Recommendations of the interdisciplinary expert group on the definition of a THC limit for road traffic (section 24a of the Road Traffic Act)

- Long version -

Status quo and mandate of the expert group

Germany does not impose a legally enshrined limit for tetrahydrocannabinol (THC, the psychoactive substance in cannabis) as part of the abstract endangerment offence defined in section 24a (2) of the Road Traffic Act (Straßenverkehrsgesetz, StVG). However, in their decisions to date, courts have applied an analytical detection limit of 1 ng/ml of THC in blood serum. This comprises a baseline of 0.5 ng/ml and a measurement error of 0.5 ng/ml.

Section 44 of the Act on the Handling of Cannabis for Non-Medical Use (Konsumcannabisgesetz, KCanG), as amended by the Cannabis Act (Cannabisgesetz, CanG), adopted by the Bundestag in its second/ third reading on 23 February 2024[1], rules that a working group convened by the Federal Ministry for Digital and Transport is to propose by 31 March 2024 a concentration of THC in blood at and above which safe driving of a motor vehicle in road traffic is generally no longer guaranteed according to the available scientific information.

The legislature assumes that the restricted permission to possess and use cannabis granted by the Act on the Handling of Cannabis for Non-Medical Use will render it necessary to replace the previous absolute ban on driving a motor vehicle under the influence of cannabis with a provision, which – like the blood alcohol limit of 0.5 per mille – defines a limit for THC, the substance found in blood after cannabis use. It is in this context that the scientific working group convened by the Federal Ministry for Digital and Transport is to draw up the limit proposal to be submitted by 31 March 2024. The legislature is then to establish the limit.

The impact on road safety and appropriate THC limits in road traffic were also discussed in 2023 as part of deliberations on the Federal Government's draft bill of a Cannabis Act. The Federal Ministry for Digital and Transport therefore established an interdisciplinary working group comprising medical, legal, traffic and police experts in December 2023. At the initial session on 6 December 2023, chaired by the Federal Ministry for Digital and Transport, the expert working group started its open-ended deliberations to assess and identify a THC limit for inclusion in the Road Traffic Act (StVG) and submit a corresponding proposal by 31 March 2024. The Federal Highway Research Institute (BASt) and the Chairman of the Joint Working Group on Limit Issues and Quality Control (Limit Commission) also contributed their expertise to the deliberations.

For the subsequent legal enactment of the THC limit, the legislature is to weigh individual liberties against the risk to road safety and protection (of the health) of the general population, as required under constitutional law. In particular, any restriction of liberty must be reasonable (appropriate, necessary and proportionate).

The expert group came together on four occasions. Based on its deliberations, it reached the conclusion that current scientific knowledge does not permit the definition of a THC limit at or above which safe driving of a motor vehicle in road traffic is generally no longer guaranteed based on the available scientific information. However, current knowledge does permit the definition of a THC limit at or above which the available scientific information indicates that a road safety-critical impact on the driving of a motor vehicle in road traffic is not unlikely. The term 'not unlikely' is intended to define a degree of probability of the materialization of the road safety risk and is understood to mean that while the occurrence of the risk is 'possible' but not 'probable', it is also not 'entirely improbable'.

The scientific findings on which the proposal and the recommendations are based represent the latest available research. This is subject to change, and must therefore be reviewed and, if necessary,

[1] The English translation is of a later date than March 2024. Section 44 of the Act on the Handling of Cannabis for Non-Medical Use entered into force on 1 April 2024.

updated in due course based on the available research and data.

Derivation and recommendation of a specific THC limit at or above which the available scientific information indicates that a road safety-critical impact on the driving of a motor vehicle in road traffic is not unlikely:

1. Which studies can be used to identify a road safety-critical impact of a defined THC concentration (risk limit) in blood serum?

Risk limits can be calculated based on empirical studies. As the primary goal of road safety is to prevent accidents, the findings of high quality accident studies and meta-analyses on accidents and their causes are initially to be incorporated. Adjusted risk values are to be used to eliminate other possible influences such as gender and age. Experimental studies measuring performance under the influence of cannabis can prove impairments in individual road safety-critical performance relatively accurately, showing shortcomings even at low THC concentrations, which are not yet associated with an elevated risk of accident (Hargutt et al. 2011; Verstraete et al. 2011). These studies therefore allow a conservative estimate of risk. Studies on forensic findings, such as the number of road traffic offences or accidents with positive THC tests, do not indicate whether cannabis was the reason for the offence or accident, and therefore cannot be used to calculate the risk of a given THC limit.

