SUBMISSION TO THE STATES ASSEMBLY OF JERSEY

P.32/2026 — Draft Road Traffic (Drug Driving) (Jersey) Amendment Regulations

This submission makes one request:

Add a statutory medical defence to P.32/2026 before it is enacted.

The defence requires three things: that the drug was lawfully prescribed; that it was taken in accordance with the prescriber's directions; and that the defendant's driving was not impaired. All three must be proved on the balance of probabilities.

This adds one regulation. It changes nothing else. It is modelled on section 5A(3) of the Road Traffic Act 1988 (UK), which has operated since 2018 without road safety incident.

Without it, P.32/2026 will criminalise prescribed, non-impaired patients for a pharmacological process they cannot control — and will do so using an enforcement mechanism whose reliability for that population is not supported by the scientific evidence.

Submitted by	Daniel Hansen
Email	[redacted]
Date	March 2026
Proposition	P.32/2026 — lodged 9 February 2026 by the Minister for Infrastructure
Scrutiny panel	Children, Adults, Health and Parishes (CAHP) Scrutiny Panel

Contents

Section 1

The Existing Law — Impaired Driving Is Already a Criminal Offence

P.32/2026 is presented as closing a road safety gap. The gap does not exist. Jersey law already criminalises drug-impaired driving, and has done so for decades.

The existing offences

Article 26 of the Road Traffic (Jersey) Law 1956 makes it an offence to drive while unfit through drink or drugs. Article 27 makes it an offence to drive while one's ability to drive properly is impaired by any drug, including cannabis. Both offences are available to prosecutors. Both remain fully in force.

These offences are evidence-based: they require proof of actual impairment. A driver who is genuinely impaired by cannabis — regardless of the blood concentration at which that impairment occurs — is already caught. The law does not need P.32/2026 to address that driver.

What P.32/2026 actually adds

P.32/2026 introduces per se blood THC limits: 5 micrograms per litre as a standard threshold and 2 micrograms per litre for certain categories of driver. These are strict liability offences. Prosecution requires no proof of impairment — only a blood reading above the threshold.

> **The critical point:** P.32/2026 does not close a road safety gap. It closes a gap in the ability to prosecute drivers who are not impaired. If a driver is genuinely impaired by cannabis, Article 27 already applies. P.32/2026 adds liability only for those who are not impaired but whose blood THC exceeds the threshold — a category that, as the evidence below demonstrates, consists substantially of prescribed, non-impaired patients.

This matters for proportionality. Where a less restrictive alternative already achieves the stated road safety objective — as Article 27 does — the more intrusive measure is not necessary. That is the proportionality test under Article 8(2) of the ECHR, as incorporated by the Human Rights (Jersey) Law 2000.

Section 2

The Science — Why Blood THC Does Not Measure Impairment

P.32/2026 applies the alcohol per se model to cannabis. That model is scientifically valid for alcohol. It is not valid for THC in chronic or medical cannabis users. The two substances are pharmacologically distinct in ways that are directly relevant to the reliability of a per se threshold.

Property	Alcohol	THC (chronic/medical users)
Solubility	Water-soluble	Fat-soluble — stored in adipose tissue; released over days to weeks
Elimination	Predictable, linear	Highly variable; terminal half-life 5–13 days in chronic users
Blood level / impairment	Reliable correlation	No reliable correlation in tolerant users — confirmed by five independent stud
Residual levels	None without recent use	Documented in 5.3% of regular users at baseline with zero impairment (Marco
Effect of body composition	Minimal	Significant — higher body fat percentage produces longer detection windows
Effect of exercise	None	Measurably elevates blood THC via fat mobilisation (Wong et al. 2013)

Five independent studies, one conclusion

Ramaekers et al. (2011), Hartman et al. (2015), Marcotte et al. (2025), Sewell et al. (2009), and a 2024 open-label clinical trial all confirm the same finding: blood THC concentration does not reliably predict driving impairment in chronic or medical cannabis users at the concentrations targeted by P.32/2026's threshold. The threshold was calibrated on occasional users. The population most affected by P.32/2026 is a different population for whom those calibrations do not apply.

Three compounding biological problems

Exercise and fat mobilisation. Thirty-five minutes of moderate cycling produces a statistically significant increase in plasma THC concentration via lipolysis — the metabolic process by which stored fat is broken down and THC is released into the bloodstream (Wong et al. 2013). A patient who exercises before driving may test above the threshold based on fat-store release that has nothing to do with recent cannabis use or impairment.

