station by 2012. We will monitor progress to ensure the Government meets its target so that no further time is lost.
(Response at paragraph 10.24-10.33)

10. Drug screening devices for use at the police station should only be an interim measure. The Government's aim for the medium-term should be to develop and type-approve a drug screening device for use at the roadside, drawing on experience in other parts of the world in developing such devices.
(Response at paragraph 10.24-10.33)

11. On balance we favour the adoption of a "zero-tolerance" offence for illegal drugs which are known to impair driving, which are widely misused, including among drivers, and which represent a substantial part of the drug driving problem. As with alcohol, "zero-tolerance" would not necessarily mean the detection of drugs in the bloodstream. An appropriate quantity would need to be detected in order to rule out, for example, passive inhalation.
(Response at paragraphs 12.1-12.10)

12. If a new offence is created, the Government should retain the current impairment offence to cover other drugs that impair driving ability, such as medicines and 'legal highs'.
(Response at paragraph 12.3)

Annex C – Changing the prescribed alcohol limit for driving – an assessment of potential impacts

Background

1. This note considers evidence for estimating some of the costs, benefits and impacts that may be associated with a recommendation that the drink-drive limit of 80 milligrammes (mg) of alcohol per 100 millilitres (ml) of blood should be lowered to 50 mg/100 ml. These include the potential benefits of avoiding casualties but it has not considered the full range of potential health benefits that might be associated with a reduction in the harmful use of alcohol.

2. This annex aims to set out some initial estimates on potential costs and benefits, which will be developed via further analysis, going beyond preventing casualties. It is not a complete cost benefit analysis and therefore caution must be taken over interpretation of the estimates presented in this paper.

Risks and uncertainty

3. It is not possible to make definite forecasts about the effects of changing the prescribed limit because there is insufficient evidence to know what changes in driver behaviour might result. Some costs are calculable – for example for replacing a known quantity of police equipment, but in most cases estimates have to be based on stated assumptions, and considered as a range.

4. The extent of behavioural change creates uncertainty around the impact of a lower prescribed limit on enforcement costs. At one end of the range of outcomes, there are limited safety benefits, as simply lowering the drink-drive limit may have no impact on any one already exceeding the 80 mg/100ml limit. The majority of drivers would not need to lower consumption to stay legal with a lower limit, but these people have the choice to drink even less – and especially to drink less when they are out. If that happened, it would have a substantial impact on the businesses they patronise. It is possible, on some assumptions that limited safety benefits might be at a high economic cost.

5. On the other hand, moderate drinkers might continue to behave as they do now, while a large number of the high-end drink-drivers (those liable to test over 110 mg/100ml who are responsible for most deaths and injuries) see the lower drink-drive limit as sufficiently totemic to result in them taking a new approach and stopping drink-driving. This would yield limited costs and large safety benefits.

6. The real world outcome lies somewhere between these extremes, and all depends on who changes their behaviour. Public information and awareness could be important in influencing behaviour, though the high-end offenders have already shown that it is very difficult to reach them and to get them to change their behaviour.

7. Therefore, in the absence of further evidence, the assessment has involved the creation of five high-level benefit scenarios – representing different, low, medium and high levels of behavioural change. The analysis for each scenario is then used to provide a range which serves to highlight the potential benefits which could result from a change to the prescribed limit. In some cases, costs and benefits overlap and care is therefore needed not to count them twice in any assessment. This assessment does not therefore attempt to determine what the cost or benefit of lowering the limit in Great Britain will be.

8. There may be costs for drivers more generally if, as a result of the new limit, they feel obliged to constrain their social opportunities, resulting in a welfare cost. However, in the absence of further evidence, it is not possible to estimate this welfare cost, although it should be recognised that this is likely to be a significant category of cost as it implies an impact on lifestyles. On the other hand, any measure which successfully induced people to reduce alcohol harm by moderating consumption would have health benefits in addition to the benefits of avoiding road casualties. This would result in benefits for individuals, reduced sickness leave costs to employers, and cost savings to the NHS. These health effects and related cost savings have not been considered in this assessment, because there is no basis on which to estimate the extent of such an effect from a change to the prescribed limit.

9. This assessment looks at costs and benefits under the following headings:

- Costs to Government
- Safety benefits
- Economic impact

Costs to Government

Public information

10. Government would incur a one-off cost associated with amending legislation, although this is assumed to be relatively small. Government would also incur – as a minimum - a one-off cost associated with the undertaking of a publicity campaign to raise awareness of a new limit amongst the general public. This could be linked to the wider programme of Think! campaigns, and based on the cost of previous campaigns of this type would require a budget of up to £2.75m. This is a low-end estimate: publicity campaigns might be needed for a significant amount of time – both leading up to a change in the law and post implementation.

