Transport Committee – Call for evidence on Road Safety Strategy

The Institute of Alcohol Studies (IAS) is an independent institute bringing together evidence, policy and practice from home and abroad to promote an informed debate on alcohol's impact on society. Our purpose is to advance the use of the best available evidence in public policy decisions on alcohol.

Ambitions and evidence

a. The strategy sets targets of a 65 per cent reduction in people killed or seriously injured (KSI), and a 70 per cent reduction in child KSIs, by 2035. Do these targets reflect the right level of ambition?

N/A

b. Are governance, delivery and resourcing arrangements across Government departments and key partners strong enough to achieve these targets?

Specifically on motoring offences and drink driving, current governance and resourcing arrangements are not yet sufficient to deliver the Strategy's targets. Responsibility for road safety is dispersed across transport, justice, health, and policing — departments that do not always share data, align funding, or coordinate delivery. For drink driving, this fragmentation is hugely consequential. A lower blood alcohol content (BAC) limit, for instance, requires simultaneous action from the Department for Transport (legislation and communications), the Home Office (policing powers and resources), the NHS (identification and treatment of alcohol dependence), and the Crown Prosecution Service and courts (timely proceedings). Without a named cross-government accountability structure and shared outcome metrics, there is a serious risk that each department delivers its own element in isolation, replicating the experience of Scotland after 2014 where the absence of sustained, coordinated follow-through substantially undermined the impact of the BAC limit reduction.

Resourcing is an equally pressing concern. Roads policing officer numbers in England and Wales have fallen by more than 1,000 over the last decade (RAC, 2025), breath tests have dropped 63% since 2009 (Home Office, 2024), and safety camera partnerships have also declined (RAC, 2025). The Strategy rightly identifies enforcement as central to its ambitions but says nothing on how enforcement capacity will be restored or funded. Any reduction in the drink drive limit will be of limited effect without officers to enforce it — a lesson reinforced by both the Scottish experience and international evidence showing that perceived risk of detection, rather than penalty severity, is the primary driver of behaviour change. The Government should commit to transparent, ring-fenced resourcing for roads policing and enforcement alongside any legislative changes.

Stronger links with health services are also essential. A significant proportion of drink-driving offenders exhibit heavy drinking patterns or alcohol dependence, and enforcement and sanctions alone will not reduce long-term reoffending in many of

these cases. The criminal justice system needs systematic, funded connections to alcohol treatment and recovery services. The new clinical guidelines for alcohol treatment (2025) provide a clear framework for identification and referral; the Strategy should explicitly require that this pathway is operational and resourced as part of delivery. Governance arrangements must therefore extend beyond transport to include health as a core delivery partner, with measurable outcomes and transparent reporting across all relevant agencies.

Finally, ambitions to reduce drink driving in England and Wales would have a greater chance of success if complemented by cross-government action to tackle record high rates of alcohol harm. The UK has not had a national alcohol strategy in place since 2012, and since the COVID-19 pandemic higher rates of heavy drinking have led to record alcohol-specific deaths, which increased 42% in England between 2019-2023 (ONS, 2025). International evidence shows that policies to tackle the affordability, availability and promotion of alcohol are the most effective and cost-effective interventions to reduce harm. This applies to road safety outcomes also, with a 10% increase in alcohol pricing linked to a 7% decrease in road deaths (Castillo-Manzano, J. I., 2017). IAS has worked with alcohol experts across the UK to develop a long-term vision for tackling alcohol harm, including ambitious but achievable targets for the next 10 years and a policy roadmap to meet them – which includes lowering the drink-drive limit. Please see here for more details: https://www.ias.org.uk/report/a-healthier-future-a-long-term-vision-to-tackle-alcohol-harm-in-the-uk/.

c. Are the measures set out in the Strategy collectively sufficient to deliver its targets? What further measures, if any, would strengthen its impact?

N/A

d. Are the measures set out in the Strategy based on robust evidence?

