Submission to the Environment, Housing and Infrastructure Scrutiny Panel on P.32/2026

Version 1.0

16th February 2026

Produced by

END CANNABIS PROHIBITION

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Introduction

No one should drive while impaired, whether that be from alcohol, prescribed medication or illicit drugs.

This premise is reflected in the current *Road Traffic (Jersey) Law 1956*, which specifies offences while being “unfit to drive through drink or drugs”.

Roadside testing of substances that may affect one's ability to drive should therefore be used to determine whether or not someone is impaired, rather than to target mere use.

While we appreciate that there is a political desire for an objective test for whether someone is “unfit to drive” after using cannabis, it must be understood that the presence of THC in bodily fluids does not correlate to impairment.

Cannabis is not like alcohol. There is no defined standard unit for cannabis consumption. THC can remain in the body for several weeks post consumption, and over time, users develop tolerance.

Fundamentally, there is no way for a cannabis user to know what level of THC is present – and detectable – in their body.

For medicinal cannabis patients, the lack of a statutory medical defence (as implemented in UK and Guernsey legislation) in P.32/2026 Draft Road Traffic Law (Drug Driving) (Jersey) Amendment Regulations 202- is particularly concerning.

The scientific evidence does not support the use of *per se* limits for THC in bodily fluids as an indication of either recent use or impairment. Further evidence of impairment from cannabis should be required to justify a conviction under the proposed regulations.

We hereby request that the Environment, Housing & Infrastructure Scrutiny Panel call in P.32/2026 in order that the concerns expressed in this and other submissions be given due consideration.

Medical Defence

The principle of a statutory medical defence was introduced in the UK by *The Drug Driving (Specified Limits) (England and Wales) Regulations 2014*, which amended the *Road Traffic Act 1988* to establish roadside drug testing, and came into force in March 2015.

Section 5A of the *Law* on Driving or being in charge of a motor vehicle with concentration of specified controlled drug above specified limit stipulates:

(3) It is a defence for a person ("D") charged with an offence under this section to show that—

(a) the specified controlled drug had been prescribed or supplied to D for medical or dental purposes,

(b) D took the drug in accordance with any directions given by the person by whom the drug was prescribed or supplied, and with any accompanying instructions (so far as consistent with any such directions) given by the manufacturer or distributor of the drug, and

(c) D's possession of the drug immediately before taking it was not unlawful under section 5(1) of the Misuse of Drugs Act 1971 (restriction of possession of controlled drugs) because of an exemption in regulations made under section 7 of that Act (authorisation of activities otherwise unlawful under foregoing provisions).

(4) The defence in subsection (3) is not available if D's actions were—

(a) contrary to any advice, given by the person by whom the drug was prescribed or supplied, about the amount of time that should elapse between taking the drug and driving a motor vehicle, or

(b) contrary to any accompanying instructions about that matter (so far as consistent with any such advice) given by the manufacturer or distributor of the drug.

The medical defence does not provide a *carte blanche*:

> "If the police had evidence that the patient's driving was impaired due to drugs, whether prescribed or not, they can prosecute under the existing offence of driving whilst impaired through drugs offence described in section 4 of the *Road Traffic Act 1988*, for which there is no statutory "medical defence"." (Drug driving: guidance for healthcare professionals)

The *Law* specifies the limits for 17 different drugs under the following groupings:

- "a zero tolerance approach to 8 drugs most associated with illegal use, with limits set at a level where any claims of accidental exposure can be ruled out;
- a road safety risk based approach to 8 drugs most associated with medical uses;
- a separate approach to amphetamine that balances its legitimate use for medical purposes against its abuse."

For reference, the limit for delta-9-tetrahydrocannabinol (cannabis) is set at 2 micrograms per litre of blood under the UK's zero tolerance / accidental exposure approach.

The Road Traffic (Drink Driving) (Guernsey) Law, 1989 (Amendment) Ordinance, 2025 was approved by the States of Deliberation in March 2025. It includes similar wording to that of the UK legislation with regard to the provision of a medical defence.