Police costs

11. Costs would be incurred in order to ensure that police forces were equipped with the screening and evidential equipment required to effectively enforce a new limit. Equipment would need to be type approved for the lower drink-driving alcohol limit.

12. DfT has recently invested in equipping police forces with new digital screening devices and some reconfiguration of this equipment would be required. Screening devices would need to be taken out of use briefly to be reconfigured and this process would need to be carefully orchestrated and managed to ensure that it did not create operational and legal difficulties. It is likely that this task will need to be undertaken by the device manufacturer and although the time taken per device would be relatively small, the total number of devices in use (nearly 14 thousand in England and Wales) could result in a fairly lengthy and complex process. No estimates of costs and likely timeframes exist at this stage and further investigation of this matter will need to be undertaken.

13. In addition, evidential equipment installed at police stations would need to be reprogrammed to reflect any change in the prescribed limit. The software version used in this equipment is stated in the type approval notice and so any new version would need to be reapproved. Such approval, and associated testing, is time consuming, costly and would need to be carefully managed to avoid operational and legal difficulties. No cost estimates are available at this stage and again further investigation will be required.

14. A change in the prescribed limit does not mandate the level of enforcement activity which is to be undertaken by police and so does not directly impose any additional operational costs on police services (e.g. through a requirement for additional officers). Police resources are finite and it would remain a local decision as to how these resources are deployed and how issues are prioritised. It is therefore assumed, for the purposes of analysis, that there will be no change in the resources and methods used by police for detecting drink-drivers. However, any increase in detection of drink-drive offences would place demands on the time of existing officers meaning that they would not be available for other duties during the time taken to process these offenders. Although it has not been possible to quantify this impact the existence of such an opportunity cost should be recognised.

Judicial system costs

15. It is possible that lowering the prescribed limit will lead to an increase in the number of offences detected, and therefore an increase in costs incurred by HMCS. There were around 700,000 roadside screening breath tests carried in 2008[42]. An estimated 3% of individuals tested fall within the 21-35 micrograms (mcg) of alcohol per 100 millilitres (ml) of breath[43], roughly equivalent to 50-80mg/100ml BAC. These figures have been used in the scenarios constructed for this assessment to assess the potential for reducing casualties. These estimates were also used to provide an upper estimate of the potential increase in offenders detected assuming no behavioural change would take place. It should be noted that these estimates are based on partial and early evidence on the use of digital screeners and should be reviewed as more evidence becomes available.

16. Studies that have attempted to examine the behaviour changes as results of a change in the BAC limit have generally found difficulties of disentangling the effects of the law change, enforcement changes and media campaigns. A lower estimate has been

[42] Article 3 in Reported Road Casualties Great Britain: 2009 Annual Report,- source Home Office

[43] Provisional Statistics on Breath Alcohol Screening Tests in England and Wales 2009 (Experimental Statistics).

constructed on the basis that 75% of those who currently drive with a BAC of between 51 and 80mg/100ml would adjust their behaviour and be found compliant with the lower limit. This assumption results in an estimated 5,250 new offenders, who were assumed would go to proceedings in a magistrates' court.

17. The extra cost on the judicial system as a result of lowering the prescribed drink-driving limit is estimated to be between £3.5 million to £14.0 million per annum using the scenarios described above. In addition, it is assumed that:

- there is no change in the penalty regime (if offenders who record BACs at the lower end of the scale were dealt with by a fixed penalty notice, this would reduce the enforcement costs incurred)
- offenders would go to proceedings in a magistrates' court (although some would be subsequently referred to crown court resulting in higher costs)
- the average length of a drink-driving case takes 0.5 hours at magistrate courts, and a magistrate session lasts 5 hours on average45
- 18% of drink-driving offenders were assumed to be placed on probation, and 275 per 100,000 offenders were assumed to receive a custodial sentence44
- the average cost per magistrate session is £1,97244 per year
- the average cost per probation case is £1,93044 per year
- the average cost per prison place is £43,97044 per year
- It is acknowledged that some cases may be referred to crown court resulting in higher costs
- Further increases to the prison population may also have wider implications, e.g. by exacerbating overcrowding issues.

18. The changes to the number of offenders, and the resulting costs incurred are summarised in the table below:

[44] Ministry of Justice cost-benefit framework for drink driving.

