

FACULTY OF FORENSIC & LEGAL MEDICINE

of the Royal College of Physicians, London

Registered Address

11 St. Andrews Place
Regent's Park,
London NW1 4LE
Telephone 020 7935 1174
Textphone 020 7486 5687
Facsimile 020 7487 5218



Registered Charity No: 1119599

Correspondence Address

3rd Floor
116 Great Portland Street
London
W1W 6PJ
Telephone 020 7580 8490
E-mail info@fflm.ac.uk

Sir Peter North
North Review Team
2/17 Great Minster House
London
SW1P 4DR

21st February 2010

Dear Sir Peter

Re: The North Review of Drink and Drug Driving

Thank you for the opportunity to respond to this consultation.

The Faculty of Forensic and Legal Medicine was established in 2006 by the Royal College of Physicians of London and has been founded to achieve the following objectives:

- To promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine.
- To develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity.

The Faculty includes three different professional groups:

- Forensic physicians
- Medically qualified coroners
- Medico-legal advisers to the medical defence organisations

General comments

- Evidence of drugs in road traffic fatalities/accidents is limited with the last study into the incidence of drugs in road fatalities in 2001 (Tunbridge et al); data on non-fatal accidents is more limited as drug analysis is very expensive. More research is needed.
- The assessment of drug levels in drivers is an immensely complex area; it is impossible to relate the level of impairment to drug concentration because of the range of tolerance.

- Consideration should be given to a zero tolerance approach, such as that in Germany, where if a driver has a level above the forensically (toxicological) normal level of detection he/she is deemed guilty of an offence. If deemed to be “impaired” found guilty of a more serious offence.
- The vast majority of evidence suggest that it is mainly an illicit drug problem (95%) – cannabis, opiates, amphetamine and cocaine. But there is a problem related to benzodiazepines which are prescribed but also used illicitly. There will occasionally be problems with prescribed drugs e.g. lithium, antihistamines, insulin and other illicit drugs such as volatile substances, khat, LSD, GHB, ketamine.
- There is a need to screen at the roadside; this is likely to detect 95% of the drugs of concern with greater than 90% accuracy.

SUPPLEMENTARY QUESTIONS

1. Police officers are trained in the Field Impairment Test (FIT) which allows a systematic assessment of impairment at the roadside. How is impairment assessed by Forensic Physicians in order to guide their decision on whether a subsequent blood test is required?
 - a) *The primary role of the forensic physician (FP) (outlined in GPG 12) is not to assess impairment but is to ensure that the suspect is fit to be detained – patient safety. The FP has a duty of care.*
 - b) *Following arrest the FP will be called to examine the person at the police station. The objectives of a section 4 examination under the RTA are to:*
 - *assess whether the DP is fit to be detained and ensure their physical well-being;*
 - *exclude a condition that may mimic intoxication;*
 - *determine whether there is a condition that might be due to drink or drugs;*
 - *determine whether a person’s ability to drive is impaired – may give an opinion.*
 - c) *The FP should be able to exclude any recent or current medical problem that may affect the interpretation of any tests used to assess fitness to drive e.g. a current ear infection which may have an affect on balance (Romberg’s test).*
 - d) *The physical examination is also important to document physical signs (physiological effects) of a drug e.g. tachycardia, conjunctival reddening.*
 - e) *The FP may perform a number of 'impairment tests', for which a pro forma may be of assistance (see FFLM proforma).*
 - f) *The overall view is that the field impairment tests as performed by police officers and outlined in MG DD/F have NOT been fully validated. Any abnormal findings need interpretation.*
 - g) *FPs should base their opinions on a global assessment rather than relying entirely on these tests.*

- h) *There are no pass or fail criteria*
 - i) ***Impairment** is not defined by the Act. It is a decision reached by the Court after hearing evidence from several sources which may include bystanders, police officers, the doctor and forensic scientists. Medical evidence is not essential in order to secure a conviction (Leatham v DPP, 1998).*
 - j) *A “condition” is not defined by the Act. There is also uncertainty as to whether a condition relates to the time of arrest (driving) or the time of the doctor’s examination.*
 - k) *The doctor needs to advise the police officer that there is a condition due to a drug.*
2. In the context of suspected drug driving and the required assessment of impairment ahead of a blood test, what are the advantages of having a Forensic Physician over, for example, a Custody Suite nurse?
- a) *Once again the FP is not primarily performing an assessment of impairment but needs to advise the police that the suspect has a “condition” due to a drug.*
 - b) *A suitably trained forensic physician will have the competences (knowledge, skills, attributes, experience) to perform a comprehensive assessment and to exclude disease or injury that might account for any abnormal physical findings.*
 - c) *Concerns regarding nurses are related to their level of overall training and competence to perform such a role; whether they have the ability to diagnose a condition that might mimic intoxication?*
3. What is the Faculty’s opinion of the various drug testing equipment being discussed for both roadside and police station-based use?
- a) *We are aware of the commercially available screening devices such as Cozart oral fluid sampling which could be used now under the Railways and Transport Safety Act 2003.*
 - b) *We would support the introduction of a Preliminary Roadside Drug Test. If this test is positive the suspect is arrested and brought to a police station for an evidential sample (blood for confirmatory test) to be taken and for a prompt assessment by a suitably trained forensic physician to ensure there is not some underlying medical problem that is accounting for their behaviour.*
4. How important is it that Coroners routinely collect information about drug and drink driving in fatal accidents? Should this collection of data be made mandatory?
- a) *Coroners are restricted as to what they can do – what tests they can ask for.*
 - b) *There is a cost and resources issue with regard to toxicological samples which are very expensive.*
 - c) *Already collect data on fatal accidents.*

5. The likely extent to which this form is used by Forensic Physicians (FP) around the country

This is unknown. Other versions may be used.

