

THE 2012 FEDERAL LEGISLATIVE REVIEW

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THE CURRENT STATE OF FEDERAL IMPAIRED DRIVING LAW

In 2001, MADD Canada conducted a comprehensive review of the federal impaired driving legislation and prepared a federal legislative agenda entitled *Taking Back Our Roads: A Strategy to Eliminate Impaired Driving in Canada*. It surveyed issues ranging from enhanced enforcement powers, clarifying the criminal impaired driving offences and eliminating questionable defences, to rationalizing sentencing, streamlining enforcement procedures, and other administrative matters. In terms of reducing impaired driving crashes, however, the most important recommendation was the proposal to introduce a federal criminal offence for driving with a blood-alcohol concentration (BAC) in excess of .05%.

Since the Report's release, MADD Canada has met with the last five federal Ministers of Justice, opposition justice critics, and leading Parliamentarians from all parties. In addition, the case for the various recommendations has been set out in position papers, international conference proceedings, public education materials, presentations to Parliamentary committees, and both law and traffic safety journals.

MADD Canada has achieved many of the goals that were set out in *Taking Back Our Roads*. The sentences for impaired driving offences have been increased,¹ and conditional sentences (ie house arrest) for those convicted of impaired driving causing bodily harm or death have been eliminated.² Police have been given statutory authority to demand standard field sobriety testing and drug recognition evaluations.³ The *Criminal Code* now allows for a reduced federal driving prohibition if offenders participate in a provincial alcohol interlock program.⁴ Finally, the evidentiary presumptions regarding breath and blood-test evidence have been strengthened, and have virtually eliminated the so-called "Carter" and "last drink" defences.⁵ These are important measures because they close loopholes, ensure more appropriate sanctions, and encourage offenders to address their underlying alcohol problems.

That said, the measures that the federal government has enacted to date will not significantly reduce impaired driving or alcohol-related crashes, deaths and injuries. Nor will these measures streamline the cumbersome, slow and expensive process of apprehending and prosecuting the federal impaired driving offences.⁶

Two reforms are required to achieve significant reductions in impaired driving: a federal .05% BAC offence and random breath testing (RBT). These measures have been proven worldwide to be the most effective means of deterring impaired driving and reducing its tragic consequences. However, as discussed in section III(b) below, the federal government has indicated that it is unwilling to introduce a .05% BAC offence. Accordingly, the main focus of this report and of MADD Canada's ongoing federal legislative reform efforts is RBT.

The introduction of RBT in Canada should pave the way for two other important enforcement-related reforms: random roadside saliva screening for drugs and the taking of blood samples from drivers who are hospitalized following a crash. Together with RBT, these measures will

maximize alcohol and/or drug-impaired drivers' actual and perceived risk of being apprehended and charged. In turn, this will deter impaired driving among Canadians and thereby reduce related crashes, injuries and deaths.