Changes to offences and Judicial system costs per annum	Upper estimate – no behavioural change	Lower estimate – 75% behavioural shift
Estimated increase in offenders	21000	5250
Increased Magistrate Court hours	10500	2625
Increased Magistrate Court sessions	2100	525
Increased Magistrate Court costs (£million)	4.1	1.0
Increased probation cases	3780	945
Increased Probation costs (£million)	7.3	1.8
Increased prison population	58	14
Increased prison costs (£million)	2.5	0.6
Total cost to judicial system (£million)	14.0	3.5

19. A lowering of the prescribed limit is likely to lead to an increase in disqualifications, and some of these individuals may incur a subsequent custodial sentence as a result of being caught driving while disqualified.

20. It is also possible that if there was a radical shift in behaviour simply as a consequence of the lower drink-drive limit there could be less overall offences being committed and hence fewer offenders being caught. If those who are drinking and driving were to reduce their alcohol consumption sufficiently, then overall offences would fall. However it appears extremely unlikely that just lowering the drink-drive limit would have this impact, and this sort of impact has not been seen in other countries introducing lower limits.

21. Costs incurred by drivers who are detected as being offenders under the new limit are not included in the impact assessment. However, such costs may include lost leisure time (if a custodial sentence if given), lost earnings (if conviction results in an individual being unable to work) and costs associated with the use of public transport while disqualified.

Safety benefits

Road casualties

22. A lowering of the prescribed limit would be expected to result in a reduction in the number of drink-drive accidents and associated fatalities/casualties. The following

paragraphs describe scenarios suggesting that the annual reduction might be between 20 and 188 fatalities and between 629 and 16,900 non-fatal injuries[45].

23. The monetary value of these reductions has been estimated using the Department's estimated values of preventing a fatality and serious injury and, again based on the scenarios, suggests a potential benefit[46] between £57m and £899m per annum.

24. The benefit estimates do not include the potential costs avoided in relation to damage only accidents. Reliable statistics on the incidence of damage only accidents are not available because they are generally not reported to police; estimates suggest there may be some 2.45 million. The Department estimates that the value of preventing a damage only accident is around £2,000[47] (average figure over all road types) which helps to illustrate the potential benefit that can be realised if damage only accidents reduce as a result of a lower limit.

Construction of scenarios

25. A number of attempts have been made to estimate the effect of a reduction in the prescribed alcohol limit in GB, with a focus on estimating the associated reduction in drink-drive accidents and casualties. In order to address a gap in knowledge regarding the change in behaviour that would follow such a change, these studies tend to assume a general reduction in drivers' drinking behaviour which corresponds with the change in the limit which is under consideration. However, this implicitly treats drivers as homogenous groups according to their drinking behaviour and does not account for the unmeasured and often unpredictable behaviour which occurs in reality. In addition, there is also a need to take account of the uncertainty which exists regarding the response of those who already drink and drive at a level which exceeds the current limit, and therefore present the greatest danger to other road users.

26. Research evidence regarding behavioural change does not exist in a GB context because there has been no previous change in the prescribed limit. Some evidence is available regarding the experience in other countries[48] and, although this generally shows a positive shift in behaviour, it does little to explain the actual reasons behind this. This lack of exploration of the explanatory variables, combined with limitations in the research methodologies used (e. g. it is unclear how far the figures may have been distorted by the particular sampling regime employed), and differences in context (including enforcement methods and the penalty regime), mean that any attempt to transfer these findings in order to predict the response in GB would be imperfect. However, a systematic review of international evidence undertaken by NICE on behalf of the Department concludes that:

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[45] Based on accidents reported to the police in Great Britain in 2008. It has long been known that a considerable proportion of non-fatal casualties are not known to the police, further information and estimates can be found in Reported Road Casualties Great Britain 2008 and 2009 (pages 58-84, 61-83 respectively)

[46] Based on reported casualties in GB in 2008 and average cost of prevention per reported casualty – see Reported Road Casualties Great Britain:2008 Annual Report - page27

[47] Reported Road Casualties Great Britain:2008 Annual Report - page27

[48] For example, Albalate's study of the European experience and papers by Kloeden et al and Brooks et al which are focused on Australia.

- There is sufficiently strong evidence to indicate that a lowering of the prescribed limit changes the drink-driving behaviour of drivers at all BAC levels as drink-drive law appears to have a general deterrence effect and the beneficial effects are not just restricted to those who drive at the BAC levels involved.

- Overall there is sufficiently strong evidence to indicate that lowering the prescribed legal BAC limit for drivers is effective in reducing road traffic injuries and deaths in certain contexts.