Oral oil preparations. Cannabis-based medicines in oral oil form — the dominant format for prescribed patients in Jersey — produce delayed absorption peaks (typically 2–6 hours post-dose), extended elimination windows (8–12 hours or more), and enhanced fat-tissue deposition compared to inhaled cannabis. Taking the medication with a fatty meal as clinically directed increases bioavailability by a factor of 2.5 to 4 (Zgair et al. 2016). Following the prescription precisely creates greater legal exposure under P.32/2026.

Body composition. The volume of distribution for THC — the measure of how extensively it distributes into body tissue — is among the highest of any drug, at approximately 10 litres per kilogram. Two patients with identical prescriptions and identical compliance will have different blood THC readings if their body fat percentages differ. Criminal liability under P.32/2026 depends in part on physiology, not behaviour. A patient advised by their general practitioner to lose weight may produce positive tests weeks after their last dose as stored THC is released from shrinking fat stores.

> **The threshold does not reliably identify the harm it targets. It identifies a blood reading. For the population most affected by this legislation, those are different things.**

Section 3

The Enforcement Mechanism — A Three-Step System That Fails at Every Step

P.32/2026 relies on a three-step evidential chain: a roadside oral fluid screen detects THC; a blood test confirms the concentration; and that concentration is taken to indicate impairment. For occasional cannabis users, each step has some scientific basis. For chronic and medical cannabis users, each step rests on an assumption that does not reliably hold.

Step	What the law assumes	What the evidence shows
1 ***Oral fluid***	A positive oral fluid result indicates blood THC above the legal threshold	Oral fluid THC and blood THC diverge significantly in chronic users due to oral mucosa contamination and differing pharmacokinetics. The Dräger DrugTest 5000 produced a **14.5% false positive rate** in real-world Norwegian police use (Gjerde et al. 2018). The Securetec DrugWipe 5S has demonstrated sensitivity as low as 45% in controlled studies (Arkell et al. 2019). Neither device consistently meets the EU DRUID minimum 80% accuracy standard.
2 ***Blood THC***	Blood THC above the threshold indicates recent cannabis consumption	In chronic and medical users, blood THC above 5 µg/L is consistent with use 48–72+ hours earlier. Residual fat-store release is pharmacologically indistinguishable from a recent dose. Marcotte et al. (2025) confirmed that **5.3% of regular users exceeded 5 ng/mL at baseline** with no impairment and no correlation with recent use.
3 ***Impairment***	Blood THC above the threshold indicates the driver was impaired	Five independent peer-reviewed studies confirm no reliable impairment-THC correlation in tolerant users at the concentrations targeted by P.32/2026 (Ramaekers 2011; Hartman 2015; Marcotte 2025; Sewell 2009; open-label 2024).

The evidential cascade: The result is not an evidential safeguard but an evidential cascade that increases the probability of wrongful enforcement at each stage. A system that is both substantively and procedurally unreliable cannot meet the requirement of rational and proportionate enforcement.

Process harm before any prosecution

A patient who fails a roadside oral fluid screen — even where the subsequent blood test falls below the threshold — has already been detained at the roadside, prevented from continuing their journey, required to provide a blood sample, and subjected to a police investigation. In a jurisdiction of 100,000 people with approximately 4,000 active medical cannabis patients, applying the documented 14.5% false positive rate to even conservative assumptions about testing frequency produces an estimate of approximately 58 wrongful roadside detentions per year from the screening device alone — before any blood test or prosecution arises. This harm occurs regardless of the eventual legal outcome.

Section 4

The International Picture — Seven Jurisdictions Have Already Solved This

Seven comparable jurisdictions have enacted statutory medical defences or equivalent protections for prescribed, unimpaired cannabis patients. The jurisdictions that have not done so are the subject of sustained academic, clinical, and legislative pressure for reform. Jersey is not entering new territory. It is choosing a position others are leaving.

Jurisdiction	Limit	Medical defence	Key point
United Kingdom	2 µg/L blood	YES s.5A(3) RTA 1988	Enacted simultaneously with the per se limit in 2018. NatCen review (2022): worka
Tasmania	Zero tolerance	YES Poisons Act 1971	Operating for years. No increase in road injuries or fatalities.
Victoria	Zero tolerance	YES From 1 March 2025	Reformed after nine-year review. See Section 5.
New Zealand	Oral fluid	YES	Defence for prescribed patients not impaired.
Norway	Per se limits	YES	Exemption for unimpaired prescribed patients.
Germany	3.5 ng/mL serum	Partial	Expert panel set threshold. Prescription raised in proceedings.
Ireland	Per se limits	YES	Exemption for unimpaired prescribed patients.
Jersey — proposed	**5 µg/L / 2 µg/L**	NONE	**Higher threshold than UK. No defence. More punitive in effect than all above**
Canada	2–5 ng/mL	NONE	Widely criticised in academic and clinical literature. Cautionary model.