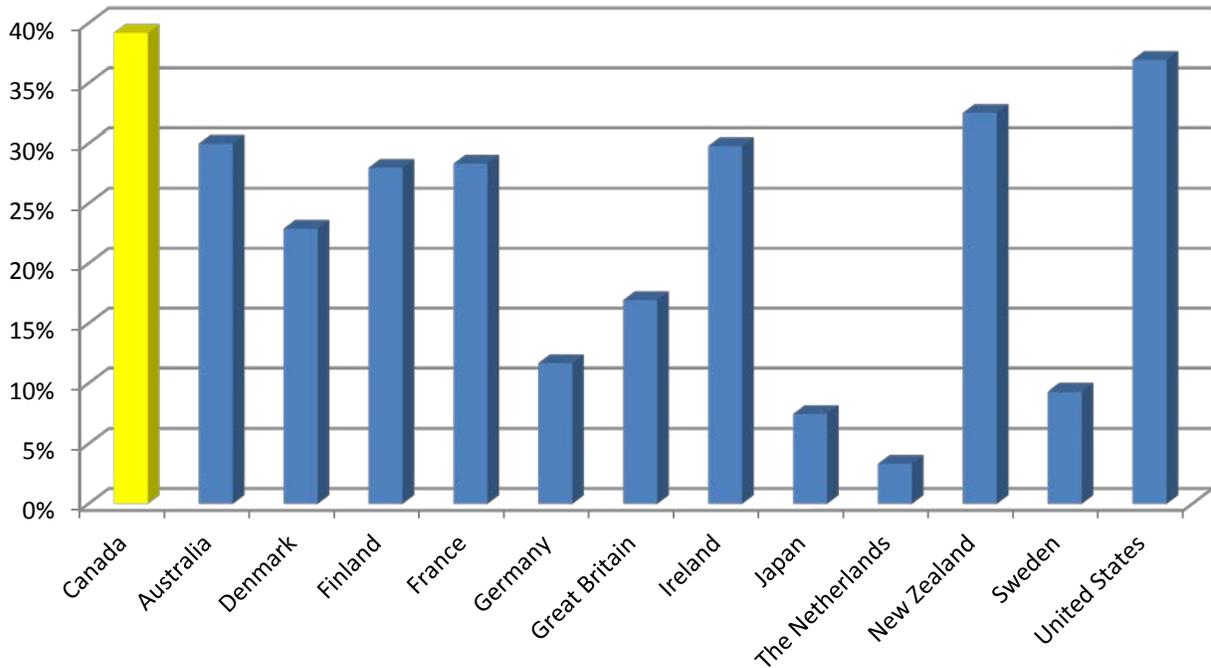
CANADA'S IMPAIRED DRIVING RECORD IN AN INTERNATIONAL PERSPECTIVE

Impaired driving deaths in Canada peaked in the early 1980s,⁷ prompting an unparalleled flurry of federal⁸ and provincial⁹ legislative amendments. Research, public health, government and grassroots organizations launched major public awareness and education programs. The public, politicians and the media adopted more critical attitudes toward drinking and driving.¹⁰ These and other measures led to significant declines in impaired driving deaths and injuries. However, the rate of decline slowed in the mid-1990s and, by 2000, had all but stopped.¹¹

In the past decade, there have been numerous federal¹² and provincial¹³ legislative amendments; ongoing awareness and educational campaigns; the introduction of responsible serving practices by municipalities, post-secondary institutions and the hospitality industry; and the implementation of alternate transportation policies, such as designated driver programs. Unfortunately, these measures have failed to achieve further declines in impaired driving deaths and injuries. The totals in 2009, the latest year for which there are national data, are comparable to the 2000 levels.¹⁴ It was conservatively estimated¹⁵ that there were 181,911 impairment-related crashes in 2009, which resulted in 1,074 deaths, 63,338 injuries, and 209,336 vehicles damaged in non-injury crashes.¹⁶ The total financial and social costs of these losses were estimated to be \$20.15 billion.¹⁷ Impaired driving remains Canada's leading criminal cause of death, claiming almost twice as many lives per year as all types of homicide combined.¹⁸

While comparative data must be used with caution, Canada's impaired driving record is clearly poor relative to that of other developed democracies. As illustrated in Figures 1-3, Canada has one of the lowest rates of per capita alcohol consumption among comparable developed countries, but one of the highest rates of alcohol-related crash deaths.¹⁹ In other words, Canadians drink far less than residents of other countries, but are involved in significantly more alcohol-related crashes. Those countries are doing a far better job of separating drinking from driving. Not coincidentally, almost all of those countries have both lower criminal BAC limits than Canada and comprehensive RBT programs.

Figure 1: Alcohol-Related Fatalities as a Percentage of Total Traffic Fatalities (2008)*



* See Appendix I, which contains technical data related to Figures 1 and 2. Crash data are from 2008 except for Australia (2010), Japan (2007), and the United States (2009).

Figure 2: Alcohol-Related Crash Deaths per 100,000 (2008)

