Draft Road Traffic Law (Drug Driving) (Jersey) Amendment Regulations

P.32/2026

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These observations concern one specific aspect of the Draft Road Traffic Law (Drug Driving) (Jersey) Amendment Regulations (P.32/2026), lodged by the Minister for Infrastructure on 9 February 2026 and due for debate by the States Assembly from 24 March 2026. They address the absence from the draft Regulations of a statutory defence for persons who drive with a blood THC concentration above the prescribed limit while taking medicinal cannabis in accordance with a lawful prescription.

The introduction of statutory concentration limits and roadside testing powers for drug-impaired driving serves a legitimate road safety objective, and the case for clearer enforcement powers is set out in the Minister's accompanying report.

The draft Regulations insert a new Article 28A into the Road Traffic (Jersey) Law 1956. Article 28A(1) provides that a person commits an offence if the proportion of a specified drug in their blood exceeds the prescribed limit and they drive, attempt to drive, or are in charge of a motor vehicle on a road or other public place.

The prescribed limit for Delta-9-Tetrahydrocannabinol (THC), set out in new Article 28B, is 5 micrograms per litre of blood for standard licence holders. A lower limit of 2 micrograms per litre applies to holders of Group 2 or public service vehicle licences, to registered driving instructors when instructing, and to any driver who simultaneously exceeds the prescribed limit for alcohol.

Article 28A(2) provides that a person convicted of the offence is liable to imprisonment for up to 12 months and a fine of level 3 on the standard scale. Article 28A(3) provides for mandatory disqualification from holding a driving licence of 12 months for a first offence and 3 years for a second or subsequent offence within 10 years, subject to the court's discretion to order otherwise for special reasons under Article 28A(5).

Article 28A(7) contains a defence, but only for the 'being in charge' limb of the offence. That defence, which mirrors the existing alcohol equivalent, allows a person charged with being in charge of a vehicle to establish that at the time of the alleged offence there was no likelihood of their driving the vehicle while the proportion of the specified drug in their blood remained likely to exceed the prescribed limit. No equivalent defence exists for the driving or attempting to drive limbs of the offence.

There is no medical defence anywhere in the draft Regulations in relation to any limb of the Article 28A offence.

The draft Regulations create an offence based on blood THC concentration without any requirement to establish that the driver was impaired. This mirrors the structure of the existing alcohol concentration offence under Article 28 of the 1956 Law. The approach is coherent in legislative design terms. However, it gives rise to a materially different risk for

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prescribed medicinal cannabis patients than the equivalent alcohol offence does for prescribed medication users, for the following reason.

It is well established in the scientific literature that THC is a highly lipophilic compound, meaning that it is absorbed into fatty tissue following consumption and released back into the bloodstream over an extended period. Published research indicates that detectable THC concentrations in blood can persist beyond the period during which any psychoactive effect is present, particularly in persons who use cannabis regularly. The relationship between a measured blood THC concentration and current driving impairment is not straightforward and is not directly comparable to the relationship between blood alcohol concentration and impairment.

It is not an empirical fact that prescribed medicinal cannabis patients will, as a matter of established scientific certainty, test above 5 micrograms per litre several days after their last use in all or most cases. The evidence on the specific concentration profile at 5 micrograms per litre in a medicinal cannabis patient population is an area of ongoing research, and the literature is not uniform. What the published evidence does apparently support is the broader proposition that blood THC concentration does not reliably indicate present impairment, that detectable THC may persist beyond the period of acute psychoactive effect, and that the degree to which this occurs will vary depending on the individual's pattern of use, body composition, and the dose prescribed.

The consequence for current purposes is that a medicinal cannabis patient who takes their prescription in accordance with medical guidance and who is not impaired when driving may nonetheless test above the prescribed limit. Without a statutory medical defence, that patient would have no defence to a charge under Article 28A(1)(a) or (b) in relation to the driving or attempting to drive limbs of the offence.

The Minister's accompanying report acknowledges the medicinal cannabis patient population. The report states that the limit for regular drivers has been set at 5 micrograms per litre, compared with the United Kingdom limit of 2 micrograms per litre, because the Working Group was aware of the number of people who take medicinal cannabis for legitimate reasons. The report also states that there is no requirement for drivers to carry proof of a prescription, and that the regular driver limit applies regardless of whether cannabis has been prescribed, 'to ensure equity and avoid potential discrimination.'

The concern is that a higher threshold, while reducing the number of compliant patients who will be captured by the offence, does not eliminate that risk. Given the variability in individual THC metabolism described above, there will be some patients on higher prescribed doses, or with slower metabolic profiles, for whom a blood THC concentration above 5 micrograms per litre may persist for some time after use. A threshold-based approach without a medical defence will capture those patients.