The direction of travel is consistent: every jurisdiction that has examined this question through evidence-based processes has concluded that a per se limit requires a medical defence to be proportionate. No jurisdiction that has enacted a medical defence has subsequently repealed it on road safety grounds.

Jersey's proposed threshold of 5 micrograms per litre is already higher than the UK's 2 micrograms per litre — a tacit acknowledgement that lower thresholds risk capturing non-impaired patients. The medical defence is the logical completion of that acknowledgement.

Section 5

Victoria: The Nine-Year Warning

Jersey in 2026 is Victoria in 2016. The structural choice is identical. The pharmacology is identical. The relevance of the Victorian experience is not illustrative — it is predictive. Jurisdiction does not change biology.

Year	What happened in Victoria	Relevance to Jersey
2016	Medicinal cannabis legalised. No medical driving defence enacted.	The same structural choice Jersey is making in 2026.
2017-2022	Prescribed patients test positive. Unimpaired patients lose licences. Employment loss, healthcare access barriers, and rural mobility impacts documented across six years.	**These are not theoretical risks.** They are documented outcomes from a jurisdiction that made the same choice.
2023	Magistrate Tony Parsons appointed to review. Finds: *"A level of inequity exists for Victorian motorists who are prescribed medicinal cannabis... currently they are sanctioned for taking their medicine if they return a positive roadside test, even in the absence of any evidence of impairment."*	The Victorian review and the scientific evidence in this submission reached the same conclusions independently — because the pharmacology is the same.
Oct 2024	Roads and Road Safety Legislation Amendment Act 2024 passed.	The same three-element medical defence this submission proposes.
1 Mar 2025	Reform in force. Applied retrospectively. No road safety deterioration documented.	The retrospective application signals Parliament regarded earlier outcomes as unjust — not merely imperfect. The regime itself was wrong.

A regime producing documented harm without corresponding safety benefit cannot satisfy a proportionality analysis. The Victorian review did not merely find the regime imperfect. It found it unjustified.

The consequences Victoria documented across eight years are the consequences P.32/2026 will produce in Jersey: licence cancellation for non-impaired patients; loss of employment for those in driving-dependent roles; inability to access medical appointments; disproportionate impact on rural residents for whom car travel is the only practical means of transport; and a chilling effect causing

patients to reduce or discontinue their prescribed medication to avoid prosecution.

Jersey has no rail network. Public transport is limited. The mobility consequences of licence cancellation fall more heavily on Jersey patients than they did even in rural Victoria. Jersey has the evidence before it. The evidence is no longer uncertain. The only question is whether the States Assembly chooses to repeat a known failure or to avoid it.

Section 6

Jersey-Specific Impact — Numbers and Economics

The scale of the affected population

Metric	Jersey	England
CBPM patients — % of total population	~4.01%	0.04%
CBPM patients — % of working-age population	~6.08%	0.05%
Prescriptions dispensed in 2024	53,477	—
Estimated active patients (2024)	~4,000	—
Ratio — Jersey vs England (working-age)	~120 times higher	Baseline

Source: 2023 Audit of Unlicensed CBPM Dispensing in Jersey; Written Answer to States Assembly Written Question (2024).

The "bought and sold" argument — and why it fails

It has been argued that Jersey's high prescription rate — approximately 120 times higher than England's by working-age population — suggests recreational misuse of the medical prescribing route. The economics of the Jersey market directly refute this argument.

	Jersey	England
Illicit street price per gram	~£20/gram (Jersey Police intelligence, JEP December 2025)	£10–15/gram (2025 market data)
Medical prescription cost per gram	~£7–10/gram (60g/month at £500–600/month)	~£5–8/gram equivalent (£150–250/month for smaller quantities)
Street vs prescription	**Prescription is CHEAPER per gram than street in Jersey**	**Street is CHEAPER than a private prescription**

In Jersey, a medical prescription costs approximately £7–10 per gram at standard clinic volumes — less than the local street price of approximately £20 per gram. The financial incentive to misuse the medical route in Jersey is therefore negative: a recreational user would pay more, not less, by obtaining a prescription. A Jersey Police officer confirmed the contrasting UK dynamic directly in the Jersey Evening Post (December 2025): in the UK, street cannabis is cheaper than a prescription, which is precisely why the UK prescription rate is low. That dynamic does not apply in Jersey.