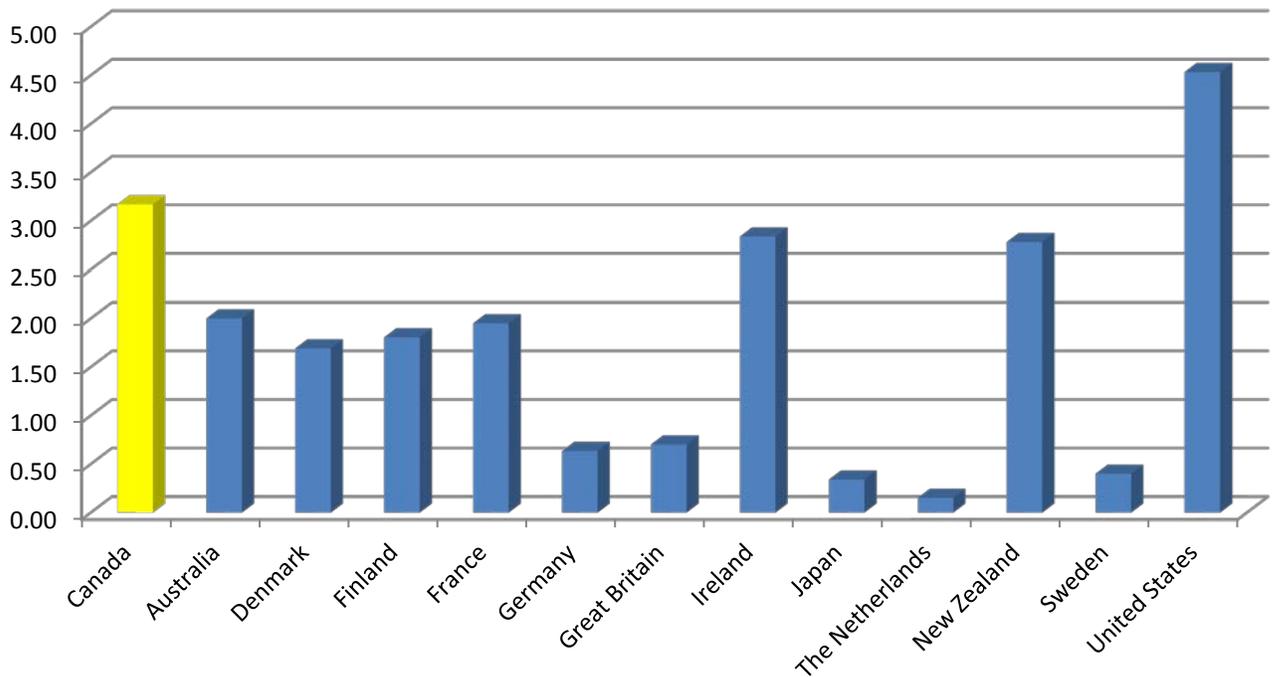
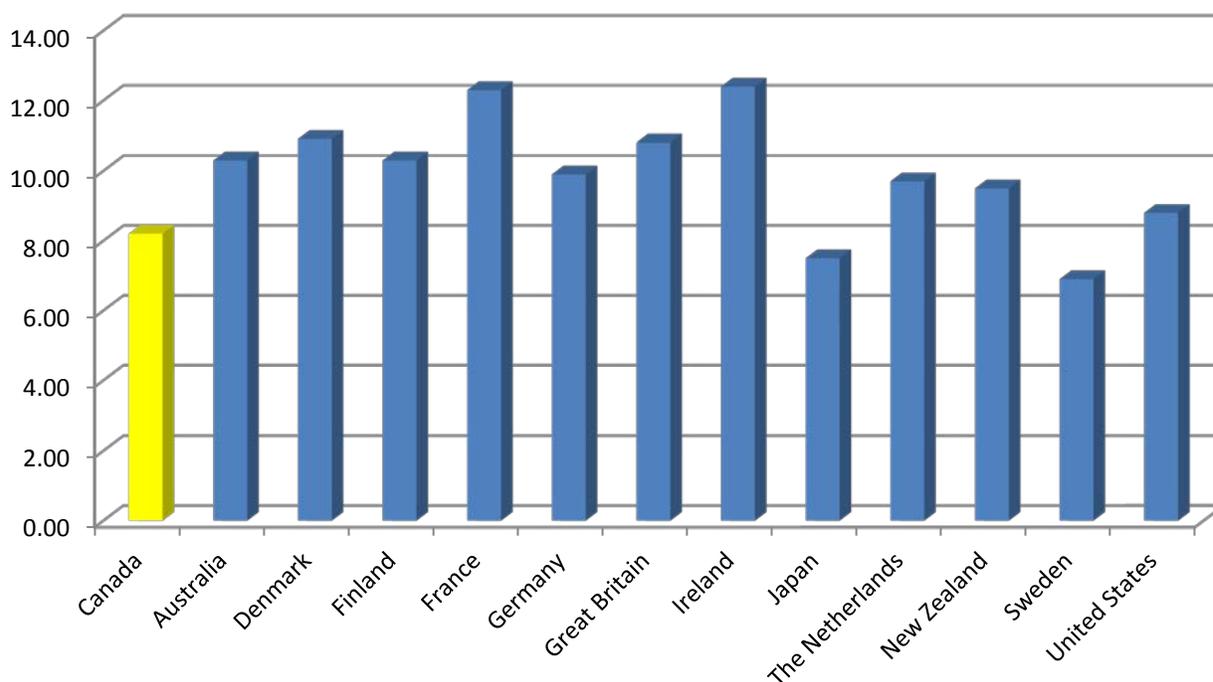


Figure 3: Consumption in Litres of Pure Alcohol Per Capita (2008)*



* See Appendix II, which contains technical data related to the figure.