Under Article 2C of the *Law* on Driving, or being in charge, whilst over the limit for specified drugs:

(3) Subject to subsection (4), it is a defence for C if charged with an offence under subsection (2) to prove, on the balance of probabilities, that -

(a) the specified controlled drug had been prescribed or supplied to C for medical or dental purposes,

(b) C took the drug in accordance with any directions given by the person by whom the drug was prescribed or supplied, and with any accompanying instructions (so far as consistent with any such directions) given by the manufacturer or distributor of the drug,

(c) either -

i. no advice was given by the person by whom the drug was prescribed or supplied about the amount of time that should elapse between taking the drug and driving a motor vehicle, or

ii. such advice was given and C's actions complied with the advice, and

(d) either -

i. no accompanying instructions were given by the manufacturer or distributor of the drug about the amount of time that should elapse between taking the drug and driving a motor vehicle, or

ii. such instructions were given and C's actions complied with those instructions (so far as those instructions were consistent with any advice given of the kind mentioned in paragraph (c)(ii)).

(4) The defence in subsection (3) is not available if the prosecution proves beyond reasonable doubt that C's possession of the drug immediately before taking it was unlawful under section 4(1) of the *Misuse of Drugs (Bailiwick of Guernsey) Law, 1974* (restriction of possession of controlled drugs).

The majority of the *Ordinance* has yet to come into force, with drug limits to be "specified by regulations made by the Committee for Home Affairs".

The medical defence exists in UK and Guernsey legislation "to protect those patients who may test positive for certain specified drugs taken in accordance with the advice of a healthcare professional or the patient information leaflet that accompanies the medicine." (Drug driving: guidance for healthcare professionals)

The omission of a statutory medical defence from the *Draft Road Traffic Law (Drug Driving) (Jersey) Amendment Regulations 202-* is therefore a surprising oversight, which is not adequately explained in the accompanying report.

Given that the recent comparable legislation in Guernsey includes a statutory medical defence which mirrors that of the UK, the lack of such a provision in the draft Jersey law requires justification.

While there are as yet no defined limits for the presence of controlled drugs in bodily fluids in the *Law*, the prosecution in Jersey does take into account UK guidance in determining impairment:

> "…[Article] 27 of the *Road Traffic (Jersey) Law 1956*, is silent as to any de minimis levels of drugs that may be contained in the blood of a suspect and disregarded for the purpose of prosecution. However, the court learnt that the prosecuting authorities in Jersey had regard to guidance published in England and Wales on a non-statutory basis for the purpose of considering whether or not a person should be charged with an offence of driving whilst unfit through consumption of drugs."

Presumably, that guidance also includes the application of the UK's statutory medical defence, which we assume would continue to apply in the interim to drugs other than cannabis that are yet to be included in the *Law.*

As new drugs are included in the scope of the *Law,* increasing numbers of Islanders could become subject to prosecution for being over the specified limit for their prescribed medication, despite following clinical guidance.

How will the *Law* accommodate additional drugs in future?

Will it be necessary to amend the *Law* later to include the provision of a medical defence?

If so, why hasn't the medical defence been included in the draft legislation?

The lack of a medical defence can arguably be considered to be either direct or indirect discrimination under Articles 6 and 7 of the *Discrimination (Jersey) Law 2013* in relation to whether the act is "a proportionate means of achieving a legitimate aim", and consequently also Article 14 of the *Human Rights (Jersey) Law 2000* on the prohibition of discrimination.

Disability is defined as a protected characteristic under Schedule 1(8) of the *Law*:

(2) A person has the protected characteristic if the person has one or more long-term physical, mental, intellectual or sensory impairments which can adversely affect a person's ability to engage or participate in any activity in respect of which an act of discrimination is prohibited under this Law.

(4) For the purposes of paragraph (2), a long-term impairment is an impairment which –

(a) has lasted, or is expected to last, for not less than 6 months; or

(b) is expected to last until the end of the person's life.

The Panel should give consideration as to whether the omission of a medical defence from the draft law constitutes discrimination.