1.1 Accident studies

There is scientific consensus that the risk of causing an accident under the influence of cannabis, irrespective of the THC blood concentration, is similar to the risk expected at a moderate alcohol intoxication of between 0.1 and 0.5 per mille, and thus is equivalent to a 0 to 2 times higher risk of accident (Preuss et al. 2021; Rogeberg et al. 2019; EMCDDA 2012) (see 4). The risk level depends on the severity of the accident. In the case of accidents involving serious injuries or fatalities, the risk of culpability at a blood alcohol concentration (BAC) of 0.5 per mille is even higher. A high quality Australian culpability analysis found that drivers with a BAC of between 0.1 per mille and 0.5 per mille are three times more likely to become involved in an accident than sober drivers. Cannabis users only reach a comparable accident risk at THC concentrations of ≥ 5 ng/ml in blood (7 ng/ml in blood serum) (Drummer 2020). A Canadian study found that the risk increases by a factor of just 1.7 at this THC concentration level. Furthermore, this increase was not significant compared with sober drivers. Overall, this study showed only a minor increase in the risk of causing an accident under the influence of cannabis (1.13 times higher than that of sober drivers) (Brubacher 2019).

1.2 Experimental studies

Experimental studies, both on-road studies and studies using driving simulators, have uniformly shown that acute THC use impairs driving performance (Pearlson et al. 2021; McCartney et al. 2021). In a recent road traffic study, 40 minutes after use, cannabis containing THC led to an impairment in the driving performance of occasional cannabis users similar to that in drivers with a BAC of 0.5‰. After 4 hours, the effects were no longer significant and more equivalent to the level typical for drivers with a BAC of 0.2‰ (Arkell et al. 2020).

Studies in driving simulators show a significant impairment in lane adhesion after cannabis use. At 8.2 ng/ml of THC in blood (11.5 ng/ml in blood serum), this impairment was comparable to that at a BAC below 0.5‰, while at 13.1 ng/ml of THC in blood (18.4 ng/ml in blood serum), it was comparable to that at a BAC below 0.8‰ (Hartmann et al. 2015).

A high quality experimental study that assessed a range of driving safety-critical performance parameters in a battery of tests did not find any performance shortcomings at THC levels in blood serum of below 2 ng/ml. In 71% of the cases, initial performance deficits in fine motor skills did not occur until between 2 ng/ml and 5 ng/ml of THC in blood serum. At between

5 ng/ml and 10 ng/ml of THC in blood serum, other performance areas were affected in 75-90% of the cases. This study only included occasional users who use cannabis no more than once a week (Ramaekers et al. 2006). For comparison: alcohol studies showed initial impairments in fine motor skills starting from a BAC of 0.2‰ (Irwin et al. 2017).

2. Duration of road safety-critical impairments and THC detectability in blood

Road safety-critical effects of cannabis are strongest 20-30 minutes after smoking and fade after 3-4 hours (Preuss 2021). A meta-analysis of experimental studies with comparable results therefore advised waiting 5 hours after inhaled cannabis use (McCartney et al. 2021). Conversely, no impairments were detected by 3 hours after use at the latest in more frequent to regular users. For example, a driving simulator study found that while the psycho-motor skills of older (> 65) long-term cannabis users were impaired after 30 minutes, that was no longer the case after 180 minutes (Di Ciano et al. 2024).

The period during which THC can be detected in the blood depends on the frequency of use. For persons who use cannabis no more than once a week – often termed 'occasional users' in scientific literature – a concentration of 1 ng/ml or more of THC in blood serum can be expected for up to 12 hours after use (Huestis et al. 1992). Experiments have shown that, in occasional users, THC concentrations in blood serum typically fall below the current analytical limit of 1 ng/ml of THC in blood serum within 5 to 8 hours of use (Tönnes et al. 2015). With more frequent use, the THC can accumulate in the body and therefore be detected far longer than the duration of the impairment. As a result, with chronic use (daily or several times a day), THC can be detected in the blood even several days or weeks after the last use (Peng et al. 2020). It can be assumed that, in persons who use cannabis between once a week and several times a day, the THC window of detection is far longer than the impairment, becoming longer with increasing frequency of use.