Canadian survey data are equally worrying. The percentage of Canadians who reported driving after drinking in the past 30 days rose from 16.7% in 2001 to 17.6% in 2007, and to 24.7% (representing over 5.5 million drivers) in 2010.²⁰ Rates of binge drinking (consuming five or more standard drinks on a single occasion) are also on the rise, particularly among Canada's vulnerable youth population.²¹ Combined with upward trends in alcohol availability,²² there is little reason to be optimistic that Canada's impaired driving record will significantly improve in the coming years.

Indeed, the results of Canada's national transportation strategy, *Road Safety Vision 2010 (RSV)*, have been extremely disappointing.²³ The *RSV* sought a 40% reduction in alcohol-related deaths and injuries among drivers by 2010 compared to the 1996-2001 baseline period. An external mid-term review of the *RSV* reported that only the Yukon was on track to meet its targeted reductions in alcohol-related deaths, and that no jurisdiction was on track in terms of injuries. In fact, alcohol-related deaths and injuries had increased above the baseline period in five jurisdictions.²⁴ The authors were highly critical of the federal government's legislative inaction and specifically recommended lowering the criminal BAC limit to .05% and enacting RBT legislation.²⁵ A contemporaneous Transport Canada review indicated, without comment, that the *RSV* had failed to achieve 81% of its target reductions in alcohol-related crash deaths.²⁶

Canada's current impaired driving record is unacceptable, and would be far worse but for the progressive measures undertaken at the provincial level. In any event, significant improvements are unlikely without substantive changes in the federal law.

The remainder of this Review identifies MADD Canada's federal legislative priorities for the coming years. The Review concentrates on the two federal measures that are most likely to achieve substantial reductions in impaired driving and alcohol-related crashes: the enactment of comprehensive RBT legislation and a federal .05% BAC offence. While it would be ideal to introduce both of these measures, there is little support for a .05% BAC offence in the current political climate. Accordingly, MADD Canada's main priority at the federal level should be the introduction of comprehensive RBT legislation and programs.

The Review then addresses practical measures for strengthening the apprehension and prosecution of impaired drivers admitted to hospital following a crash (taking blood samples), and drug-impaired drivers (random saliva screening). These measures, which are based on principles complementary to RBT, should be simpler to advocate once federal RBT legislation is enacted. The Review concludes with a brief discussion of proposed amendments to the *Criminal Code's* alcohol interlock provisions.

MADD CANADA'S FEDERAL LEGISLATIVE PRIORITIES

I. FEDERAL RANDOM BREATH TESTING (RBT) LEGISLATION

(a) Introduction

There is considerable support at the federal level for introducing RBT. In 2009, the House of Commons Standing Committee on Justice and Human Rights unanimously recommended that the federal government enact RBT legislation.²⁷ The government accepted the Committee's recommendation in principle, and the Department of Justice issued a discussion paper and convened a two-day workshop endorsing RBT in March 2010.²⁸ The federal government is currently considering this recommendation.

Enacting RBT legislation would change the grounds that police need to demand a preliminary breath test on an "approved screening device" (ASD). While Canadian police currently have a common law power²⁹ and, in most jurisdictions, express statutory authority³⁰ to stop any vehicle at random, they can only demand an ASD test from a driver who they reasonably suspect has alcohol in his or her body.³¹ Sobriety checkpoint programs like Canada's, in which preliminary testing requires individualized suspicion, involve what is generally referred to as "selective breath testing" (SBT).