6. Whether the form is routinely used as evidence in court or only if the FP is called to be a witness for a case

The form is part of the doctor's contemporaneous note so would be used to write a statement and it would be statement that is used in court.

7. Whether there are similar assessment forms for the other FP roles

Yes there are – for fitness to detain/mental health assessment/examination of sexual assault complainants/domestic violence, etc.

8. How long, on average, it takes for a FP to arrive following the arrest of the driver.

This is impossible to say.

However we would expect a FP to attend promptly for such an evidential procedure to ensure that the best evidence is obtained.

STAKEHOLDER QUESTIONS

DRUGS

The current law

1. What are your views regarding the adequacy and effectiveness of the current law on drug driving?
They are inadequate because many individuals who are not fit to drive are able to evade conviction, not generally by the use of loopholes but simply due to inadequacies of evidence and over-reliance on non-science based (and thus easily-challengeable) evidence (e.g. PIT, Sobriety testing etc).
2. What are your views on the enforcement of the current law and the current penalty regime? How could it be made more effective?
That anyone who has been arrested for such an offence must be seen as soon as possible by an appropriately trained forensic physician (FP) capable of performing a full assessment including a physical examination with the ability to diagnose. Therefore there would be an immediate contemporaneous assessment taking into account disclosed medical history, disclosed drug/alcohol use, disclosed licit drug use, with a final determination.

The FP should exclude medical conditions that may mimic intoxication and performed the necessary tests, including tests of co-ordination, divided attention tests, to establish whether there is any evidence of drug use. See supplementary questions.

It should be noted that nowhere in the current legislation are the terms “unfit”, “impaired” or “condition” defined.

A new offence

3. What are your views on the need for a new or amended offence/s of driving whilst under the influence of drugs? **There is no need for a new offence – there is need for better application of current legislation (see above).**
4. What are your views regarding how any new or amended 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 certain drugs within the driver's system? **This is where the problems lie and which can in part be addressed by suggestions in 1 and 2, because of the endurance of certain drug metabolites which may be present (quantified or unquantified). The FP should provide the solid evidence base – the defence can challenge it. However such challenges are much more difficult to do if the contemporaneous evidence is provided by a trained forensic physician rather than a nurse or police officers working to pro formas where the requisite knowledge, skills and experience of basic anatomical, physiological, pharmacological, pathological and toxicological to explain or interpret are lacking.**
5. If a new offence is created for some drugs, does the existing offence of driving under the influence of drugs need to be retained for others? **N/A**

The approach to drugs

6. Do you consider there to be any justification for distinguishing between certain drugs or types of drugs? Do you consider there to be any benefit in focusing on those drugs that frequently feature among casualties? **No – the determinations must simply be on whether whatever drug it is has impaired driving skills. There should be a presumption that those on prescribed drugs which may affect performance and for which warnings are present on dispensed medication (e.g. diazepam) and those using drugs or combining drugs licit or illicit +/- drugs or alcohol must be aware of the risks and cannot declare they didn't know. Any change in legislation must be supported by a massive advertising campaign using all media including viral distribution.**
7. Do you consider that there should be any relationship between the legal classification of drugs and the drug driving offence? **No – see 6**
8. Which drugs, if any, do you consider should or could be covered by any new drug specific offence? What factors need to be taken into account? **See 6 - thus the following – which are almost impossible to determine – become factors that are irrelevant.**
 - e.g. the duration of the action of drugs and how long certain levels of the drug remains in the system after being taken?
 - Is there impairment from taking the drug or its after effects or is the drug still traceable but there is no impairment?
 - What drugs (or their metabolites) might remain traceable for some time but cause minimal or no impairment?
 - Are there drugs where the cumulative effect, even at low levels cause impairment but if taken individually at the same level, would not?
9. What is your view regarding the inclusion of prescribed medicines – generally or specifically - in a new offence? **See – 6 – if warnings are given on medication and patient leaflets on drugs affecting performance with or without other substance such as alcohol – there is a presumption that that knowledge was available to them.**
10. What is your view on compulsory drug and alcohol testing of all drivers involved in fatal (or serious) road accidents? **Essential tool.**

The current procedures

11. What do you consider to be the current legal or procedural barriers or problems to securing a conviction for drug-driving? What alternatives or improvements can you suggest? **See above.**
12. What is your knowledge and view of available drug testing equipment? How acceptable do you consider the test/s to be to the public? **The responsible drug and alcohol using public shouldn't have a problem. Screening tests can be used to initiate the primary assessment as soon as possible by a forensic physician. Declining to be assessed should be made an offence with a compulsory driving ban – this in part takes the onus off the doctor to establish consent and does prevent a delaying tactic.**

International comparisons

13. What is your knowledge of drug offence regimes, drug testing evidence and the tests employed in other countries? **Extensive, but the suggestions above are likely to result in fewer lost convictions.**

ALCOHOL

The current drink driving regime

1. What is your view on amending the current drink / drive limit?

We are in favour of a reduction in the blood alcohol limit to 50mg/100ml.

With best wishes

Yours sincerely



Margaret M Stark
LLM MBBS FFFLM FACBS FHEA DGM DMJ DAB DME
Academic Dean

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