

16TH NI PCDOs CONFERENCE · 17 SEPTEMBER 2026

Diabetes and Driving Masterclass

Assessing fitness to drive in primary care

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Almost Five Miles On The Wrong Side Of A Dual Carriageway

5 miles

driven in the wrong direction before the collision

40

the age of Christopher Paul Jones, killed instantly

None

recollection of the crash, the other driver told the inquest

The driver, who had diabetes, told the inquest he had no recollection of the collision. He had been confused after a hypoglycaemic event.

The question for this room: could this be one of my patients — and would my notes show that I gave the right advice?

Five People Died. The Sensor Alarmed Ten Times.

Type 1 diabetes · severe hypoglycaemia · five killed including two children, six injured

17:17	17:18–18:07	~17:20	18:07	After
Sensor glucose 2.9 mmol/L	Ten low-glucose alarms recorded by the app	Driver seen asking for food	Vehicle entered the pub dining area	Glucose below 1.1 mmol/L

The technology worked. The data were there. The alarms sounded ten times in fifty minutes. CGM is not a safety net unless the driver acts on it.

In 2024 all criminal charges were dropped: the magistrate found insufficient evidence for conviction, and medical evidence could not exclude severe hypoglycaemia and involuntary behaviour. A coronial inquest heard the sensor data in March 2026. This is an Australian case — the legal outcome does not map onto UK law.

THE PHYSIOLOGY BEHIND THE RULES

Why Hypoglycaemia Is Different

It impairs the very judgement needed to recognise the impairment

REACTION TIME

slows measurably below 2.7 mmol/L

JUDGEMENT

affected; risk-taking increases

CONCENTRATION

impaired; attention narrows

BEHAVIOUR

confused, irrational, sometimes aggressive

AWARENESS

may disappear entirely with recurrent hypos

CONSCIOUSNESS

seizure or coma below 2.2 mmol/L

DVLA's own patient guide (INF294): below 4.0 mmol/L reaction time slows, judgement is affected and driving may become erratic. Severe hypoglycaemia can cause loss of consciousness.

AND IN THE UK COURTS

Garrowby Hill, East Yorkshire — 2019

Driver with type 1 diabetes had a hypo and crossed onto the wrong side of the road. Two motorcyclists were killed. The coroner criticised the medical assessment process itself, not only the driver.

A5, Northamptonshire — 2021

A 19-year-old with type 1 diabetes had what the court accepted was an unpredictable hypo with no warning symptoms. An 81-year-old man was killed. That defence is the clinical picture of impaired awareness.

Mr B, 62, type 2 diabetes on metformin and gliclazide. He drives a car only, and has never had a hypo. Under DVA rules in Northern Ireland, must he tell the DVA?

- A** No — tablet-treated diabetes never needs to be declared
- B** Yes — sulphonylurea and glinide treatment is a notifiable condition to DVA
- C** Only if he has had two or more severe hypos in 12 months
- D** Only if his HbA1c is above 58 mmol/mol

LEARNING OUTCOMES

Five Things To Take Home

The rest is detail you can look up

1

Know who must notify

Insulin, sulphonylureas and glinides, impaired awareness, severe hypos, eye and nerve complications — the trigger list is short and learnable.

2

Screen for impaired awareness at every review

One question (the Gold score) takes 20 seconds and identifies the highest-risk drivers you have.

3

Know the NI process, not just the GB rules

DVA runs a three-stage vocational process. You will be asked to complete DIA32 (VOC) and often DLM1.

4

CGM rules changed on 1 August 2026 in NI

Group 2 drivers may now use CGM, with defined criteria. A backup finger-prick meter is still mandatory.

5

Document the conversation

Advice given, notification duty explained, and your action if the patient keeps driving against advice.

Key Definitions

Get these right and most licensing questions answer themselves

Severe (disabling) hypoglycaemia

An episode of hypoglycaemia requiring the assistance of another person. This includes episodes during sleep — the waking/sleeping distinction was removed in 2011.

Adequate awareness — the Group 1 standard

Being able to recognise the onset of hypoglycaemia in time to stop the vehicle safely. CGM alarms may supplement this, but must not replace the person's own symptom recognition.

Impaired awareness of hypoglycaemia (IAH)

Inability to detect the onset of hypoglycaemia because warning symptoms are absent. Group 2 requires full awareness — any impairment disqualifies. Group 1: IAH is notifiable and licence is refused or revoked.