Research indicates that police, using their unaided senses, fail to detect the great majority of drinking drivers, even at SBT checkpoints. An early Swedish government report found that the majority of drivers with BACs of .05% to .15%, and nearly half of the drivers with BACs above .15%, aroused no suspicion when stopped by police at a simulated roadblock.³² A 1997 American study reported that the police missed over 60% of drivers with BACs above .08%, and almost 90% of those with BACs of .05%-.079%.³³ Other American studies suggest that police

fail to detect about 50% of drivers with BACs of .10% or more, and 75% of those with BACs of .05%-.099%.³⁴

A Canadian study published in 1982 concluded that approximately 95% of drivers with BACs above .08% were not detected during an Etobicoke sobriety checkpoint (SBT) program.³⁵ This is consistent with an earlier Alberta study, which found that the police detected only about 8% of the drivers with BACs above .08% whom they had stopped and checked.³⁶ Although these studies are dated, little appears to have changed. In 2009, the House of Commons Standing Committee on Justice and Human Rights reached a similar conclusion on detection rates at sobriety checkpoints.³⁷ Although millions of Canadians are stopped at SBT checkpoints each year, only a tiny fraction are subject to ASD testing.³⁸

Indeed, researchers have questioned the deterrent impact of SBT checkpoints that rely exclusively on the officer's subjective judgment as to whether breath testing is warranted. For example, Professor Ross Homel, Australia's most prolific RBT researcher, stated in a 1990 article:

[M]any drivers... play "breathalyser roulette," perceiving the odds of apprehension are slight and that they can conceal their drinking successfully. Consequently, any method of enforcement that relies on subjective judgments of impairment... is unlikely to work over the long term simply because the perceived probabilities of apprehension cannot be maintained at a high level.³⁹

In other words, the low detection rates associated with SBT not only allow impaired drivers to escape criminal sanction and continue driving, but also reduce the deterrent effect of the law. If drivers' experience is that they can evade detection, even at a sobriety checkpoint, they will be more likely to drink and drive in the future. In contrast, all drivers passing through RBT checkpoints are subject to ASD testing, thereby greatly increasing actual and perceived detection rates, and enhancing the law's deterrent effects. As the international experience, outlined below, indicates, the increased deterrence associated with RBT leads to substantial reductions in alcohol-related crashes, injuries and deaths.

Apart from the basis for demanding an ASD test, RBT would not alter impaired driving enforcement processes. As is currently the case, the results of ASD testing based on RBT would be inadmissible in criminal proceedings, but rather would be used solely to screen drivers to determine if evidentiary breath testing is warranted. Drivers who test above a predetermined BAC (typically .10%) would be required to provide evidentiary breath samples on an approved instrument at the police station, and would be afforded the right to legal counsel and all the procedural safeguards that evidentiary testing entails.⁴⁰ Drivers who register a "pass" on the RBT test would be free to go, and no record of the test would be kept.

(b) The International Experience with RBT

The persistence of impaired driving is not a challenge that is unique to Canada. However, most developed and developing countries have chosen to respond by implementing RBT programs. A 2008 study and earlier international reviews indicate that 46 of 56 countries (82%) had an RBT program established under national or, in a few cases, state/territorial legislation (see Table 1).⁴¹

Finland, Sweden and France introduced RBT programs in the late 1970s, followed by most Australian jurisdictions in the 1980s.⁴² Most other European countries and New Zealand enacted RBT legislation in the 1990s.⁴³ In 2003, the European Commission recommended that all member states of the European Union introduce comprehensive RBT legislation.⁴⁴ Ireland, the most recent country to do so, initiated its RBT program in 2006.⁴⁵

Table 1: Reported Use of Random Breath Testing in Selected Countries

With RBT			Without RBT
Argentina	Germany*	New Zealand	Canada
Austria	Greece	Norway	Dominican Republic
Australia	Guatemala	Peru	Ecuador
Belgium	Honduras	Poland	El Salvador
Brazil	Hungary	Portugal	Panama
Bulgaria	Iceland	South Korea	Russia*
Chile	Ireland	Romania	South Africa
China	Italy	Slovakia	United Kingdom
Columbia	Japan	Slovenia	United States
Costa Rica	Latvia	Spain	Venezuela
Cyprus	Lithuania	Sweden	
Czech Republic	Luxembourg	Switzerland	
Denmark	Malta*	Turkey	
Estonia	Mexico	Ukraine	
Finland	Moldova		
France	The Netherlands		

*The sources differed regarding RBT in these countries.