In the simulator study by Di Ciano et al. (2024) cited above featuring long-term cannabis users, performance impairments in lane adhesion occurred 30 minutes after smoking but were no longer present after 3 hours. Their average THC concentrations before cannabis use – at the start of the study – were 3.5 ng/ml (SD: 5.6) in blood serum[2], rising to an average of 36.6 ng/ml (SD: 39.4) in blood serum after half an hour. After three hours, they decreased to 6.7 ng/ml (SD: 8.9) in blood serum (Di Ciano et al. 2024).

3. Role played by frequency of use

3.1 Performance decreases

The decreases in performance differ depending on the frequency of use. Accordingly, the performance of frequent users decreases less under acute cannabis influence than that of occasional users (Müller et al. 2006; Ramaekers et al. 2009). In spite of this, ad libitum cannabis smoking (i.e. higher doses) by regular users could still lead to impairments in driving performance in driving simulation studies (Marcotte et al. 2022).

3.2 Driving and accident risk under the influence

The frequency of use is also a relevant factor for the frequency of driving under the influence of psychoactive substances (Walter et al. 2011), as more frequent users also use the roads significantly more often under the influence of cannabis (Borodovsky et al. 2020; Ramaekers et al. 2009) and are also involved in more accidents (Blows et al. 2005; Pulido et al. 2011). In a representative survey of users, the willingness to drive a motor vehicle within 2 hours of the

[2] For better comparability, certain THC concentrations in blood are converted to blood plasma or serum and marked with (*). A mean full blood-plasma ratio of 0.71 is assumed for this [20].

last use also rose with increasing frequency of use (Borodovsky et al. 2020).

With regard to the frequency of driving under the influence of intoxicants, a large-scale European study involving more than 50,000 drivers showed fewer cases with proven cannabis use than alcohol consumption (1.3% vs. 3.5%). Of 2,492 accidents involving injuries and 1,118 accidents with fatalities, alcohol-positive drivers accounted for between 14% and 30% of accidents with injuries and between 16% and 39% of accidents with fatalities, while cannabis-positive drivers accounted for between 0.5% and 2.2% and between 0% and 1.8 % respectively (EMCDDA, 2012).

In the Netherlands, where cannabis use is legal, 1.67% of all drivers drove under the influence of cannabis. Due to the extremely low accident rate of drivers under the influence of cannabis, cannabis use in the Netherlands was not found to increase the accident risk (Houwing et al. 2011). In Germany, a representative survey found that 0.14% of driving is done under the influence of cannabis (German Smartphone Survey; Walter et al. 2011). In the 1990s, 0.57% of drivers stopped for random spot checks were found to have been driving under the influence of cannabis (German Roadside Survey; Krüger et al. 1998).

4. Dealing with other risks: alcohol as an example

The risk of accidents is influenced by various factors. To a certain extent, these risks are accepted by policymakers and society. For example, BACs below 0.5‰ when driving a motor vehicle in road traffic are tolerated, although there is an increased risk of accidents even at lower BACs.

The effects of alcohol are first seen in the brain centres involved in highly integrated functions, such as driving skills. Analysis of sensory information, the control of movement patterns and short-term memory are especially sensitive to alcohol (Ogden & Moskowitz 2004). There is no evidence of a threshold effect for alcohol, as some impairment of performance occurs even at the lowest measurable levels. Several controlled epidemiological studies have been conducted, one of the first of which was by Borkenstein et al. (1964) in the USA. The breath alcohol levels of around 6,000 drivers involved in accidents were compared with those of 7,600 control persons who were not involved in an accident. The study showed that the probability of causing an accident is a sharply rising exponential function of the driver’s alcohol level. At a 1‰ BAC equivalent, the accident risk is about six times higher than the accident rate for alcohol-free drivers. At 1.5‰, the odds ratio was 25. The accident risk associated with alcohol below a BAC of 0.5‰ has been confirmed by culpability studies. A study by Drummer et al. (2004) found that 29.1% of fatally injured drivers had consumed alcohol, and the adjusted odds ratio for accident culpability was 6.0. The study by Laumon et al. (2005) detected alcohol in 29.8% of the cases responsible for fatal accidents and in 2.7% of the controls who were not responsible. Alcohol increased the frequency of culpability more than eightfold.