Group 1 At A Glance

By treatment type: notify, monitor, and what disqualifies

Diet / exercise only	No need to notify. No monitoring requirement. Licence to age 70. Notify only if complications develop.
Metformin, GLP-1 RA, SGLT2i, DPP-4i, pioglitazone	No hypo risk from treatment — no need to notify. Beware combinations: adding a sulphonylurea or insulin changes the rules.
Sulphonylureas / glinides	NI: notifiable to DVA. Must have adequate awareness; no more than one severe hypo in 12 months. Glucose monitoring at times relevant to driving is advisable.
Insulin	Must notify and hold a restricted 1, 2 or 3-year licence. Adequate awareness required. Check glucose no more than 2 hours before the first journey and every 2 hours while driving.
Always notifiable, whatever the treatment	Two or more disabling hypos in 12 months; impaired awareness; a disabling hypo at the wheel; laser to both eyes or the only seeing eye; visual field or acuity failure; significant leg or foot sensory loss.

Group 2 At A Glance

A different standard: zero tolerance, full awareness, annual review

Notification	Any treatment carrying hypo risk must be notified. On starting insulin the driver must stop Group 2 driving until DVA has made a licensing decision.
Hypo awareness	Full awareness required. Any degree of impaired awareness means the licence is refused or revoked.
Severe hypoglycaemia	No episode requiring the assistance of another person in the preceding 12 months. One episode means stopping immediately and notifying.
Glucose monitoring	At least twice daily including on non-driving days, at the start of the first journey, and at least every 2 hours while driving.
Evidence required (NI)	Four weeks of continuous glucose readings taken while on insulin — reduced from six weeks on 1 August 2026.
Licence duration	One year only, renewable after annual examination by a DVA-nominated independent consultant specialist in diabetes.
Also required (DVA)	Fast-acting carbohydrate in the vehicle at all times. Backup finger-prick meter with memory function. Demonstrable understanding of hypoglycaemia risk.
Other conditions	No disqualifying complications — visual fields, acuity, renal, cardiovascular. Signed undertaking to follow clinicians' directions and report changes to DVA immediately.

Which of these must a car driver treated with insulin report to the DVA?

A A single severe hypo that happened while asleep and needed help from a partner

B Two or more disabling hypos within 12 months, whether awake or asleep

C Developing impaired awareness of hypoglycaemia

D B and C

THE TWO-HOUR RULE

Monitoring For Driving

What every insulin or sulphonylurea-treated driver must do

Check glucose no more than 2 hours before the first journey, then at least every 2 hours while driving. If glucose is 5.0 mmol/L or below, eat a snack. **Do not drive below 4.0 mmol/L or if symptomatic.**

MUST CARRY IN THE VEHICLE

- Glucose meter and test strips — always, even if using CGM
- Fast-acting carbohydrate within reach of the driver's seat
- Longer-acting carbohydrate (cereal bar, sandwich)
- Identification that they have diabetes

AFTER A HYPO WHILE DRIVING

- Stop the vehicle in a safe place
- Switch off the engine, remove the keys, leave the driver's seat if possible
- Treat, then wait 45 minutes after glucose is back above 5.0 mmol/L before driving
- A hypo at the wheel is notifiable — Group 1 and Group 2

WHAT CHANGED, AND WHEN

CGM And Driving: Where The Rules Now Stand

Group 1 has had CGM for eight years; Group 2 only just caught up

1 Jan 2018 Group 1, GB	CGM permitted for glucose monitoring at times relevant to driving for car and motorcycle drivers (regulation 72(6)(b), 1999 Regulations).
15 Feb 2019 Group 1, GB + NI	DVLA and DVA jointly confirm flash glucose monitoring is acceptable for Group 1, following the Diabetes UK campaign.
7 Nov 2025 Group 2, GB only	SI 2025/1085 replaces "blood glucose monitoring" with "appropriate monitoring". Bus, coach and lorry drivers in England, Wales and Scotland may use CGM.
1 Aug 2026 Group 2, Northern Ireland	DVA aligns. NI Group 2 drivers may use a CGM approved for treatment decisions and storing at least four weeks of readings. Evidence requirement cut from six weeks to four.