27. Given the limitations in existing data, the approach taken here has been to construct a series of scenarios - essentially representing a high and low behavioural shift. These scenarios take account of available research evidence while also highlighting the associated limitations and caveats.

Assumptions

28. It is assumed that:

- the penalty regime for drink-driving remains unchanged (i.e. the penalty currently applied to those who are found to be driving in excess of the prescribed limit would continue to apply following a lowering of the limit) - any proposed changes to the penalty regime will be considered separately at a later date

- the level of enforcement activity undertaken remains unchanged (i.e. police will not devote additional man-hours to detection of offenders). In reality, pressure on police capacity will make it very difficult for forces even to maintain the status quo

- it is not cost-effective – especially given pressure on police resources – to adopt the sort of random testing strategies reported in some other countries

- final 2008 casualty figures reported to the police are used as the basis for all scenarios

Proposed scenarios

Scenario A

29. Work undertaken in 2005 by Professor Richard Allsop, of University College London, to estimate the impact of a lowering of the prescribed limit to a BAC of 50mg/100ml, assumes that everyone currently driving at a level of alcohol between the current and lower limit would reduce their intake to comply with a lower limit. He further assumes that everyone currently driving at a level in excess of the present limit (between 80mg/100ml and 110mg/100ml) would reduce their intake so that they drive at an equivalent point above the lower limit as they were above the old limit. Those driving in excess of 110mg/100ml are assumed to be unaffected by any change. Using these assumptions resulted in an estimated saving of 65 fatalities per year (Allsop et al, 2005). However, this may be an overestimate given that it assumes that some of those already driving at a level above the present limit will reduce their consumption. It also assumes that those currently driving at a level between the current and lower limit are willing and able to accurately reduce their consumption to achieve compliance.

30. It is suggested that this approach is used to produce a scenario which assumes a 10% reduction in casualties. The North report has taken this work and, on the basis of 2008

provisional data, arrived at an estimated saving of 43 fatalities per year. This work is used as the basis of Scenario A which assumes an estimated 10% reduction in the final number of casualties in drink-drive accidents in 2008.

Scenario B

31. In response to the Allsop work, Dr John Maloney of the University of Exeter argued that those already driving above the current limit may not change their behaviour in response to a lower limit (Social Affairs Unit – Web Review, May 2005). Assuming that they do not produces a more conservative estimate of 23 fatalities saved per year. However, this still assumes that those who currently drive at a level between the two limits will be willing and able to modify their consumption to achieve compliance.

32. It is suggested that this work is used as the basis for Scenario B which assumes an estimated casualty reduction of 5 percent in the number of casualties in drink-drive accidents.

Scenarios C-E

33. According to the North Review (pages 6, 68-69), a reduction of the drink-drive limit to 50mg/100ml would save between 43 and 168 lives in the first year post-implementation. The lower figure is based upon the Allsop analysis, and the upper figure is based upon the NICE research[49].

34. The NICE research examined a range of international evidence. Model[50] estimates suggested that lowering the drink-drive limit could save 144 deaths and 323 serious injuries in the first year after implementation (6.4% and 1.4% respectively of fatalities and reported serious casualties) in England and Wales. The analysis also suggested that the saving could grow over time to an upper estimate of 303 lives saved after six years. Using the estimates taken from the Albalate[51] Study (2006) based on experience with lowering of the prescribed limit from 80mg/100ml to 50mg/100ml in a number of European countries indicated a reduction in fatal casualties ranging between 77 and 168 lives, 3.4% and 7.4%. It should be noted that the casualties saved may not necessarily be reported as drink-drive casualties, and the estimates assume that changes to the legal limit would affect the BAC distribution at all levels. Therefore the percentages are applied to all road fatalities and casualties.

NICE research

35. The key studies which NICE used for the modelling of the impact involved a mixture of a lower drink-drive limit and significant increases in enforcement. The countries involved generally had a more serious drink-driving problem than the UK even after the changes in legislation and enforcement. The upper, longer term estimates suggest that

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[49] "Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths", 16 June 2010, www.nice.org.uk/additionalpublications.jsp.

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

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

changing the vast majority of the drink-drive problem in Great Britain could be eradicated simply by lowering the drink-drive limit. This has not been experienced by any other country. Achieving any impacts of this level crucially depends upon significant behavioural change by the high-end offenders – those already well above the 80 mg/100ml of blood alcohol. In practice, further reductions in the problem will require a range of measures, in which effective enforcement of the prevailing limit is likely to be crucial.

