

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

Wednesday, 10 October 2012

Present:	Professor E Gilvarry (Chairperson) Professor A R W Forrest Dr K Wolff Dr A Brind Dr J Marshall Professor C Gerada Dr O Bowden-Jones	
Lay Members:	Mrs P Moberly	
Observers:	Professor D Cusack Dr P Collins Howgill	Forensic Physician and Director of the Medical Bureau of Road Safety, Dublin Civil Aviation Authority
DfT:	Mr N Thakore Ms E Shovelton	
DVLA:	Dr J Morgan Dr P Prasad Dr M DeBritto Ms J Chandaman Mr B Jones	Senior Medical Adviser Medical Adviser, Panel Secretary Medical Adviser Medical Licensing Policy Business Change & Support Manager

SECTION A: Introduction

1. Introduction – New Panel Members

1.1 Professor Gilvarry welcomed the new Panel members: Dr Jane Marshall, Professor Clare Gerada and Dr Owen Bowden-Jones to the Panel meeting.

2. Apologies for Absence

2.1 Apologies were received from Dr N Sheron, Dr P Rice, Dr A Lowe, Mrs J Cave, Dr S Ryder, Professor R Jalan, Dr M Prunty and Dr C Campbell, Mr D Bastin and Mr K Rees.

3. Chair's Remarks

- 3.1 The Chair advised that several members of the Panel had attended regular meetings for the Drug Driving Advisory Working Group and would be preparing a report on certain drugs in the context of a possible future specific offence of driving whilst under the influence of drugs.
- 3.2 The Chair advised that the topic of impairment caused by the use of prescribed/multiple medication had not yet been discussed with the Chairman of the Secretary of State for Transport's Honorary Medical Advisory Panel on Driving and Psychiatric Disorders.

4. Panel Chairmen's Meeting held on 21 June 2012

- 4.1 Dr Kim Wolff attended the annual Panel Chairmen's meeting on behalf of Professor Gilvarry. The minutes of the Panel Chairmen's meeting were provided for information. Several areas were discussed including the response to the North Report and the establishment of a Panel of experts on Drug-Driving.
- 4.2 It was agreed that co-working on prescribed medication with the Psychiatry Panel would be beneficial and it was suggested that representatives from the Panel would attend the Psychiatry Panel meeting in March 2013. Professor Gilvarry will liaise with the Psychiatry Panel Chair regarding attendance.

5. Annual Report

- 5.1 The Annual Report of the Secretary of State for Transport's Honorary Medical Advisory Panel on Alcohol, Drugs and Substance Misuse and Driving, January to December 2011, was discussed and agreed as accurate.

6. Minutes of the last meeting held on 7 March 2012

- 6.1 Professor Cusack requested that the spelling of his surname should be corrected. His title should also be corrected from Forensic Pathologist to Forensic Physician, Medical Bureau of Road Safety, Ireland.
- 6.2 The minutes were otherwise agreed as accurate.

SECTION B: Ongoing Discussion Topics

7i. Update on Hepatic Encephalopathy

7i.1 The Panel had requested an update from the Hepatic Encephalopathy Working Party but the members were unable to attend this Panel meeting. The Chair requested that this topic is discussed further at the next Panel meeting.

7ii. Update on CDT Testing

7ii.1 The Panel was updated on the Carbohydrate Deficient Transferrin (CDT) pilot that commenced in February 2012. The Panel had recommended the use of CDT rather than traditional blood analysis of liver function tests and MCV to diagnose ongoing alcohol misuse. CDT was not yet used for all HRO cases, but Medical Advisers had started to refer drivers for CDT testing on an individual basis. Cases were considered for a CDT level where there was uncertainty in the interpretation of abnormally raised blood tests which were currently used as markers of alcohol misuse, and where licence recommendation could not otherwise be made. The latest statistics from the Drivers' Medical Business Change and Support Group were presented.

7ii.2 A summary was given to the Panel on the CDT results of the pilot. It was noted that in a small number of cases a CDT level was unobtainable and further work was ongoing to understand the reasons behind these results.

7ii.3 It was noted that approximately 10% of the samples were over the 'red' cut-off level of 3%CDT, and the highest level obtained was 15%CDT. The average result in this group was 6.6%CDT.

7ii.4 Within the 'amber' zone of CDT cut-off levels, between 2.3 to 2.9, it was noted this represented about 4% of the total cases that had been analysed to date. The lowest score overall was 0.2%CDT.

7ii.5 When CDT is introduced as part of the HRO Scheme the Panel recommended that a communication is sent to the medical profession. No appeals had yet been heard on the basis of a refusal or revocation of a driving licence based on a CDT result. It was confirmed that serial CDT has been useful in medico-legal work.

7ii.6 Professor Gilvarry requested that an update on the CDT Pilot be presented at the next Panel meeting.