The United Kingdom, which operates a statutory medical defence alongside a THC limit of 2 micrograms per litre, has not found that defence to be incompatible with fairness or to give rise to discrimination concerns.

Section 5A of the Road Traffic Act 1988 creates a concentration-based drug driving offence that is structurally similar to the offence proposed under Article 28A of the Jersey draft Regulations.

Section 5A(3) provides a statutory defence. The defence is available where the defendant can show three things: first, that the specified controlled drug had been prescribed or supplied to them for medical or dental purposes; second, that they took the drug in accordance with any directions given by the prescriber or supplier, and with any accompanying instructions given by the manufacturer or distributor so far as consistent with those directions; and third, that their possession of the drug immediately before taking it was

not unlawful under section 5(1) of the Misuse of Drugs Act 1971, by reason of an exemption under section 7 of that Act.

The section 5A(3) defence does not require the defendant to establish that their driving was unimpaired. Impairment is addressed separately, through the existing offence of driving while unfit through drink or drugs. The section 5A defence is concerned only with lawful medical use and compliance with prescription and manufacturer guidance. Section 5A(4) qualifies the defence. It is not available if the defendant's actions were contrary to any advice given by the prescriber or supplier about the time that should elapse between taking the drug and driving, or contrary to any accompanying manufacturer or distributor instructions on that matter. This qualification is significant: it means that a patient who has been told not to drive within a certain number of hours of taking their medication cannot rely on the defence during that period, even if they are not in fact impaired.

Section 5A(5) provides a procedural protection of some importance. Once the defendant adduces evidence sufficient to raise the section 5A(3) defence, the burden shifts to the prosecution to disprove it beyond reasonable doubt. The defendant is not required to prove the defence on the balance of probabilities; they need only raise it with sufficient evidence.

The United Kingdom government's published guidance for healthcare professionals on drug driving states, in terms, that a medical defence is necessary '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.'

Guernsey has incorporated a medical defence into its equivalent drug driving framework.

The position is that both the United Kingdom (in England and Wales) and Guernsey, being the most directly comparable jurisdictions to Jersey, operate statutory medical defences alongside concentration-based drug driving offences. Jersey would therefore be adopting a stricter approach to compliant patients than either of those jurisdictions if the draft Regulations are passed without amendment.

Article 28B(5) of the draft Regulations provides that the Minister for Justice and Home Affairs may by order amend the Law to make further or different provision about which drugs are specified drugs, about the prescribed limits in relation to a specified drug, and about the persons to whom a prescribed limit applies. THC is the only specified drug in the draft as lodged, but other substances including opioid analgesics and benzodiazepines could be added by ministerial order in the future without a further States Assembly vote on the primary framework.

The Environment, Housing and Infrastructure Scrutiny Panel has raised concerns about the breadth of this order-making power, and has proposed an amendment that would require any future alteration to specified drugs or prescribed limits to be subject to States Assembly regulation-making powers rather than ministerial order alone. That concern is one of constitutional principle rather than of patient welfare, but it is relevant to the present discussion. If the Assembly considers that a statutory medical defence is appropriate in principle, the case for including it in the amended statutory framework now, rather than seeking to add it later, is strong. Any future order adding a new specified drug would be made under a statutory framework that contains no medical defence unless the framework is amended. Opioid patients and patients on other prescribed medications that may be added in future would find themselves in the same position as medicinal cannabis patients are in today. A defence included in the framework now would apply to all specified drugs, present and future, without requiring a further legislative amendment.

The draft Regulations as lodged may produce unintended consequences for some medicinal cannabis patients who are taking their prescribed medication in accordance with medical guidance and who are not impaired when driving.

The most straightforward way to address that concern would be the inclusion of a statutory medical defence modelled on, or drawing from, the approach taken in section 5A(3) and (4) of the Road Traffic Act 1988. Such a defence would not weaken the legislation's road safety objective: it would not be available to a driver who is actually impaired, who would remain prosecutable under the existing impairment offence; it would not be available to a patient who had ignored their prescriber's or manufacturer's guidance about driving; and it would be subject to the prosecution's ability to disprove it beyond reasonable doubt once it is raised. Its effect would be to ensure that a patient who is following their prescription, has complied with any relevant guidance about driving, and is not impaired, has a route to establish that in court.

Whether the Assembly adopts such a defence, and in what form, is a matter for States Members. These observations only serve the purpose that the absence of such a provision, and its consequences, are clearly before the Assembly before it votes.

Neel Sahai

CEO – Green Island Growers Ltd

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