5. Proposal for a limit and assessment of proportionality

The expert group established by the Council of Europe on rules for driving under the influence of substances stated the following in its general conclusions: “The law enforcement and judicial authorities should have clear legislative and regulatory provisions, in line with which they can prosecute and convict individuals driving a vehicle whilst under the influence of psychoactive substances.” (Pompidou Group. Road Traffic and Psychoactive Substances. Strasbourg: Council of Europe; 2004). It is therefore of crucial relevance when defining a limit to establish clear and comprehensible rules users can follow. It is our objective to ensure that cannabis use and driving a motor vehicle in road traffic are separated, i.e. that nobody under the influence of cannabis drives a motor vehicle in road traffic as long as there is road safety-critical impairment.

In order to define a proposal for a THC limit, the high quality studies and meta-analyses mentioned above are shown in a table with ascending THC concentrations in blood serum.

ng/ml THC in blood serum	**Accident risk**	**Road safety-critical performance**
< 2		
2 - 5		Initial signs of fine motor skills impairment in some occasional users (Ramaekers et al. 2006), impairment equivalent to that at a BAC of 0.2‰ (Irwin, et al. 2017).
5 – 10		In 75–90% of cases, occasional users show significant impairment in various performance tests (Ramaekers et al. 2006).
< 7	No increased risk of culpability (Drummer at al. 2020).	--
7 – all cases	Accident risk equivalent to that of moderate alcohol intoxication at a BAC of 0.1 to 0.5‰ (Drummer et al. 2020). Especially more frequent users operate motor vehicles and are involved in accidents (Borodovsky et al. 2020, Ramaekers et al. 2009; Blows et al. 2005; Pulido et al. 2011).	Performance impairment also possible in the case of regular use, in particular after higher doses (Marcotte et al. 2022). In the case of more frequent use, a lower performance impairment is to be expected than in the case of occasional use. (Ramaekers et al 2009, Müller et al. 2006)
11,5		Performance impairment in lane adhesion equivalent to a BAC of 0.5‰ (Hartmann et al.; 2015)
13,8 – 18,4	A tenfold increase in the accident risk is equivalent to a BAC of approx. 1‰ in the study (Drummer et al. 2020)	Performance impairment in lane adhesion equivalent to a BAC of 0.8‰ (Hartmann et al.; 2015)

Table 1 Accidents and performance impairment as a function of THC concentration

An increase in the current analytical THC limit should not entail an increase in the road safety risk greater than that tolerated for other risk factors (e.g. alcohol consumption). The aim was to define a THC limit at or above which the available scientific information indicates that a road safety-critical impact on the driving of a motor vehicle in road traffic is not unlikely[3]. Accident studies show a low risk of becoming involved in an accident under the influence of cannabis. An increased risk comparable to that at a BAC of between 0.1 and 0.5‰ starts at 7 ng/ml of THC in blood serum; here, as a result of the delay in blood collection described above, a higher THC concentration would have to be assumed. In accident studies, blood samples are collected 2 to 5 hours after the accident. Unfortunately, it is not possible to back-extrapolate the actual THC concentration at the time of an accident or to distinguish between current and previous use. It is therefore problematic to define a THC limit solely on the basis of epidemiological studies. As it is not possible to derive exact limits from accident studies, we recommend defining the limit on the basis of experimental studies. Experimental studies measuring

[3] For the definition of 'not unlikely', see above under **Status quo and mandate**, page 1 paragraph 6 sentence 4.

performance under the influence of cannabis can detect impairments in individual road safety-critical performance relatively accurately, showing shortcomings even at low THC concentrations, which are not yet associated with an elevated risk of accident. In consequence, this approach allows for relatively conservative risk estimation (Hargutt et al. 2011, Verstraete et al. 2011).

Here, performance shortcomings comparable to those under the influence of a BAC below 0.5‰ should be chosen as a benchmark for a not unlikely impact. Initial performance shortcomings in fine motor skills can be observed in some (not all) occasional users at between 2 ng/ml and 5 ng/ml of THC in blood serum. At between 5 ng/ml and 10 ng/ml of THC in blood serum, other performance areas are affected.

The impairment at between 2 ng/ml and 5 ng/ml of THC in blood serum more or less corresponds to that at a BAC of 0.2‰. We therefore recommend assuming the median of this range at 3.5 ng/ml of THC in blood serum as a value at which a road safety-critical impact would not be unlikely in occasional users.