England's low prescription rate reflects access barriers, not lower clinical need. Jersey's high prescription rate reflects a functioning, accessible prescribing system responding to genuine patient demand.

The false positive projection

Applying the documented 14.5% real-world false positive rate for the Dräger DrugTest 5000 (Gjerde et al. 2018) to conservative assumptions about Jersey's patient population produces the following estimate:

Calculation	Figure
Active CBPM patients in Jersey (2024)	**~4,000**
Estimated proportion who drive (conservative: 50%)	~2,000
Encountering roadside testing in a given year (conservative: 20%)	~400 tests
DrugTest 5000 real-world false positive rate (Gjerde et al. 2018, Norwegian police)	**14.5%**
Estimated wrongful roadside detentions per year — screening device alone	**~58 patients per year**
Additional wrongful outcomes from blood THC / impairment disconnect	*Not quantified — additional to the above*

These figures are conservative. They do not account for the downstream blood-THC-to-impairment disconnect that adds further wrongful outcomes at the prosecution stage, nor for the chilling effect on patients who curtail driving preventatively or discontinue treatment.

Section 7

The Human Rights Case

P.32/2026 was lodged without a formal ECHR compatibility assessment. The Human Rights (Jersey) Law 2000 requires that legislation engaging Convention rights be proportionate and not discriminatory. P.32/2026 without a medical defence engages and fails both requirements.

Article 8 — Right to respect for private life

Medical cannabis is lawful treatment prescribed by a licensed clinician. The pharmacological consequences of that treatment — residual blood THC — are an inevitable feature of the treatment. A law that criminalises those consequences without any gateway for the patient to raise their clinical context constitutes an interference with Article 8(1).

To justify that interference under Article 8(2), the measure must be necessary and proportionate. Where a less restrictive alternative exists that achieves the same legitimate aim — as the UK medical defence model does — the more intrusive measure is not necessary. The UK Parliament reached this conclusion explicitly: it enacted section 5A(3) simultaneously with the per se limit in 2018 because the per se limit without a defence was regarded as disproportionate on its face. The United Kingdom enacted this defence at the point of introducing per se limits; Jersey proposes to do the opposite without evidential justification.

Article 14 — Prohibition of discrimination

Article 14 prohibits indirect discrimination: a facially neutral rule that disproportionately burdens a protected group without objective justification. P.32/2026 applies equal rules to unequal situations.

Recreational cannabis users can achieve compliance with the per se limit by abstaining before driving. Prescribed medical patients cannot: residual blood THC from fat stores persists for days to weeks regardless of abstinence, particularly for patients using oral oil preparations. The pharmacological characteristic that triggers the offence is an inherent consequence of their lawful medical status. Treating these two groups as legally equivalent — when they are pharmacologically unequal — is the paradigm of indirect discrimination.

Many patients requiring cannabis-based medicines — those with chronic pain, multiple sclerosis, epilepsy, or psychiatric conditions — are disabled within the meaning of the Equality (Jersey) Law 2018. Their body composition, which determines residual blood THC persistence, is frequently a consequence of those conditions. Criminal liability that depends on a physiological characteristic associated with a disability cannot be objectively justified.

Requirement	Without medical defence	With medical defence
Legitimate aim	YES — road safety accepted	YES — preserved

Prescribed by law	YES	YES
Necessary	FAILS — UK model achieves same aim without criminalising compliant patients	PASSES — targeted patients; Article 2
Proportionate	FAILS — forces choice between treatment and licence; catches non-impaired patients	PASSES — genuinely impaired or non-
Article 14	PRIMA FACIE FAILS — neutral rule disproportionately burdens medically supervised group; no objective	PASSES — defence equally available to all; no

Jersey would be defending, before the Royal Court, a regime more restrictive in effect than the UK — without the evidence base the UK relied upon, without the ECHR analysis the Human Rights (Jersey) Law 2000 requires, and against a background of clear international consensus that the medical defence is necessary for the legislation to be proportionate.

Section 8

The Amendment — Draft Text and Commentary

The proposed amendment is modelled on section 5A(3) of the Road Traffic Act 1988 (UK). It requires no change to the threshold, the testing process, the enforcement infrastructure, or any other provision of P.32/2026. It adds one regulation.