36. Of the total reported road accident fatalities in Great Britain in 2008, where a BAC was recorded, 78% of fatalities were below 80 mg/100ml (the legal alcohol limit). Within the total, 76% of fatalities had a BAC below 51mg/100ml; while 2% were between 51 and 80 mg/100ml. Over a fifth of fatalities (22%) were over the prescribed limit and 21% were over 100mg /100ml. The latest data from the digital breath alcohol screening devices, although incomplete and not yet submitted by all police forces in England and Wales, suggests a similar picture. Overall, 91% of people screened for alcohol at the roadside provided negative tests (i.e. the results were up to and including the legal alcohol limit of 35 micrograms (mcg) of alcohol per 100 millilitres (ml) of breath (equivalent to a blood alcohol level of 80 mg/100 ml)). Screening tests following a road traffic collision indicated that 93% of people tested were within the limit, while 2% of drivers had between 21-35 micrograms (mcg) of alcohol per 100 millilitres (ml) of breath (broadly equivalent to 50-80 milligrams of alcohol per 100 millilitres of blood).

37. This all demonstrates the importance of reducing the high-end drink-driving in order to achieve significant reductions in deaths and injuries. Given the uncertainties with the estimates, as with Sir Peter North's analysis, and the NICE research, three further scenarios have been used:

    Scenario C - Reductions based on the lower estimate using the Albalate study of reductions in fatalities of 3.4%. It is assumed that non-fatal casualties are reduced at the same rate

    Scenario D - Reductions based on the higher estimate using the Albalate study of reductions in fatalities of 7.4%. It is assumed that non-fatal casualties are reduced at the same rate

    Scenario E - Reductions based on the NICE / Sheffield University modelled outcomes of a 6.4% reduction in fatalities and a 1.4% reduction in non-fatal injuries.

Casualty reduction

38. Potential casualty reductions have been estimated against the final 2008 (baseline) figures for reported casualties in GB according to the scenarios outlined above.

	2008 estimated number of casualties in drink-drive accidents	2008 numbers of reported casualties	Scenario A	Scenario B	Scenario C	Scenario D	Scenario E
	a	b	10% of a	5% of a	3.4% of b	7.4% of b	6.4%/1.4% of b
Fatal	400	2,538	40	20	86	188	162
Serious	1,620	26,034	162	81	885	1,927	364
Slight	10,960	202,333	1,096	548	6,879	14,973	2,833

39. The monetary value of these reductions has been estimated using the Department's estimated values of preventing a fatality and serious injury. There is some evidence that the value of preventing a fatality may vary by the age of the casualty. However, there is no consensus on the best method to calculate the age-specific value of prevention and thus the average values are used for the estimates below. The average age for casualties as a result of drink-driving is lower than the average for all road casualties. Therefore it is possible that the values of preventing drink-drive casualties could be greater than the average values of preventing road casualties.

	Value of prevention per casualty in 2008	Scenario A	Scenario B	Scenario C	Scenario D	Scenario E
		£m	£m	£m	£m	£m
Fatal	£1,683,800	67.35	33.68	145.30	316.24	273.50
Serious	£189,200	30.65	15.33	167.47	364.50	68.96
Slight	£14,600	16.00	8.00	100.44	218.60	41.36
Total	£52,600	114.00	57.00	413.21	899.34	383.82

Economic impact

40. The following section presents initial estimates of the economic impact to the drinks and related industries of a reduction in the drink-driving limit. It should be emphasised that the output, employment and income generated by the drinks and related industries are not measures of the economic benefits generated by these industries. It would be expected that, if spending in these industries is reduced, this expenditure would be diverted to other goods and services in other sectors of the economy. If employment in the drinks and related industries contracts, the affected workers should, in a well functioning economy, be able to find employment elsewhere. However, during the transitional period, there could be impacts to the economy, while resources are diverted

from the alcohol related industries towards other sectors of the economy. Similarly, at least in the short to medium term, workers may find it difficult to obtain alternative employment, particularly in local areas where there are limited other types of employment available.

Impact on the drinks industry

41. The drinks industry can be divided in three different sectors: the production, the on-trade (licensed premises) and the off-trade (supermarkets and off licences) sectors. The impact of a reduction in the prescribed drink-driving limit on each sector was explored in turn. Estimates of these impacts depend on the quality of data available about the sectors concerned. This is assessed to allow only scenarios which illustrate the potential range of the impacts.

Impact on the production sector

42. In 2007, the alcohol industry is estimated to have directly contributed just under £13 billion to UK GDP: 20% (almost £2.6 billion) comes from the production[52]. It is likely that a change in the drink-drive limit would have a minimal impact on the production sector. Pub sales would decrease if a reduced number of customers visited these establishments, thus affecting the sale of alcohol in the on-trade sector. However, this is expected to be offset by more people buying alcohol in supermarkets and off licences for consumption at home.