One Caveat: The Paperwork Hasn't Caught Up

The rule change is real — expect colleagues to stay cautious until DVA formalises it

I emailed DVA directly to check this before today. Their Vocational Team confirmed the 1 August 2026 change is genuinely in force — but as of 8 September 2026 the DIAB2 (VOC) form has not been updated, and **no formal circular has gone out to clinicians.**

WHAT DVA CONFIRMED

- The NI Direct website has been updated with the current diabetes driving rules
- The DLM1 medical report has already been revised
- The 1 August 2026 CGM change for Group 2 is correct as described in this deck

WHAT'S STILL OUTSTANDING

- The DIAB2 (VOC) form is still being amended — “in due course,” no date given
- No formal notice has reached GPs or consultants — this only surfaced by chance, via the website
- Whether wider communication to clinicians is coming was not confirmed
- Until it does: treat the change as clinically real but administratively unconfirmed

The Criteria Your Patient Must Meet

Not "CGM is allowed" — CGM is allowed on conditions

Device standard	Medically approved for non-adjunctive use — i.e. licensed for making treatment decisions from the sensor reading alone.
Data available at review	At least 4 weeks (30 days) of CGM data available to the assessing consultant.
Sensor wear	At least 70% data capture over that period. Above 90% is preferred.
Time below range	Time below 3.9 mmol/L must be 10% or less.
Alarm setting	Low-glucose alarm set at a level safe for driving — 4.0 mmol/L.
Backup	A finger-prick meter with memory function must always be carried when driving, in case of sensor failure.
Confirm with a finger-prick reading whenever: sensor glucose is 4.0 mmol/L or below · the patient has hypo symptoms · the reading does not match how they feel.	

THE PRACTICAL CORE

The Licence Application Process

*DVA Group 2 in Northern Ireland, stage by stage — and the forms that
land on your desk*

DO NOT COPY



Stage 1 — Getting The Application Started

The gate most applications fall at

The application cannot start until the condition has been stable for at least one month and at least four weeks of glucose readings taken while on insulin are available.

WHAT THE DRIVER DOES

- Renew the bus or lorry licence, or request form DL2 plus a DIAB1 (VOC) medical questionnaire
- DVA customer services: 0300 200 7861 (Mon–Fri, 9am–5pm) or dva@infrastructure-ni.gov.uk
- Complete the online renewal or the paper forms and return them to DVA
- DVA assesses before releasing the application to Stage 2

WHERE YOU CAN HELP — OR CAUSE DELAY

- Do not start the clock early: without one month of stability and four weeks of readings the application stalls
- On starting insulin, the driver must stop Group 2 driving that day and wait for the licensing decision
- Advise applying early — renewal delays are recognised, and not all employers accept Section 88 cover
- Check the sensor or meter is actually recording and downloadable before they apply

Stage 2 — Your Own Doctor's Questionnaire

This is the stage that lands in primary care

DIAB2 (VOC)	Issued by DVA once the driver clears Stage 1. Completed by whoever manages the diabetes — GP or diabetes consultant
Who pays	DVA pays the fee for DIAB2 (VOC), up to a maximum of £40.
DLM1	A Medical Examination Report, completed by the driver's own doctor. Required on the first Group 2 application; then every 5 years until age 65; then annually from 65.
Who pays for DLM1	The driver is responsible for any fee charged for the DLM1.
GP fees generally	DVA pays the appropriate fee for completing medical forms on the first occasion only. Duplicates are the driver's responsibility.
Practical point	Do not send an application if the qualifying conditions cannot be met — DVA advises against it, and it wastes months.
Before you sign: hypo count in the last 12 months · awareness status · glucose data for four weeks · visual fields · foot sensation · current treatment and any recent change.	

Stage 3 — Independent Specialist Examination

Insulin-treated drivers only, and repeated every 12 months

HOW IT WORKS

- DVA nominates an independent hospital diabetes consultant
- The consultant completes an Annual Diabetes Examination report
- DVA pays the fee for this examination
- If the standards are met, the licence is issued for one year only

WHAT THE CONSULTANT MUST SEE

- Four weeks of continuous readings immediately before the assessment, while on insulin
- From a meter with memory function, or from CGM (since 1 August 2026)
- For CGM: 30 days of data, 70% wear, time below 3.9 mmol/L of 10% or less

THE QUALIFYING CONDITIONS THE DRIVER MUST SATISFY THROUGHOUT

No hypoglycaemic event requiring the help of another person in the last 12 months

