Driver & Vehicle Licensing Agency

MINUTES OF THE SECRETARY OF STATE FOR TRANSPORT'S HONORARY MEDICAL ADVISORY PANEL ON DRIVING AND DISORDERS OF THE NERVOUS SYSTEM

Meeting held on Thursday 12th March 2026

Present:

Panel Members:

Dr Paul Cooper (Chair)	Consultant Neurologist
Professor John Duncan	Professor of Clinical Neurology
Dr Kirstie Anderson	Consultant Neurologist
Dr Wojciech Rakowicz	Consultant Neurologist & Medical Examiner
Dr Jeremy Rees	Neuro-Oncologist
Dr Peter Keston	Consultant & Clinical Lead Diagnostic & Interventional Neuroradiologist
Professor David Werring	Professor of Clinical Neurology
Dr Emily Henderson	Consultant Senior Lecturer in Ageing & Movement
Dr Ralph Gregory	Consultant Neurologist
Mr Julian Cahill	Consultant Neurosurgeon
Dr Claire Howard	Consultant Orthoptist (Secretary of State for Transports Panel Chair on Driving and Visual Disorders)

OBSERVERS:

Dr Sue Stannard	Chief Medical Advisor, Maritime and Coastguard Agency
Dr Ewan Hutchinson	UK Civil Aviation Authority
Dr Karen O'Connell	Irish National Office for Traffic Medicine

EX-OFFICIO:

Dr Athanasios Lamprakis	Senior DVLA Doctor
Dr Amanda Edgeworth	DVLA Doctor
Dr Laura Tattersall	DVLA Doctor
Dr John Evans	DVLA Doctor
Dr Aaron Chan	DVLA Doctor
Dr Anca Birliga	DVLA Doctor
Dr Maria Debritto	DVLA Doctor
Dr Nerys Lewis	DVLA Doctor
Dr Nick Jenkins	DVLA Doctor
Dr John MacAdie	DVLA Doctor
Anne Church	DVLA Nurse
Claire Hughes	Driver Licensing Policy
Edward Foxell	Driver Licensing Policy
Jordan Kwan	Drivers Medical Business Change/Support
Andrea Lee	Drivers Medical Business Change/Support
Sharann Oliver	Service Management
Suzanne Richards	Service Management
Michelle Davies	Doctors Casework Management and Support
Emma Nelson-Jones	Doctors Casework Management and Support Lead

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SECTION A: INTRODUCTION

1. Apologies for Absence

Apologies were received from:

Clare Forshaw	Principal Strategy Implementation Manager RSSB
Mr Jonathan Bull	Consultant Neurosurgeon & Complex Spinal Surgeon
Miss Hayley Misell	Lay Member
Professor Catrin Tudur-Smith	Professor of Biostatistics
Tom Mogford	Drivers Medical Business Change/Support Lead
Siân Taylor	DVLA Panel Coordinator/PA to the Senior DVLA Doctor

2. CHAIR'S REMARKS

The Chair welcomed all attendees. Panel members were reminded to ensure their declarations of interest were up to date, and that conflicts of interest were to be declared.

3. ACTIONS AND MATTERS ARISING FROM THE PREVIOUS MEETING

i. Time off Group 2 driving following isolated seizure

The Panel revisited an ongoing workstream concerning the risk of epilepsy following a first unprovoked seizure, particularly in relation to driving licensing decisions.

Panel members noted that much of the existing literature, reports cumulative recurrence risk following the first seizure, and is typically expressed as the probability of recurrence within a given timeframe (e.g., within one year). However, this metric is not directly applicable to DVLA licensing decisions.

For licensing purposes, what is required is conditional future risk, for example:

- The risk of seizure recurrence in the next 12 months given that the individual has remained seizure-free for six months.
- The risk of recurrence after one year seizure-free.

This type of conditional risk information is necessary to support evidence-based decisions about when individuals may safely return to driving.

A systematic review protocol has been circulated and will be undertaken with support from the University of Liverpool, with Dr Tudur-Smith leading the workstream.

The aim is to review available evidence and derive conditional risk estimates that may be used to inform DVLA guidance, for Group 1 (cars and motorcycles) and Group 2 licences (bus and lorry) drivers.

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Panel members noted that earlier evidence had supported the current six-month restriction for Group 1 licences following an isolated seizure. At least five years off driving is required for Group 2 drivers following an isolated unprovoked seizure, but more recent research has suggested a longer duration before recurrence risk falls below 2%.

The Panel agreed that no change to standards should be made based on a single paper, hence the importance of the systematic review.

ii. Head Injuries/ Traumatic Brain Injury and Group 2 Licensing and Medication withdrawal and Group 1 Licensing

DVLA provided an update on two changes advised by panel in relation to the Group 2 standards for Traumatic Brain Injury and for medication withdrawal and Group 1 licensing. A targeted consultation had been undertaken for each with relevant stakeholders including epilepsy and brain injury charities. The deadline for responses was 11 February 2026.