Impact on the on-trade sector

43. In 2007, the on-trade sector is estimated to have directly contributed about £8.8bn to UK GDP, 68% of the total alcohol industries' direct contribution to GDP. In 2008, according to the British Hospitality Association's publication, British Hospitality: Trends and Developments, the food and drink sales were £7.7 billion and £8.8 billion in hotels and restaurants respectively.

44. There is little research on the exact shift in customer behaviour as a result of drink-driving limit changes. It is possible that customers may choose not to visit licensed premises rather than modify their drinking behaviour to remain within the new drink-drive limit. This could lead business closures, especially pubs that primarily depend on drink sales.

Impact on pubs

45. The British Beer and Pub Association (BBPA) estimates 1.5 million people drive to pubs each week53. Once accompanying passengers are taken into account, an estimated 2.5 million customers are dependent on private transport to the pub each week. This is

[52] Oxford Economics. The economic outlook for the UK drinks sector and the impact of the changes to excise duty and VAT announced in the 2008 Budget and Pre-Budget Report. February 2009. http://www.beerandpub.com/documents/publications/news/Oxford%20Economics%20Alcohol%20Industry%20final%20report%2024%20feb%202009.pdf

[53] House of Commons Transport Committee, Drink and drug driving law, First Report of Session 2010–11, Volume I.

http://www.publications.parliament.uk/pa/cm201011/cmselect/cmtran/460/460.pdf

equivalent to 17% of the 15 million customers to pubs per week. In addition, BBPA estimates customers spend around £20 per person per visit53.

46. Following a reduction in BAC limit, BBPA estimated that 1/3 of the pub customers arriving by car (1/3 of 2.5 million customers per week) will no longer visit pubs. This represents a reduction of approximately 833,333 customers per week. However, no specific evidence/market research was given to support this consumer behaviour assumption. In addition, BBPA suggest the greater proportion of the sale losses would be from reduced food sales. So the assumption of 1/3 of all pub customers arriving by car should be viewed as very much an upper estimate in the loss in sale given the scope to change drinking patterns and/or travel arrangement. The BBPA estimates were considered as Scenario A when assessing the impact of BAC limit changes on pub sales.

47. Three further plausible scenarios on customer behaviour were considered with similar caveats and uncertainties as with the BBPA estimates:

Scenario B: assuming numbers of people who arrive by car to pubs would remain unchanged. However, these individuals would only spend £15 per person rather than £20 per visit assuming they would drink less as a result of the BAC limit changes.

Scenario C: assuming a reduction of 10% of pub customers arriving by car as a result of BAC limit changes. Individuals were assumed to continue to spend £20 per person per visit.

Scenario D: assuming a reduction of 5% of pub customers arriving by car as a result of BAC limit changes. Individuals were assumed to continue to spend £20 per person per visit.

48. Potential revenue losses for pubs based on estimates from BBPA and behaviour changes listed above:

	Scenario A	**Scenario B**	**Scenario C**	**Scenario D**
	BBPA estimates	**25% reduction in spending for customers arriving by car**	**10% reduction in customers arriving by car**	**5% reduction in customers arriving by car**
Number of pub customers arriving by private transport per week (million)	2.5	2.5	2.5	2.5
Proportion of customers arriving by private transport who will no longer visit pubs	33%	0%	10%	5%
Number of customers who will no longer visit the pub per week as a result of BAC limit change	833,333	0	250,000	125,000
Estimated expenditure per person per visit for pub customers reliant on private transport	20	15	20	20
Losses to pub revenue per week (£million)	16.7	12.5	5	2.5
Losses to pub revenue per year (£million)	867	650	260	130

49. These scenarios suggest that a lower drink-drive limit has the potential to yield losses of revenue for pubs of between £130 million and £867 million a year. We believe the estimates would be towards the lower limit since there is scope for pubs to continue to sell food, especially as BBPA suggest that "today's pub culture has become more family friendly, more focused on food and alternatives to alcoholic drinks offering entertainment accompanied by drinks rather than the old-style drinks orientated public houses".

50. A loss to pub revenue will not be a commensurate loss for UK GDP, although it would be a loss for the on-trade drinks industry. The amount of money will be replaced in the UK economy because people will spend this money in other trade sectors. So for every £1 not spent in a pub, we might expect 50p to be spent in the off trade sector and 50p to be spent in other UK trade sectors. While these second round impacts would mitigate the impacts on GDP, the loss of rural pubs may have wider knock on impacts for local economies, and there would be welfare losses for consumers from the changes in leisure activities. The direct impacts on revenues for the drinks sector therefore appear a reasonable proxy of the economic impacts.