Glucose monitoring at times relevant to driving, using a device that measures and records

No other medical condition making them a danger when driving on a vocational entitlement

Full awareness of the symptoms of hypoglycaemia, and demonstrable understanding of the risks

Fast-acting carbohydrate carried in the vehicle at all times, and a backup finger-prick meter with memory

Signed agreement to follow treating doctors' directions and report any significant change to DVA immediately

Which Form, Which Patient

DVLA in GB and DVA in NI use different paperwork

SITUATION	DVLA (GB)	DVA (NORTHERN IRELAND)
Group 1, insulin or hypo-risk tablets	Report online, or form DIAB1	Notify DVA; paper forms issued
Group 2, insulin	Form VDIAB1I	DL2 + DIAB1 (VOC), then DIAB2 (VOC)
Group 2, sulphonylurea or glinide	Form VDIAB1SG	DL2 + DIAB1 (VOC)
Group 2, other non-insulin agents	Form VDIAB1GEN	DL2 + DIAB1 (VOC)
Doctor's questionnaire	Requested directly by DVLA	DIAB2 (VOC) — DVA pays up to £40
Medical examination report	D4 (as part of Group 2 renewal)	DLM1 — driver pays the fee
Annual specialist review (insulin)	Independent consultant, 4 weeks of data	DVA-nominated consultant, 4 weeks of data

DVA drivers medical: 0300 200 7861 (Mon–Fri 9am–5pm) · dva@infrastructure-ni.gov.uk · Drivers Medical Section, DVA, Castlerock Road, Waterside, Coleraine BT51 3TB

Failing to tell DVA about a condition affecting driving: fine up to £1,000. Driving after a false health declaration: fine up to £2,500.

Impaired Awareness Of Hypoglycaemia

Common, under-recognised, and largely reversible

20–25%

of adults with type 1 diabetes have impaired awareness

~10%

of insulin-treated type 2 diabetes have impaired awareness

6x

higher risk of severe hypoglycaemia with impaired awareness

THE EVIDENCE

- Meta-analysis prevalence 23–58% in type 1 diabetes, depending on the classification method used
- In insulin-treated type 2 diabetes: 7–46% in single-centre surveys; 9.7% in a Dutch nationwide cohort
- More than 30% of insulin-treated type 2 patients report a severe hypo in the preceding year

WHY THIS IS WORTH YOUR TIME

- It is a functional defect, not fixed damage — 2–3 weeks of strict hypo avoidance can restore thresholds
- It is notifiable, and it disqualifies Group 2 outright
- It is invisible unless you ask: patients rarely present saying "I have lost my warnings"

What CGM Reveals — And What It Misses

Patient-reported and sensor-detected hypos are not the same thing

>50%

of CGM-detected hypos below 3.9 mmol/L were completely asymptomatic

~45%

of patient-reported symptomatic hypos had no CGM confirmation at all

75%

of CGM-detected hypos in type 2 diabetes were unrecognised by the patient

73%

of unrecognised hypo events occur at night; nocturnal hypos are twice as common as daytime

Sensor-detected and patient-reported hypoglycaemia cannot be used interchangeably. A clean sensor download does not prove intact awareness, and a normal history does not exclude frequent asymptomatic lows.



Screening For Impaired Awareness

One question, then four follow-ups — under two minutes

“Do you know when your hypos are commencing?” — Gold score, 1 (always aware) to 7 (never aware)

1

2

3

4

5

6

7

Score 1–3: normal awareness

Score 4 or above: impaired awareness

THEN ASK THESE FOUR

- Any hypo needing someone else’s help in the last 12 months?
- Any readings below 3.0 mmol/L with no symptoms at all?
- Any hypos at night that a partner noticed and you did not?
- Do you rely on the CGM alarm rather than your own symptoms?

RED FLAGS

- Gold score 4 or above
- Severe hypo reported by ambulance or A&E, not by the patient
- Long-duration type 1 with a tight HbA1c below 48 mmol/mol
- Loss of autonomic symptoms: no sweating, tremor, palpitations

Mrs D has had type 1 diabetes for 22 years. She scores 5 out of 7 on the Gold score. Her sensor download shows 14% of time below 3.9 mmol/L. She drives a car to work each day. What do you do?