Those who responded were supportive of the proposals and the changes will now move to operational implementation within DVLA. Updates will be made to Assessing Fitness to Drive (AFTD) guidance, operating instructions, and related documentation.

The DVLA acknowledged the panel's request that these changes should be implemented as soon as practicable.

SECTION B: TOPICS FOR DISCUSSION

4. Medical standards for sleep-related disorders

The Panel Chair advised that the medical standards relating to sleep related disorders currently fall within the remit of the Neurology Panel. These conditions are presently distributed across two sections of Assessing Fitness to Drive (AFTD):

- the Neurology Chapter (e.g. hypersomnias / narcolepsy), and
- the Miscellaneous Chapter (e.g. "Excessive sleepiness – including obstructive sleep apnoea syndrome").

The Panel was asked to consider whether this distribution remains appropriate and to discuss any recommendations for the future structuring or categorisation of these conditions within AFTD.

The Panel discussed whether sleep-related disorders should continue to fall under the neurology panel or whether responsibility should move to another panel, such as respiratory medicine.

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Currently, conditions such as narcolepsy and hypersomnias have been addressed within the neurology section of AFTD and Obstructive Sleep Apnoea Syndrome (OSAS) appears within a miscellaneous section of the guidance.

Panel members observed that although OSAS is commonly managed by respiratory physicians, sleep medicine is not a distinct specialty in the United Kingdom (UK), and clinical responsibility varies between neurologists, respiratory physicians, and other specialists. It was also noted that OSAS generates a very high volume of DVLA casework, while narcolepsy is relatively rare. DVLA confirmed that the current structure does not create operational difficulties in day-to-day case management.

Discussions also highlighted that OSAS is associated with a significant risk of road traffic accidents, although objective assessment is difficult. Current guidance relies on self-reported excessive daytime sleepiness, clinical judgement and evidence of previous driving incidents.

The panel noted several challenges:

- Patients may underestimate or fail to recognise sleepiness.
- Clinical practice varies between sleep services.
- Objective sleep tests show night-to-night variability.

Despite limitations, the existing guidance has become widely adopted across sleep clinics.

The Panel agreed that sleep disorders should remain under the neurology panel rather than on any new dedicated panel. A subgroup will be convened to review sleep disorder standards periodically and additional external expertise will be invited where appropriate.

5. Craniectomy

Following panel discussions in Autumn 2021 and Spring 2022, the medical standard entitled "Craniectomy and subsequent cranioplasty" was renamed in the May 2022 published guidance as "Cranioplasty". The DVLA asked Panel's advice on how craniectomy should be represented in the published guidance.

The Panel agreed that the guidance should have a craniectomy standard and advised that the wording should include:

- Must not drive.
- Must notify DVLA.
- Fitness to drive depends on the underlying neurological condition and recovery.

The existing cranioplasty standard was considered acceptable and does not require revision.

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6. Stroke

Salford Community Stroke and Neurological Rehabilitation Team wrote to the DVLA about the inconsistency in advice provided by clinicians across the UK when advising their patients on when they could return to driving. A related question was also raised by Dr Claire Howard, Chair of the Honorary Medical Advisory Panel on driving and visual disorders, who joined the panel meeting to ask for clarification of the guidance on when driving can resume, and if notification to the DVLA is required where the effects of stroke last longer than a month but are unlikely to last longer than 3 months.

The current rules state that:

- Patients must not drive for at least one month following a stroke.
- If a neurological deficit persists at one month, the patient must notify DVLA.

However, the general guidance exempts an individual from notifying the DVLA if their medical condition is temporary and will not last beyond three months. This has been perceived by some clinicians as allowing three months for someone to recover before they are required to notify.

The Panel was advised of situations where a patient has a significant visual field loss immediately after a stroke. At one month, the deficit has improved substantially but is not fully resolved.

In these cases, patients are advised not to drive. Some clinicians advise immediate DVLA notification, but others allow additional time for recovery of up to three months before advising patients to notify.

Dr Claire Howard advised that evidence suggests approximately 50% of visual field defects recover, often within the first three months. If patients notify DVLA prematurely, licences may be revoked unnecessarily, leading to an administrative burden for DVLA, delays in licence reinstatement and unnecessary anxiety for patients.

The Panel discussed whether the one-month notification point is optimal. Arguments for three months included that most neurological recovery after stroke occurs within this timeframe. It may avoid unnecessary licence revocation.

However, it was recognised that the current rule ensures that individuals with persistent deficits are not lost to follow-up. A subgroup subsequently reviewed the wording within the Assessing Fitness to Drive guidance to reduce ambiguity and add clearer cross-references between temporary medical condition guidance and stroke guidance. Panel also agreed to establish a future workstream reviewing stroke-related driving standards, including visual field recovery timelines and we will include representation for the Vision panel in this workstream.