Jurisdictions that have introduced RBT programs have experienced significant reductions in impaired driving and alcohol-related crashes, deaths and injuries.⁴⁶ The best documented and most widely studied RBT programs are the Australian programs. Beginning with the State of Victoria in 1976, RBT programs were introduced throughout Australia during the 1980s. The early results of RBT were extremely dramatic,⁴⁷ such that “[m]any early reactions to RBT by police, the medical profession and the media could only be described as euphoric.”⁴⁸ However, the early studies also indicated that the impact of RBT would wane over time unless high rates of testing and publicity were maintained.⁴⁹

The most comprehensive review of the Australian RBT programs was a rigorous time series analysis of the long-term effects of RBT in four jurisdictions, published in 1997.⁵⁰ Consistent with the earlier research, the 1997 study identified four essential elements of successful RBT programs. First, maximizing RBT’s deterrent impact requires high levels of testing. The equivalent of at least one-third of licensed drivers must be tested each year,⁵¹ but even higher testing levels are preferable.⁵² Second, the program should be extensively publicized, focusing specifically on the high risk of apprehension. Third, enforcement should include both mobile

RBT and high-visibility stationary RBT checkpoints. Fourth, in order to sustain the ongoing deterrent impact of an RBT program, enforcement and publicity levels must be maintained.⁵³ The RBT program in New South Wales included these elements from the outset, and was regarded as the most successful program⁵⁴ and as a model for effective RBT implementation.⁵⁵

Broader reviews of impaired driving countermeasures have also noted the general success of the Australian RBT programs. For example, a 2005 study stated that the Australian RBT programs resulted in as much as a 24% reduction in nighttime crashes, especially in metropolitan areas.⁵⁶ A 2009 review reported that RBT reduced total crashes in Australia by 22%.⁵⁷

Similar positive results have been reported in other jurisdictions that introduced comprehensive RBT programs. RBT was largely credited with reducing the percentage of Dutch drivers with BACs over .05% from 15% in 1970 to 4.5% in 2000.⁵⁸ The Finnish RBT program was found to have reduced the number of drinking drivers on the road by 58% between 1979 and 1985.⁵⁹ Moreover, a 2008 study involving the capital cities in the countries of the European Union reported that all of the cities with above-average decreases in traffic fatalities had RBT programs in place.⁶⁰

In Ireland, RBT was credited with reducing total road fatalities by 19% from the preceding 12 months.⁶¹ There was also a reported 10% decrease in traffic-related hospital admissions in the six months following the introduction of RBT.⁶² Moreover, the deterrent impact of Ireland's RBT program appears to have risen dramatically in the ensuing four years. A 2010 report indicated that total traffic fatalities in Ireland had fallen 42% since the 2006 introduction of RBT.⁶³

Of particular relevance to Canada is the impact of RBT in New Zealand, a country which, like Canada, had an SBT program prior to the introduction of RBT in 1993. New Zealand's RBT program has been described as having had "dramatic, sustained effects" that are "unusually high for highway safety measures."⁶⁴ A 2009 meta-analysis found that the introduction of RBT in New Zealand led to a 14% reduction in total crashes.⁶⁵ The New Zealand experience strongly supports the contention that RBT is more effective than SBT.

(c) Random Breath Testing versus Selective Breath Testing

In addition to New Zealand, other jurisdictions have reported significant declines in impaired driving deaths after moving from SBT to RBT. For example, Queensland's RBT program resulted in a 35% reduction in fatal crashes, whereas the previous SBT program had resulted in only a 15% reduction.⁶⁶ Thus, RBT was more than twice as effective as SBT in reducing fatal crashes.⁶⁷ In commenting on the shift from SBT to RBT, Ross Homel stated, "[n]othing in the Australian experience encourages the belief that, without the use of full random testing, roadblock or sobriety checkpoints are capable of delivering a substantial and sustained reduction in alcohol-related casualty crashes."⁶⁸ As discussed below, this comparative effectiveness of SBT and RBT will be important in justifying any violations under the *Canadian Charter of Rights and Freedoms*.⁶⁹

While some researchers have reported little difference in the effectiveness of RBT and SBT,⁷⁰ their results must be viewed with caution. As we have explained elsewhere,⁷¹ these studies did

not directly compare RBT and SBT checkpoints, nor did they consider the additional traffic safety benefits achieved when jurisdictions like Queensland, Western Australia, New Zealand and Ireland replaced their SBT programs with RBT programs.