The evidence base for reducing the drink drive limit in England and Wales is extensive and robust. Studies show that impairment in critical driving functions begins at low BAC levels, and most individuals are significantly impaired at 0.05% BAC (Fell and Voas, 2009). NICE research (2010) establishes a clear dose-response relationship between BAC and crash risk: drivers at 0.02–0.05 BAC face at least three times the risk of dying in a crash, rising to six times at 0.05–0.08, and eleven times at 0.08–0.10. At 0.07 BAC — below the current English and Welsh limit — drivers exhibit significant lane weaving and impaired reaction times, yet rate their own driving as unimpaired (Garrisson, 2022).

The evidence also supports randomised roadside breath testing (RBT) as an effective enforcement tool. Meta-analyses find that sobriety checkpoints reduce alcohol-involved crashes by at least 17%, with reductions of up to 22% in fatalities (NICE, 2010). The Strategy is broadly consistent with this evidence base; the key risk is not the quality of its evidence, but whether delivery and resourcing plans match the ambition. The collapse in breath testing — down 63% from 2009 to 2023 — and the 21% reduction in roads policing officers over the last decade represent serious structural weaknesses that the Strategy, as currently set out, does not adequately address.

e. The Government has said its Strategy is informed by Sweden's Safe System approach. What other international or UK examples offer the most relevant lessons for reducing deaths and serious injuries?

Sweden's experience is particularly instructive, and not only for its Safe System approach. Sweden introduced a 0.02 BAC drink drive limit in 1990, and in the following years saw a 9.7% reduction in fatal crashes and 11% reduction in single-vehicle crashes (Nordström and Laurell, 1997). More broadly, countries that have combined lower BAC limits with intensive random breath testing and sustained public awareness campaigns have achieved the most significant reductions. Australia's Queensland and New South Wales saw fatal accident reductions of 18% and 8% respectively when their limits were reduced from 0.08 to 0.05, with enhanced random breath testing identified as a key driver of the improvement (NICE, 2010).

Scotland provides a cautionary domestic example. Following its 2014 reduction to 0.05 BAC, initial research found limited impact on collisions, largely attributed to poor enforcement and short-lived public awareness campaigns (Francesconi & James, 2021). However, longer-term data from Transport Scotland shows that drink-drive incidents and casualties have since fallen by 64% and 66% respectively between 2010 and 2020, suggesting that the Scottish experience underscores the importance of sustained, well-resourced implementation rather than a one-off legislative change.

Theme 1: Supporting road users

f. What measures would be most effective in reducing deaths and serious injuries involving new and novice drivers? What are the likely impacts of introducing a minimum learning period for learner drivers?

We support a lower drink drive limit for new and novice drivers, and recommend this be set at 0.02 BAC. Research shows that new drivers are three times more likely to be injured in a crash if they have been drinking alcohol, and that adolescents and young people face greater relative crash risk than standard drivers at all positive BAC levels. A 2025 survey found that 18% of drivers under 25 admitted to drink driving, and that 37% of 'Generation Z' believed it was more socially acceptable to drive marginally over the legal limit, compared with just 9% of 'Baby Boomers' (Direct Line, 2025).

Evidence from Europe confirms that lower limits for novice drivers reduce alcohol-related collisions by approximately 15% within the target group (Straßgütl and Evers, 2022). The EU is moving towards a two-year zero-tolerance alcohol limit for all novice drivers. Given this evidence, we recommend that a minimum learning period for novice drivers be accompanied by a 0.02 BAC limit, and that this be paired with clear public messaging and targeted awareness campaigns. There is a risk, noted by RoSPA, that if novice drivers face a lower limit but full-licence drivers do not, some may misinterpret the change as permission to drink more once they pass their test — a further argument for applying 0.02 BAC universally.

g. What is the right approach to safe driving later in life? What safeguards are required to protect both safety and independence of older drivers?

N/A

h. What should the proposed work-related road safety charter require of organisations that employ people to drive or ride for work?

We strongly recommend that the proposed work-related road safety charter require organisations to apply a 0.02 BAC limit for all employees who drive or ride for work, in line with the standards already applicable to pilots, train drivers, cabin crew, and other safety-critical transport roles under the Railways and Transport Safety Act 2003. Commercial drivers frequently operate large and heavy vehicles with greater stopping distances and the capacity to cause more severe harm in a collision; any level of alcohol impairment therefore carries a disproportionate risk.