As it is possible in practice that the THC concentration decreases considerably between when a road traffic offence occurs and when blood is collected, 1 ng/ml of THC is deducted from the above-mentioned baseline. This corresponds to the decrease in THC concentration that can be expected after the initial exponential elimination phase in the following linear elimination phase in a timeframe of 1.5 hours (Kelly et al. 1992, Toennes et al. 2011, Toennes et al. 2008, Kauert et al. 2007, Grotenhermen et al. 2003). In forensic toxicological tests, a measurement uncertainty of up to 40% must be taken into account in the low concentration range.

With a general safety margin of 40%, the THC limit at which the available scientific information indicates that a road safety-critical impact on the driving of a motor vehicle in road traffic is not unlikely[4] is made up as follows:

- Baseline of 3.5 ng/ml as a median concentration at which occasional users may exhibit an impairment comparable to that at a BAC of 0.2‰.
- Compensation for the decrease in THC concentration that may result from the delay between the incident (accident, road traffic check) and blood collection by means of a deduction of 1 ng/ml.
- General safety margin of 1 ng/ml (40% of 2.5 ng/ml) to offset possible measurement errors.

The limit of 3.5 ng/ml of THC in blood serum is considerably below the threshold above which the accident risk increases. The risk increases only from 7 ng/ml and is comparable to the risk of drunk driving at a BAC between 0.1 and 0.5‰.

Cannabis users who consume several times a week may exhibit THC concentrations above the analytical limit currently used by the German courts, even without acute use. This means that, when applying the limit of 1 ng/ml of THC in blood serum, section 24a (2) of the Road Traffic Act (StVG) also covers persons who waited (sufficiently) long and only commenced their journey at a time when a road safety-critical impact can be virtually ruled out. These users are then nevertheless sanctioned in accordance with section 24a (2) of the Road Traffic Act.

The introduction of a limit of 3.5 ng/ml in blood serum would reduce the frequency of sanctions in accordance with section 24a (2) of the Road Traffic Act for more frequent users without acute use. The percentage of persons with THC concentrations below 3.5 ng/ml in checks by the enforcement authorities of the federal states is high. A recent publication of forensic findings shows that almost half (45.6%) of the offences in accordance with section 24a (2) of the Road Traffic Act would no longer be sanctioned. In this publication, 16.4% of drivers

[4] For the definition of 'not unlikely', see above under **Status quo and mandate**, page 1 paragraph 6 sentence 4.

with positive THC tests had less than 1 ng/ml of THC in blood serum (Nicolic et al. 2023).

As found in the studies described above, there is no increased accident risk below 7 ng/ml of THC in blood serum, and initial performance shortcomings are observed at between 2 ng/ml and 5 ng/ml of THC in blood serum. If the analytical limit is retained, this sends the signal to cannabis users that even responsible behaviour with regard to cannabis in road traffic does not protect them from sanctions. It would contradict the general objective of defining a limit that provides cannabis users with guidance for adequate behaviour.

However, in the case of more frequent use, THC concentrations may well exceed the limit of 3.5 ng/ml of THC in blood serum in specific individual cases, despite waiting sufficiently long between use and driving. One study found, for example, THC concentrations without acute cannabis use and without performance impairment of 4.8 ng/ml (SD: 7.8) (Di Ciano, 2024) in this group. With this limit, more frequent users would constantly be considered impaired.

To counteract this effect, the use of oral fluid pre-tests with an adequate cut-off and sufficient sensitivity and specificity[5] for detecting acute use should be pursued. If drivers exhibit signs of impairment, they should provide a blood sample even in the case of a negative oral fluid test.

A THC concentration below 3.5 ng/ml detected in blood serum does not rule out that, in particular for users not accustomed to cannabis, the influence of cannabis at the time of driving was road safety-critical. The same applies to alcohol consumers with concentrations below 0.5‰. However, it is rather unlikely that this user group participates in motorized road traffic, as more frequent users also drive significantly more often under the influence of cannabis than occasional users (Walter et al. 2011; Borodovsky et al. 2020).

It should be borne in mind that this concerns driving a motor vehicle in road traffic showing unusual driving behaviour or being involved in an accident and that it can be examined in individual cases whether this constitutes a relative unfitness to drive in accordance with section 315c or 316 of the Criminal Code (StGB).

With a limit of 3.5 ng/ml of THC in blood serum, occasional users and users with a medium frequency of use can adequately separate use and driving a motor vehicle in road traffic without exceeding the THC limit. With this approach, more intensive users, for example those using several times a day, would constantly be considered to be under the influence of cannabis when driving a motor vehicle.