- A** Reassure her — the CGM alarms will warn her in time
- B** Advise her to stop driving now, tell her she must notify the DVA, and refer to the specialist team
- C** Reduce her basal insulin and review her in six months
- D** Ask her to finger-prick before every journey and carry on driving

The Rest Of The Assessment

Fitness to drive is a whole-patient judgement

Visual standards	Read a number plate at 20 metres. Acuity at least 6/12 with both eyes open. Group 1 field at least 120° horizontally; Group 2 at least 160° with no significant central defect.
Retinopathy and laser	Notify if laser is needed to both eyes, or to the only seeing eye. Re-test fields three or more months after laser. Glare and poor night vision may mean daylight-only restriction.
Visual field defects	Must meet Esterman criteria — no cluster of more than three adjacent missing points. On-road assessment possible in exceptional adapted cases.
Peripheral neuropathy	Notify if significant loss of sensation or motor function in the feet or legs affects pedal control. May need vehicle adaptation.
Renal	Group 1: notify only if severe electrolyte disturbance, disabling dizziness or faintness, or impaired cognition. Group 2: must notify.
Cardiovascular	Separate criteria after myocardial infarction, for angina and arrhythmia. Syncope or pre-syncope: must not drive until the cause is established.

When A Patient Should Not Be Driving

GMC guidance, and what to write in the notes

THE GMC SEQUENCE

- The driver, not the doctor, is legally responsible for notifying DVA
- Advise clearly that they must not drive; explain the legal duty and the insurance consequences
- If they disagree, suggest a second opinion — and advise not driving meanwhile
- If they drive against advice, you may disclose to DVA — tell them first, then confirm in writing

WHAT TO RECORD

- Driving status and licence group at every diabetes review
- Gold score and hypo frequency, as numbers
- The specific advice given, and that the notification duty was explained
- If you disclose: your decision, your reasoning, and that the patient was informed

THE FOUR-STEP HABIT

Advise verbally → document in the notes → confirm in writing to the patient → act if they keep driving. You are not required to chase up whether they notified — but if you know they are driving while unfit, you must act.

Your patient with impaired awareness refuses to notify the DVA and tells you he intends to keep driving. What does GMC guidance say you should do?

- A** Nothing further — notification is the patient's legal responsibility, not yours
- B** Inform the police
- C** Make every reasonable effort to persuade him; if he will not stop, tell him you intend to disclose, then inform DVA and confirm in writing
- D** Remove him from the practice list and document why

At Every Diabetes Review

Four questions, then act on the answers

ASK AND RECORD

- Do you drive? Car, or bus and lorry?
- Gold score — one question, record the number
- Any hypo needing help in the last 12 months?
- Have you told the DVA, if you needed to?

WHEN PRESCRIBING OR CHANGING TREATMENT

- Starting insulin? Group 2 drivers must stop driving that day and notify
- Starting a sulphonylurea or glinide? Explain hypo risk, monitoring and the NI notification duty
- Adding to existing therapy? Combinations create hypo risk where there was none

THREE THINGS TO CHANGE IN YOUR PRACTICE ON MONDAY

1

Add driving status and Gold score to your diabetes review template Two extra fields. Codeable, auditable, and it is the single change with the biggest medicolegal return.

2

Do not refuse test strips to Group 2 drivers who use CGM A backup finger-prick meter is a licensing condition, not a preference.

3

Check the low-glucose alarm is set at 4.0 mmol/L in vocational drivers Many patients set theirs lower to reduce alarm fatigue. For Group 2 that is not compliant.

KEY TAKEAWAYS

Five Things To Take Home

- 1 Hypoglycaemia at the wheel can be fatal, and it is the one cause of sudden incapacity we create with treatment.
- 2 Screen for impaired awareness at every review. Gold score 4 or above is notifiable and disqualifies Group 2.
- 3 Know the NI process: three stages, DL2 and DIAB1 (VOC), then DIAB2 (VOC) — DVA pays; DLM1 — the driver pays.
- 4 Since 1 August 2026 NI Group 2 drivers may use CGM: 4 weeks of data, 70% wear, TBR 10% or less, alarm at 4.0.
- 5 Advise, document, confirm in writing. If they keep driving while unfit, GMC guidance says you must act.



Thank you

Questions?

REFERENCES

Sources

Every title is a live hyperlink. Media links for the opening cases are on those slides.

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