7iii. Progress on HRO legislation

7iii.1 Ms Chandaman updated the Panel on the progress of current legislation on drink-driving and the High Risk Offender (HRO) Scheme. The right to drive following a re-application will be removed and the driver will not have entitlement to drive until they have undergone the medical examination and associated blood tests and a recommendation has been made by the Drivers' Medical Group. The current legislative programme is unlikely to allow modification of the law before February 2013. The HRO Scheme and the relevant offences were discussed for the benefit of the new Panel members.

7iv. Department for Transport Update

DfT Update on drug-driving

7iv.1 Mr Thakore provided the Panel with an update on the Drug Driving Policy and the proposed introduction of a new drug-driving offence. He advised that the expert Drug Driving Working Group had started meeting in April 2012 and the recommendations of the report were awaited. Separate work was ongoing with regard to Drug Analysers and Type Approval. Following submission of the Working Group's report to the Minister, a consultation would be undertaken. This Panel indicated that they would wish to respond to the consultation. It was emphasised that the accuracy of the content and questions of the consultation should be confirmed before it is released.

7iv.2 A further update would be given at the next Panel meeting.

DfT Update on drink-driving

7iv.3 Mr Thakore introduced Elizabeth Shovelton to the Panel who had recently joined the Department as Head of Legislation, Enforcement and Standards. Ms Shovelton provided the Panel with an update on drink-driving legislation. There will be a consultation on several proposals as part of the response to the North Report. One area of the consultation is the proposal to withdraw the statutory option of having a confirmatory blood test at the time of a drink-drive offence. It was noted that the technology of the alcohol breathalysers are now more reliable and the option of a blood test is no longer required. Consultation is also being considered for removing the requirement for preliminary testing where evidential testing is carried out away from the police station. Type approval of portable evidential breath analysers and the appropriate technology was awaited. In addition, the consultation will also consider the procedures to streamline obtaining evidential blood specimens on drink-drivers and drug-

drivers who are admitted to hospital, so that a wide range of registered health care professionals can obtain the necessary samples.

- 7iv.4 A full discussion took place around the ethical and medico-legal issues of the proposals. The Panel members were asked to provide names of any organisations that they felt should be consulted. The Panel was asked to be kept aware of when the consultation was to be published.
- 7iv.5 The Department is in the process of arranging the next Drink Drive and Drug Drive publicity campaigns and liaising with the communications department.
- 7iv.6 The Panel was made aware that the Scottish Government had published the consultation seeking views on lowering the drink-drive limit in Scotland and this had been published in September 2012. It was noted that there would be no change to the HRO Scheme as it was explained that the penalties would not change with regard to drink-drive offences. Professor Gilvarry advised that she will contact other members of the Panel with regard to responding to the Scottish consultation.

7v. Update on Drug Driving Advisory Panel

- 7v.1 Dr Kim Wolff, Chair of the Drug Driving Advisory Panel, provided an update on the work which had been carried out since April 2012. It was noted that the Terms of Reference encompassed the recommendations of the North Report and Government's response. The drugs that had been discussed were predominantly those that fell under the Drugs of Misuse Act. These included cocaine, amphetamine-type drugs, benzodiazepines, opiates, cannabis and any other drugs that the Advisory Panel felt was a risk whilst driving.
- 7v.2 The Panel had looked at other European countries in terms of legislation and the setting of drug levels. Epidemiological studies such as the Druid Report had been scrutinized along with case control studies in order to gather information about relevant drugs. Scientific reports including driver safety and in particular the risk estimate (as an odds ratio) of seriously injured and fatal accidents whilst under the influence of drugs were researched.
- 7v.3 The Panel had considered the blood drug concentration and type of drugs in drivers that had suffered road traffic accidents and information was gathered from various sources including DVLA notifications from the police. It was noted that concomitant use of alcohol with any psychoactive substance led to an increased risk of an accident occurring.

7v.4 A further area of the report would include advice on prescribed medication. The Panel had received several enquiries from external organisations with regards to prescribed medication. The question of tolerance had been discussed. The Panel was looking at individual drugs, for example, within the opiates drug class and it is likely that there would be different categories for illicit opiates and those opioids used for the treatment of addiction as well as those prescribed for pain relief.

7v.5 The full report was expected to be produced for the Government by the end of November 2012.

SECTION C: New Topics for Discussion

8. Presentation on Civil Aviation Authority's management of drug and alcohol problems

8.1 Dr Paul Collins Howgill, Head of Aeromedical Certification, provided an overview of the background and current medical standards with regard to drug and alcohol problems in pilots. An explanation of aviation law was given. It was noted that investigations into worldwide medically caused aviation accidents showed that more were due to alcohol and/or drug problems than other medical conditions. It was noted that the European standard for blood alcohol for flying in pilots is 20 mg per 100 ml of blood. Notification of pilots affected by alcohol or drug misuse was mainly received from airport security staff and CAA employees rather than General Practitioners. Random testing of alcohol levels was not carried out in the UK but is used in some European countries.