Impact on restaurants

51. The BBPA report that the overall turnover of restaurants is higher than that of pubs. Compared to pubs, restaurants are less likely to be in rural areas and individuals make fewer visits to restaurants. BBPA believes individuals may be more inclined to take a taxi so that they can continue to enjoy alcohol with their meal. Accordingly, the impact on the average restaurant might be less than on a typical pub.

52. BBPA estimates that the average spend per customer in a restaurant is likely to be around £25. With a total annual spend of £8.8bn this represents about 352 million visits per year.

53. If a reduction in the drink-drive limit led to a decline in visits to restaurants of just 3%, this would represent a loss of turnover of £264 million a year. With wages taking around 40% of restaurant sales, this loss of turnover would have a direct effect on employment of around £100 million of wages. The reductions assumed were not evidence based and are used for illustrative purposes only.

Impact on hotels

54. Hotels would be less affected than pubs and restaurants by a reduction of the drink-drive limit: much of the £7.7bn food and drink spend is by overnight guests and a lower limit might simply lead more diners to stay overnight rather than return home.

55. Assuming therefore a net loss of just 1% in hotel food and drink sales, this would represent a fall in turnover of £77 million, of which lost wages (30% in hotels) would be £23 million. The reductions assumed were not evidence based and used for illustrative purposes only.

56. The table below shows the estimated fall in turnover for the on-trade sector including pubs, restaurants and hotels.

Overall consequences for the on-trade sector turnover				
	Pubs		**Restaurants**	**Hotels**
	High	Low		
Fall in turnover (£million)	867	130	264	77

Impact on the off-trade sector

57. In 2007, the off-trade sector (supermarkets and off licences) is estimated to have directly contributed about £1.6 billion to UK GDP, 12% of the total alcohol industries' direct contribution to GDP. Consumption of alcohol in the home in the UK increased from 1992, peaking in 2003/04, since when figures have fluctuated54. There have been big increases in the consumption of wines and spirits. In contrast, alcoholic drinks purchased for consumption outside the home (i.e. in pubs, clubs and restaurants) decreased by 31% between 2001/02 and 2007. Purchases of beers fell by 36% over the period[54].

58. According to a Harpers Wine & Spirits Trades Review's article, a total of 70% of all alcohol sales now takes place in supermarkets – up from 53% ten years ago[55].

59. Limited consultation suggests that a new prescribed limit would not be expected to have a significant effect on off trade premises. The off trade sector may well benefit. If people stop going out to drink alcohol, the off-trade sector's sales would probably increase as people chose to drink at home.

Impact on employment

60. These data for the on and off trade sectors imply that there would be consequences for employment in those sectors; and suggest that the number of employees will tend to increase in the off-trade sector and to decrease in the on-trade sector.

61. According to Oxford Economics[56] the on-trade sector of the drinks industry employs 546,000 people, and 91,000 people are employed in the off-trade sector.

62. The exact impact as a result of the BAC limit changes on employment are hard to predict and thus the following assumptions are not evidence based. In addition, the earnings used below are gross earnings and there are wider implications i.e. for tax contributions.

63. Assuming the reduction in the BAC limit leads to a 5% reduction in the on trade employment it would result in a loss of 27,300 jobs. The equivalent losses in wages

[54] NHS Information Centre report*, Statistics on Alcohol 2009*

[55] This is a quotation of an article published on the Harpers in July 2010. This guide to the UK drinks industry is designed for drinks professional.
http://www.harpers.co.uk/news/9245-wsta-rejects-calls-for-beer-and-pub-tax-break.html

[56] see footnote 54 at paragraph 42

were estimated assuming that on average a full time individual has a gross earning of £15,696[57] per annum (the median earning for the restaurant and hotel sector in 2008). This leads to a £429 million loss in wages. It is recognised not all employees will work full time, so this figure may be an overestimate.

64. Assuming the reduction in the BAC limit leads to a 2% reduction in the off trade employment it would result in a loss of 1,820 jobs. The equivalent losses in wages were estimated assuming that on average an individual has a gross salary of £11,032[58] per annum (the median earning for sales and customer service occupations in 2008). This leads to a £20 million loss in wages.

Summary

The cost to Government

65. The following estimates summarise the potential cost to Government:

- Publicity campaigns could require a budget of around £2.75m based on past campaigns.
- Further investigations are required to estimate the potential costs to the police.
- The possible additional judicial system costs were estimated to be between £3.5-£14.0 million assuming no behaviour changes if the drink-driving limit were to change, and assuming 75% of individuals with a BAC of 51-80mg/100ml lowered their consumption to comply within the new limit.