Many European countries already apply lower or effectively zero BAC limits for commercial drivers, including Sweden, Portugal, Germany, and Belgium. The UK (excluding Scotland) remains the only European country listed by the European Transport Safety Council that retains a commercial BAC limit higher than 0.05. The charter represents an opportunity to close this gap and should require that organisations have clear policies, testing regimes, and — where appropriate — support for employees with underlying alcohol treatment needs.

i. To what extent does fear of traffic danger deter certain modes of travel, particularly walking and cycling, and what measures would be most effective in addressing this?

N/A

j. What should reform of motorcycle training, testing and licensing look like in practice?

N/A

Theme 2: Taking advantage of technology, data and innovation for safer vehicles and post collision care

k. How can Government maximise the safety benefits of Advanced Driver Assistance Systems (ADAS) and ensure they are used safely and appropriately?

N/A

l. What is the right approach to strengthening vehicle safety standards? What measures should the Government prioritise in response to issues such as headlamp glare, increasing vehicle size and any broader issues not currently being considered by the Government's consultation?

N/A

Theme 3: Ensuring infrastructure is safe

m. How should evidence on the relationship between speed limits and safety influence new guidance? Does the Strategy strike the correct balance between a nationally-set direction and local decision-making regarding speed?

N/A

n. What measures would be most effective in improving safety on rural roads, and is the Strategy's proposed approach sufficient?

N/A

o. What scope is there for road design and maintenance to further improve safety?

N/A

Theme 4: Robust enforcement to protect all road users

p. What measures would most improve compliance and deterrence in relation to motoring offences? Which such offences have the biggest impacts on collision and casualty rates?

Drink driving has the single biggest measurable impact on collision and casualty rates of any motoring offence. In 2023, 16% of road fatalities in Great Britain involved a driver over the legal alcohol limit, with 260 fatalities and 1,600 serious injuries estimated (DfT, 2025). Yet enforcement has collapsed: breath tests in England and Wales fell 63% between 2009 and 2023, roads policing officer numbers have dropped by over 1,000 in the past decade, and the proportion of positive or refused breath tests has increased by 60% over the same period — potentially meaning more drink drivers are on the road while fewer are being caught.

The most impactful measure to improve compliance would be the introduction of randomised roadside breath testing (RBT), which currently exists in Northern Ireland but not England and Wales. International evidence consistently finds RBT reduces alcohol-involved crashes by at least 17%, with reductions of up to 22% in fatalities. This should be coupled with a reduction in the BAC limit to 0.02 for all drivers, and with restored and adequately resourced roads policing capacity. Additional measures with strong evidence include: interim licence suspension for those arrested for drink driving (given a 96% conviction rate); powers to seize vehicles of suspected drink drivers; and alcolock requirements for convicted drink drive offenders. For the most serious or persistent offenders, longer disqualification periods — with disqualification running consecutively rather than concurrently with any custodial sentence — should be considered.

q. What role do the type and severity of sanctions play in deterring dangerous driving, and which sanctioning approaches are most effective at changing driver behaviour?

The evidence is clear that the perceived risk of detection deters dangerous driving more effectively than the severity of penalties alone. NICE concludes that the effectiveness of

drink-driving policy depends far more on visible enforcement than on sanction levels. Nevertheless, we consider the current minimum disqualification periods of one year for drink driving (three years for repeat offences) to be insufficient, particularly given the irreversible consequences of drink-driving fatalities.

We support a graduated penalty framework, in which sanctions reflect the level of BAC and the associated risk. Countries such as France, Italy, Spain, and Poland operate such frameworks, with criminal penalties triggered at higher BAC levels while lower-level offences attract fines and points. This approach allows a lower limit to be introduced without weakening deterrence for the most dangerous offences, and aligns sanctions with the dose-response relationship between BAC and crash risk. For the highest-risk offenders — those who cause death by careless driving while over the limit — the current minimum five-year disqualification is considered inadequate, and should be lengthened. Alcolocks, combined with mandatory alcohol rehabilitation courses, should be required for all convicted drink drive offenders returning to driving, with financial support available for those from lower socio-economic backgrounds. The evidence shows that interlocks reduce reoffending by 75% while fitted, and their combination with rehabilitation courses is associated with more durable long-term behaviour change (Elder, 2011).