DRAFT — Article [X+1] — Medical Defence

(1) It is a defence for a person (D) charged with an offence under Article [X] of these Regulations to prove, on the balance of probabilities, that —

(a) the specified controlled drug to which the charge relates was prescribed or supplied to D for medical or dental purposes by a person lawfully authorised to prescribe or supply it;

(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 given by the manufacturer or distributor, so far as consistent with those directions; and

(c) D's driving was not impaired by the drug at the time of the alleged offence.

(2) For the purposes of paragraph (1)(c), impairment is to be assessed by reference to the standard applicable under Article 26 of the Road Traffic (Jersey) Law 1956.

(3) Where D seeks to rely on the defence under paragraph (1), D must give notice of that intention to the prosecution not less than [7] days before the hearing.

(4) This Article does not affect any liability of D under Article 26 or Article 27 of the Road Traffic (Jersey) Law 1956.

How the defence works

The three elements are conjunctive: all three must be established by the defendant on the balance of probabilities. The reverse burden reflects that the defendant is uniquely positioned to adduce evidence of their own prescription and compliance — not the prosecution. This mirrors the UK approach and pre-empts any argument that the burden is inappropriate.

Element (c) — the absence of impairment — is the critical gateway. A patient who took their medication as prescribed but whose driving was nonetheless impaired by it cannot rely on the defence.

Paragraph (2) anchors the impairment assessment to the existing Article 26 standard, avoiding any new or uncertain legal test. Paragraph (4) makes explicit that Articles 26 and 27 remain fully available: the defence does not affect the prosecution of genuinely impaired drivers.

What the amendment does not do

Objection	Answer
It weakens road safety enforcement	It does not. Article 27 impairment offences remain fully available. The defence applies only to non-impair
It creates a loophole for recreational users	It does not. Elements (a) and (b) require documentary proof of lawful prescription and compliance. Recre
It will be difficult to enforce	The UK has operated an identical provision since 2018. The NatCen review (2022) confirmed it is operati
It changes the threshold	It does not. The 5 µg/L and 2 µg/L thresholds are unchanged. The amendment adds a defence gateway
Patients can simply not drive	Many have no alternative transport. Jersey's limited public transport means car travel is essential for emp

Failure to enact the amendment may itself be relied upon in any subsequent proportionality assessment before the Royal Court — as evidence that a less restrictive alternative was identified, placed before the States Assembly, and declined without evidenced justification.

Section 9

Conclusion and Request

The arguments in this submission are cumulative. Each stands independently. Together they establish a complete case for amendment.

Section	Argument	Conclusion
1	**Existing law**	Article 27 already criminalises impaired drug driving. P.32/2026 adds no road safety benefit — only strict liability for prescribed, non-impaired patients.
2	**Science**	Blood THC does not reliably predict impairment in chronic or medical users. The threshold targets the wrong metric for this population.
3	**Enforcement**	The screening device produces a 14.5% false positive rate in real-world use. The three-step evidential chain fails at every step for the affected population.
4	**International**	Seven jurisdictions protect prescribed, unimpaired patients. The direction of travel is one-way. Jersey would be choosing a position others are leaving.
5	**Victoria**	Victoria created this problem in 2016 and spent nine years fixing it. Jersey has the evidence before the harm occurs.
6	**Jersey impact**	~4,000 patients. ~58 wrongful detentions per year from screening alone. The prescription rate reflects genuine clinical demand, not price arbitrage.
7	**Human rights**	P.32/2026 without a medical defence fails proportionality under Article 8 and gives rise to indirect discrimination under Article 14. No compatibility assessment was carried out.
8	**The amendment**	**One regulation. Modelled on UK law. In operation since 2018. No change to any other provision. Ready to draft.**

The request:

Insert the medical defence set out in Section 8 into P.32/2026 before the proposition is approved. Refer the draft text to the Law Officers for formal drafting to Jersey legislative standards. The amendment requires no change to the threshold, the testing process, or road safety enforcement.

It is a defence to prove: (a) the drug was lawfully prescribed; (b) it was taken in accordance with the prescriber's directions; and (c) driving was not impaired.

This is not a question of road safety.
It is a question of whether to avoid a known failure.

The evidence is complete. The amendment is drafted.
The only remaining question is whether to adopt it.

This outcome is not uncertain. It is already documented.

Daniel Hansen | [redacted] | March 2026