The combined use of cannabis and alcohol is a special case. There should be a zero alcohol limit for cannabis users when driving a vehicle in road traffic. This corresponds to the provisions applicable for novice drivers in section 24c of the Road Traffic Act and is due to the particular dangers of combined use, which have also been proven in epidemiological studies. Accordingly, any person who consumes alcoholic beverages as a cannabis user and driver or rider of a motor vehicle in road traffic or sets off on a journey although they are under the influence of such a beverage, would also be guilty of an administrative offence. If a breath or blood sample is taken from the person concerned, in accordance with the current state of scientific knowledge, an 'alcohol effect' within the meaning of this provision is only to be assumed from a BAC of 0.2 per mille or 0.1 mg/l of breath alcohol in order to exclude measurement uncertainties and endogenous alcohol. The values stated contain the required safety margins.

6. Proposals and recommendations

[5] "Excluding studies using the Intercept or Salivette devices due to poor recovery, we found in 17,108 paired samples that the presence of THC in oral fluid as a marker for the presence of THC in blood has a sensitivity of 78.8% and specificity of 97.9%. As a biomarker for blood THC ≥ 2 ng/mL (2.8 ng/ml serum using a ratio of 0,71), the sensitivity of oral fluid testing ranged from 25.5% to 75.7% (specificity >98%). For detecting blood THC ≥ 5 ng/mL (7.0 ng/ml in serum), sensitivity ranged from 32.3% to 77.6% (specificity > 97%) (modified from Robertson et al. 2022)".

The scientific experts of the working group propose the THC limit below and make additional recommendations:

1) Based on results of experimental studies, we propose that an effect limit of 3.5 ng/ml of THC in blood serum be introduced within the context of the abstract endangerment offence as defined in section 24a (2) of the Road Traffic Act. This limit is made up as follows:

- Baseline of 3.5 ng/ml as a median concentration at which occasional users may exhibit an impairment comparable to that at a BAC of 0.2‰.
- Compensation for the decrease in THC concentration that may result from the delay between the incident (accident, road traffic check) and blood collection by means of a deduction of 1 ng/ml.
- General safety margin of 1 ng/ml (40% of 2.5 ng/ml) to offset possible measurement errors.

In this way, occasional users and moderate regular users can avoid positive tests by separating intake and driving.

2) To take account of the special endangerment posed by the combined use of cannabis and alcohol, there should be an absolute alcohol ban for cannabis users when driving a motor vehicle in road traffic, in line with the provisions set out in section 24c of the Road Traffic Act for novice drivers and young drivers under the age of 21. Accordingly, any person who consumes alcoholic beverages as a cannabis user and driver or rider of a motor vehicle in road traffic or sets off on a journey although they are under the influence of such a beverage, would also be guilty of an administrative offence. If a breath or blood sample is taken from the person concerned, in accordance with the current state of scientific knowledge, an 'alcohol influence' within the meaning of this provision is only to be assumed from a BAC of 0.2 per mille or 0.1 mg/l of breath alcohol in order to exclude measurement uncertainties and endogenous alcohol. The values stated contain the required safety margins.

3) In individual cases, it cannot be ruled out that in the case of more frequent use, the THC concentration may be above the effect limit of 3.5 ng/ml of THC in blood serum despite waiting sufficiently long between use and driving. Therefore, it is proposed that high sensitivity oral fluid tests be required as a pre-screening to detect acute use for reasons of practicability and to avoid detecting past use.

It is recommended that the details regarding the implementation of this approach be fleshed out also taking into account the experience of other countries. Oral fluid tests would provide the police with a measuring instrument with which they could identify acute cannabis use and thus a potential road safety risk. This also serves to ensure proportionality. At the same time, this can help to save costs and effort in connection with the analysis of blood samples and thereby cut red tape.

If drivers show signs of impairment, a blood sample must be taken even if the oral fluid test is negative. This, moreover, may also constitute a (relative) unfitness to drive in accordance with section 315c or 316 of the Criminal Code.

7. Vote of the Chairman of the Working Group on Traffic Police Matters (AG VPA)

On behalf of the federal and federal state police forces, the representative of Working Group II of the Standing Conference of Interior Ministers rejects the increase in the limit due to the adverse effects on road safety to be expected from a traffic policing perspective and recommends retaining the analytical limit of 1 ng/ml of THC in blood serum.

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