8.2 At the Aeromedical Centre based at Gatwick Airport fortnightly clinics are held for consultations for pilots who have alcohol and drug related medical conditions. Following a diagnosis of alcohol dependence, in-patient treatment is required as it was noted that out-patient treatment relapse rates were unacceptably high. After the in-patient treatment, pilots were closely followed-up and when deemed safe to fly would only be allowed to fly in a 2-crew environment. The pilots were reviewed at 3-monthly intervals for a year and thereafter annually for the rest of their careers. Pilots are encouraged to attend AA or similar organisational meetings and it was noted that they attended these at several major cities worldwide. Laboratory testing of individuals included liver enzymes and CDT levels. The CAA uses hair test analysis in drug misuse cases and operates a zero tolerance policy for this condition.

8.3 Referrals from several sources were noted including the courts, fleet managers, aero-medical examiners and cardiologists employed to work at the CAA, and occasionally the media.

- 8.4 The relapse rate was noted to be 15% following in-patient treatment. A comparison was given by Dr Collins Howgill with regard to the USA data for pilots and they had recorded a similar relapse rate. A member of the Panel who works on a sessional basis at the CAA advised that the pilots were often very motivated to return to work, were closely followed-up and it was often arranged for the pilots to have a phased return to work. They would have to pass a simulator test before they were able to return to flying.
- 8.5 The Panel discussed hair analysis for drug detection and whether it would be appropriate for DVLA to use this method in professional drivers. There were concerns about the quality standards in different laboratories and also the cost implications. The Panel agreed that hair testing at the present time is not recommended for use when investigating drug-driving cases.
- 8.6 A legal case concerning hair testing was discussed and details of the case report will be forwarded to the Panel members.

9. Advice on Methadone Programmes

- 9.1 The Panel discussed the advice as set out in the current 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' with regards to applicants or drivers on Methadone Maintenance Programmes. A discussion took place around the current standards and Good Practice Guidelines that are used as reference for the Medical Advisers in the Drivers' Medical Group. Currently licensing may be allowed if the driver is stable and is otherwise free from other drug and alcohol misuse. An annual review was generally required. No changes were felt necessary to the guidance but this topic will be discussed further at the next Panel meeting in the light of the Drug Driving Advisory Panel review and report. The Panel will review the structured medical questionnaires that are used by the Drivers' Medical Group at the next Panel meeting.

10. Paper: Categorisation System for Medicinal Drugs Affecting Driving Performance

- 10.1 A paper from the ICADTS Working Group (International Council on Alcohol, Drugs and Traffic Safety) was discussed. The paper categorised all prescription medication into one of three categories:

Category 1 being presumed to be safe or unlikely to produce any adverse effect;

Category 2 being likely to produce minor or moderate adverse effects;

Category 3 likely to produce severe effects or presumed to be potentially dangerous.

- 10.2 A discussion around prescribed medication and side effects took place and it was thought this paper would be a useful addition to the research for the Drug Driving Advisory Panel and it was suggested that it be brought back to the next Panel meeting for further discussion.

11. Case for Discussion

- 11.1 The Panel discussed a case of a driver who had re-applied for an ordinary driving licence and was known to have a past history of illicit drug misuse. There had been no declared illicit drug misuse for over 2 years and this had been confirmed by the driver's doctor. A urine screen analysis was positive for opiates, and GC-MS confirmed the opiate was morphine. An analysis of the second urine sample obtained at the same time as the original sample showed the presence of Thebaine. Medical evidence presented to the Panel demonstrated that at least some of the morphine in the original urine sample originated from poppy seeds. Full discussion of all the evidence took place and it was the Panel's considered opinion that the driver could be issued with a licence.
- 11.2 The members were advised that Thebaine may also be present in urine after opium had been smoked, and that several grams of poppy seeds needed to be eaten in order to show a significant level of morphine in a urine analysis. Thebaine is not routinely tested for in laboratories but following a specific request an analysis for Thebaine is possible. It was agreed that relevant research papers will be made available for discussion at the next Panel meeting.

SECTION D:

12. Any Other Business

- 12.1 Ms Chandaman advised the Panel that the Drivers' Medical Policy Group was considering extended short-term period licences, up to nine years, for certain medical conditions. At present drivers with progressive medical conditions may have a medically restricted one, two or three year licence and three years is the maximum time allowed for a medically restricted licence. Panel members were asked to consider whether any relevant medical conditions would fall into this category. The Panel considered that there was no requirement for a longer restricted licence for drivers with alcohol or drug misuse, although the Panel appreciated that other medical conditions may be suitable for consideration.

13. Date and Time of Next Meeting

- 13.1 The next meeting will be held on Wednesday, 27 February 2013.

14. Proposed Date for Future Meeting

14.1 Wednesday, 9 October 2013.



Dr P Prasad MB BCh DRCOG
Panel Secretary

12 October 2012