Cannabis Testing and Impairment

Unlike alcohol and other drugs, which display a linear correlation between impairment and bodily fluid concentration that dissipates within a couple of days, THC is fat-soluble and can remain present in the body for several weeks post consumption.

A positive test result for cannabis does not necessarily mean that the person in question is "unfit to drive"; it can only reliably inform whether a person has used cannabis in recent days / weeks.

Further evidence is required to adequately deduce whether someone is impaired from cannabis, rather than solely relying on current methods of testing bodily fluids.

Approximately 5% of the Island's adult population are in receipt of a prescription for medicinal cannabis, the vast majority of whom would likely test positive to a roadside swab and then be subject to a blood test at Police Headquarters and possible prosecution under the proposed draft law – particularly if no statutory medical defence is provided.

Others who use over-the-counter CBD products that are permitted to contain a small proportion of THC in Jersey, or who have recently returned from a jurisdiction where cannabis is decriminalised / legalised, or who use illicit cannabis, may also inadvertently find themselves in contravention of the legislation, regardless of whether or not they are actually impaired.

Without a laboratory test, there is no feasible method for a cannabis user to quantify the amount of THC in their body.

Disappointingly, no guidance is provided in the report accompanying the proposition to help inform people on how to conform with the *Law*, as exists with alcohol where the limit is commonly understood to equate to one standard unit.

There are a variety of different approaches across European countries to the limits for detecting THC, the deduction of impairment (whether additional evidence is required beyond testing), and the severity of penalties.

The UK sets a limit of 2 micrograms THC per litre of blood, which is deemed to be an "'accidental exposure' / zero tolerance approach". Medicinal cannabis patients are afforded protections by the statutory medical defence.

Norway implements a tiered approach to their THC limits, set at 1.3, 5 and 9 micrograms per litre, with the penalty increasing according to the level of THC detected.

The proposed two-tier approach in the *Draft Road Traffic Law (Drug Driving) (Jersey) Amendment Regulations 202-* appears to have been inspired by the Norwegian legislation, with the lower limit reflecting that in the UK.

Without the provision of a medical defence under the proposed legislation, PSV / Group 2 licence holders / driving instructors who are subject to the lower limit of 2 micrograms per litre will effectively be denied the use of medicinal cannabis, which could potentially be construed as discrimination.

Despite the widespread application of *per se* limits in jurisdictions around the world to determine cannabis impairment, there is a great deal of research that suggests that these approaches should be reconsidered.

> "Blood THC >2 ng/mL, and possibly even THC >5 ng/mL, does not necessarily represent recent use of cannabis in frequent cannabis users."
>
> Residual blood THC levels in frequent cannabis users after over four hours of abstinence: A systematic review, Drug and Alcohol Dependence, Volume 216, November 2020.

> "Blood and oral fluid THC concentrations are relatively poor indicators of cannabis/THC-induced impairment."
>
> Are blood and oral fluid Δ9-tetrahydrocannabinol (THC) and metabolite concentrations related to impairment? A meta-regression analysis, Neuroscience & Biobehavioral Reviews, Volume 134, March 2022.

> "Although laboratory studies have shown that marijuana consumption can affect a person's response times and motor performance, studies of the impact of marijuana consumption on a driver's risk of being involved in a crash have produced conflicting results, with some studies finding little or no increased risk of a crash from marijuana usage. Levels of impairment that can be identified in laboratory settings may not have a significant impact in real world settings, where many variables affect the likelihood of a crash occurring. Research studies have been unable to consistently correlate levels of marijuana consumption, or THC in a person's body, and levels of impairment. Thus some researchers, and the National Highway Traffic Safety Administration, have observed that using a measure of THC as evidence of a driver's impairment is not supported by scientific evidence to date."
>
> Marijuana Use and Highway Safety, Congressional Research Service, May 2019.

> "More work needs to be done to address how to best identify drivers who are under the influence of cannabis and are unsafe to drive. A brief editorial highlights many of the challenges faced when developing a reliable test of cannabis impairment. At present, the best protocol is a combination of observations in the field and toxicology testing."
>
> Per Se Driving Under the Influence of Cannabis Statutes and Blood Delta-9-Tetrahydrocannabinol Concentrations following Short-Term Cannabis Abstinence, Clinical Chemistry, Volume 71, Issue 12, December 2025.