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7. DVLA Neurology medical questionnaires

The Panel Chair requested that the DVLA involve and engage with the Panel on the development, review, and amendment of medical questionnaires. Recent changes to DVLA medical questionnaires were discussed. Panel members expressed concern that new questionnaires had been introduced without adequate consultation with the relevant medical panels, and some revision may be required to ensure they are workable, both for drivers and clinicians, and that the wording is clarified to clearly delineate the role of clinicians and the DVLA's in assessing medical fitness to drive.

DVLA confirmed that there is work in the pipeline to review its medical questionnaires and forms, and all medical panels will have the opportunity to provide input as part of the change process.

8. Update from other Panels

Panel's attention was directed to the minutes of the previous meetings and the agendas of all advisory panels.

Diabetes Panel

- Introduction of continuous glucose monitoring systems (CGMS) for Group 2 drivers.
- Exploration of how continuous glucose monitoring systems benefit individuals with hypoglycaemia unawareness and consideration is being given to whether this has a potential impact on the driving standards.

Drugs and Alcohol Panel

- Work is underway to redefine drug misuse standards.
- Consideration of a risk-based framework rather than fixed drug lists.

Vision Panel

- Review of prism-based lenses designed to expand visual fields.
- These were deemed unsuitable for driving as they cause diplopia.
- Ongoing work exploring mandatory vision testing for older drivers.

Cardiology Panel

- Functional testing for drivers with implantable cardioverter defibrillators.
- Review of hypertension standards for professional drivers.

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Psychiatry Panel

- Development of cognitive assessment frameworks.
- Discussion of delusional disorders, which were generally considered low risk for driving.

Section C: Ongoing Agenda Items

9. Test, Horizon Scanning, Research and Literature

DVLA reminded all panel members as part of the terms and conditions of the requirement to update panel regarding any information/tests/research that could impact on standards or existing processes.

Panel members discussed emerging developments relevant to driving safety, including:

- new sleep disorder treatments
- vehicle-based drowsiness detection technologies
- evolving treatments for sleep apnoea, including oral appliances and weight-loss therapies

The systematic review on seizure recurrence risk was noted as a key research priority supporting future licensing standards.

The Panel also discussed the possibility of future screening initiatives, although these would primarily be policy-driven rather than panel-initiated.

Dr John Evans presented papers on the current standards for Group 2 and subarachnoid haemorrhage. Panel thanked Dr Evans for the presentation. Panel advised no change.

10. AOB

Brain tumours – alternative treatment options for recurrent gliomas

The use of Vorasidenib in treating low risk gliomas was discussed. Panel confirmed Vorasidenib has now been approved for use in the treatment of low-risk gliomas. DVLA have reviewed cases where this treatment has started as an adjunctive treatment to the primary treatment, and cases where it has been started to treat radiological only recurrence, with no symptoms.

Panel confirmed if the treatment is used as an adjunctive treatment in addition to the primary treatment the time off driving would be from the completion of the primary treatment. If Vorasidenib is used to treat a radiological only progression (with no symptoms and no other treatment) the individual may continue to drive their Group 1 entitlement. This is as detailed in

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the medical standard for recurrence or progression identified on imaging alone treated with chemotherapy.

Joint Neuro and Psych subgroup meeting update

The Panel Chair advised that a joint meeting with the psychiatry panel will take place to discuss cognitive assessment and driving standards.

Case Discussion – Kleine–Levin Syndrome

A clinical case involving Kleine–Levin syndrome was discussed.
Key features of Kleine-Levin syndrome include:

- Episodes of profound hypersomnolence.
- Behavioural changes with impaired awareness.
- Unpredictable onset of attacks.

It was noted that, in some presentations of this condition, individuals may experience frequent episodes over relatively short periods.

Panel members agreed that such episodes are typically associated with disturbance of awareness and impaired judgement, which would render driving unsafe during active phases of the disorder.

The consensus reached was those individuals experiencing active episodes of Kleine–Levin syndrome should not drive. A sustained period of at least one year without further episodes would generally be required before driving eligibility could be reconsidered. It was confirmed one year without episodes was required in the case discussed.

Panel member departure

The Panel formally acknowledged the retirement of Professor John Duncan, thanking him for many years of service and recognising his extensive contributions to the development of neurological driving standards.

11. Date of next Meeting

Thursday 1st October 2026

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Driver & Vehicle Licensing Agency

Original draft minutes prepared by: **Siân Taylor**
Note Taker
Date: 01/04/26

Final minutes signed off by: **Dr P N Cooper**
Panel Chair
Date: 27/05/26

THE DVLA WILL CONSIDER THE ADVICE PROVIDED BY THE PANEL AND NO CHANGES TO STANDARDS WILL TAKE EFFECT UNTIL THE IMPACT ON INDIVIDUALS AND ROAD SAFETY IS FULLY ASSESSED.

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