66. The overall cost to Government (excluding police costs) is estimated at £6.25m to £16.75m. Given best estimates, and including consideration of police costs, we anticipate costs to Government to be towards the middle of this range.

Safety benefits

67. The following summarises the value of potential safety benefits:

- The annual reduction in road accident fatalities as a result of lowering the prescribed drink-driving limit may be between 20 and 188, and there may be around 629-16,000 non-fatal injuries prevented. We believe the estimates would be towards the lower end of the range since the drink-driving problem would be unlikely to be eradicated by lowering the drink-drive limit alone.
- The potential value of prevention of reported casualties were £57 to £889 million. This is equivalent to a reduction of 0.4 %-7.0% of the total value of prevention of injury accidents of £12,790 million estimated for 2008. Similarly, we believe the estimates would be towards to the lower end of the range.

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[57] Clive Dobbs, *Patterns of pay: results of the Annual Survey of Hours and Earnings 1997 to 2008 (supplementary tables)*, Economic & Labour Market Review, volume 3, no 3

[58] 2009 Annual Survey of Hours and Earnings (ASHE), http://www.statistics.gov.uk/downloads/theme_labour/ASHE-2009/tab14_7a.xls

68. The overall safety benefits are estimated at £57m to £889m. Given best estimates, including considerations that casualty values used may be higher due to the age distribution of drink-drive casualties; we anticipate benefits to be towards the lower end of this range.

Economic impact

69. A summary of the economic implications for different sectors is given below. Most of the assumptions are not evidence based and are used for illustrative purposes only. It is important to remember that impacts on different sectors are not necessarily independent of each other.

70. It is important to remember that these economic impacts should not be counted as economic costs. It is expected that, while there may be transitional impacts to the economy, income and employment losses to the drinks and related sectors would be offset by increased spending and employment in other sectors of the economy. The extent of any transitional impacts is highly uncertain.

- The possible revenue losses experienced by pubs were £130-£867 million which represented between 1% and 6% of the total pub revenue. However, assumptions used estimates from industry sources who may have overestimated losses and the additional scenarios were not evidence based. We believe the estimates would be towards the lower end of the range.

- The possible revenue loss by hotels was assumed to be 3% for illustrative purposes. This was equivalent to £264 million.

- The possible revenue loss by restaurant was assumed to be 1% for illustrative purposes. This was equivalent to £77 million.

- 5% of employees in the on trade sector and 2% in the off trade sector were assumed to lose their jobs for illustrative purposes. This was equivalent to £449 million of lost earnings.

71. The economic impacts illustrated here range between £920m and £1657m. These estimates are subject to a very high degree of uncertainty in comparison to the costs to Government and safety benefits estimates. It is emphasised that the economic impacts should not be counted as economic costs or benefits.

Overall cost-benefit analysis

72. Overall there is a wide range of estimates for both the costs and benefits of lowering the drink-drive limit, given that both the benefits and the costs depend on how people will change their behaviour. We expect the benefits will be towards the lower end of the range, given that the upper estimates of benefits depend upon people who already know they are drink-driving deciding to change their behaviour. Taking the most reasonable scenarios together, the costs of implementing the change are likely to outweigh the benefits.

73. The best estimate of potential casualty reductions uses a scenario where 100% of drivers currently between 51mg/100ml and 80mg/100ml would reduce their intake to comply with a lower limit, all drivers currently between 81mg/100ml and

110mg/100ml would reduce their intake to an equivalent level above the lower limit, and drivers above 110mg/100ml would not alter their behaviour. This scenario would result in one off advertising costs to Government of £2.75m, no change in costs to the justice system as all drivers would adjust their behaviour and so receive the same penalty, and annual safety benefits of £114m.

74. A full analysis of the impact on GDP or economic welfare is not currently available; however a reduction of only 1% in combined pub, restaurant and hotel revenue would result in a £295m loss to those industries. This is acting as a proxy for the net economic costs. It does not take into account economic activity displaced into other sectors which would reduce the economic loss. On the other hand it also does not take account of the lost welfare to people taking a highly precautionary approach and changing their behaviour, nor the wider impacts on economic activity and welfare where rural pubs and restaurants close as a result of reduced custom.

75. Given that the above is a conservative estimate of revenue loss, when it is combined with the potential costs to Government and safety benefits the overall costs of reducing the limit are likely to outweigh the overall benefits.