> "Linking recent cannabis use to driving impairment outside of the laboratory is challenging due to poor correspondence between THC levels in biological markers (such as blood or oral fluids) and behavioral measures of impairment. Experimental research points to deficiencies in the per se approach to DUIC. Advances in technology could enhance the precision and accuracy of establishing cannabis impairment. A "successful hurdles" approach that relies on a highly sensitive biomarker to detect recent cannabis use followed by behavioral assessment of impairment that has high specificity has been recommended. More research is needed to develop a consistent impairment standard for DUIC. Development of technology would not only expand the law enforcement's capacity to evaluate drivers for DUIC but could also aid individuals in making safer decisions to avoid impaired driving. For now, public health campaigns should emphasize clear guidelines on how long to wait after cannabis use before driving, rather than relying on self-assessed intoxication, to help reduce the risk of DUIC."
>
> Recent Advances in the Science of Cannabis-Impaired Driving, Current Addiction Reports, February 2026.

Ideally, given that the duration of impairment from cannabis is between 2 and 10 hours (depending on consumption method), we would look to measure the time since last use rather than the quantity of THC in bodily fluids in order to determine impairment. However, research in this area is still on-going.

Further complicating things, when it comes to medicinal cannabis use some patients find that it improves their driving and road safety:

> "Participants talked about the potential for medical cannabis to make people safer drivers by reducing impairments from illness including pain, stiffness and mental distraction due to anxiety and ADHD. Taking medical cannabis may also reduce impairment caused by other drugs (be they prescription pain drugs or illicit cannabis), although according to guidance, patients using those drugs ought not to be driving if impaired."

The application of the *Law* should reflect the uncertainty that surrounds the validity of determining impairment from cannabis based on the THC content in bodily fluids alone.

The use of field sobriety tests and / or mobile performance technology like DRUID should be utilised in conjunction with the testing of bodily fluids to provide stronger evidence of impairment for prosecution.

Conclusion

The omission of a statutory medical defence and the absence of any other drugs besides cannabis in P.32/2026 Draft Road Traffic Law (Drug Driving) (Jersey) Amendment Regulations 202- suggests that this proposition has been rushed to meet the deadline of the end of the current term of Government, perhaps in reaction to the now withdrawn P.116/2025.

There was no mention of this legislation in either the 2025 Departmental Business Plan or in response to WQ.297/2025 on legislation that was expected to be completed by the end of this term.

At the Quarterly Hearing held in December, the Minister for Infrastructure stated that cocaine would be included in the draft law, but the report accompanying the proposition does not even suggest a timeline for when other drugs could be included.

The proposition states that the legislation aims "to improve road safety by deterring drug-impaired driving", but there is no reference made to providing guidance on how the public can ensure they are compliant with the *Law*, despite evidence of the effectiveness of such campaigns.

Has any modelling been undertaken to ascertain the potential implications of this legislation on the public, Police and the courts, particularly in relation to medicinal cannabis patients?

What are the anticipated costs and staffing implications for the "evidential testing protocols and laboratory capacity"?

The medical standards for driving licences were changed in October 2024 to include whether or not an applicant has a medicinal cannabis prescription. Will the Police be using this data to target patient drivers?

This proposition is not as simple as it first seems.

Determining impairment from cannabis is both nuanced and complicated.

We hope that this submission has provided an informative introduction to some of the issues raised by P.32/2026 that are of concern to medicinal cannabis patients and the wider cannabis community in the Island. Please consider whether amendments should be brought to the legislation accordingly.

> "Public safety is not negotiable.
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> Impairment behind the wheel, from any substance, is unacceptable to us all.
>
> But toxicology reports detect molecules.
>
> Driving laws regulate behavior.
>
> If we collapse detection into impairment, we weaken both science and safety.
>
> Policy works best when biology and behavior are not confused."
>
> Dr Benjamin Caplan.