Perhaps more importantly, the studies failed to distinguish between different types of SBT programs, and consequently tended to overestimate their effectiveness. For instance, the studies included reference to several American SBT programs where police officers used passive alcohol sensors (PAS), including the famously successful “Checkpoint Tennessee.” PAS devices are small, hand-held devices that are used to detect alcohol in the ambient air around a driver’s mouth. PAS devices can improve the detection of impaired drivers by 50% or more.⁷² It is unhelpful to equate the effectiveness of such programs with Canadian SBT programs, where officers do not use PAS devices and must instead rely on their unaided senses to detect impaired drivers. Indeed, a recent American study showed that a three-year SBT program in Maryland that did not use PAS devices had no impact whatsoever on alcohol-related crashes and injuries.⁷³

It must also be noted that “Checkpoint Tennessee” and some of the other American SBT programs measured the traffic safety benefits of moving from an enforcement model that relied almost exclusively on routine patrol activities to high-visibility, heavily-publicized, intensive SBT. For example, in the Tennessee study, the number of checkpoints increased from 15 in the preceding year to 900 in the program year.⁷⁴ The accompanying mass media campaign included thousands of television and radio public service announcements, print media, mobile billboards, “earned” (independent) media coverage, and public information brochures.⁷⁵ The relevance of these studies to Canada is questionable, given our current widespread use of moderately intensive SBT programs. While strengthening Canada’s SBT programs would have traffic safety benefits, these would not approach those reported in the American studies, where there was a sudden wholesale change in the enforcement approach and its intensity.

Given the prevalence with which Canadians continue to drink and drive, and our comparatively low charge rate for impaired driving, it is obvious that Canada’s existing method of SBT enforcement is ineffective. The perceived and actual rate of apprehension is extremely low, with the consequence that the criminal law has minimal deterrent effect. The international experience indicates that RBT will significantly increase perceived and actual detection rates, and thereby improve the law’s deterrent effect. This, in turn, will reduce alcohol-related crashes, injuries and deaths.

(d) Public Support for RBT

Research indicates that RBT enjoys widespread public support. In 2002, 98.2% of Queensland drivers supported RBT.⁷⁶ Moreover, public support appears to increase significantly after RBT is enacted.⁷⁷ There is already broad support for RBT in Canada. An Ipsos Reid survey conducted in 2010 found that 77% of Canadians either “strongly” (46%) or “somewhat” (31%) support the introduction of RBT. When informed of RBT’s potential to reduce impaired driving, 79% agreed that RBT is a “reasonable intrusion on drivers.” Seventy-five percent also agreed that police should be allowed to “randomly require all drivers to give a breath test to help detect impaired driving.”⁷⁸ Finally, 98% of respondents considered impaired driving to be a “very important” (81%) or “somewhat important” (17%) public safety issue, and 87% thought that “more could be

done to address the problem.”⁷⁹ These survey data reflect not only the public’s concerns about impaired driving but also its willingness to submit to RBT in the interests of public safety.

(e) Cost-Effectiveness

RBT is generally acknowledged to be among the most cost-effective impaired driving countermeasures.⁸⁰ In 1990, the estimated annual cost of the New South Wales RBT program, including media, was \$3.5 million. At that time, the program was conservatively estimated to save 200 lives per year, with attendant savings of at least \$140 million. Based on these figures, the program had a cost-benefit ratio of 1:40.⁸¹ Most of the savings were in the area of health care and resulted from the reduction in fatalities and serious injuries. A 2003 European Union study concluded that increasing RBT testing levels to one test per 16 inhabitants would save between 2,000 and 2,500 lives, and result in a cost-benefit ratio of 1:36 or 1:55, depending on the model used.⁸² Similarly, a 2004 New Zealand study reported a cost-benefit ratio of 1:14 for RBT alone, 1:19 for RBT coupled with a media campaign, and 1:26 for RBT in conjunction with both a media campaign and “booze buses” (large, specially equipped vehicles used for on-site evidentiary breath testing, which are typically brightly coloured or otherwise distinctive to attract the attention of all nearby road users).⁸³

Although it is difficult to predict the cost savings that would result if RBT were introduced in Canada, a recent study conservatively estimated that RBT would generate total social cost savings of over \$4.3 billion.⁸⁴ A large portion of these costs reflect the human consequences of crashes, including health-related expenditures and lost productivity. The same study estimated that, while RBT would undoubtedly entail increased police enforcement costs, these would largely be offset by a reduction in the police resources devoted to attending and following up on impairment-related crashes.⁸⁵

(f) Driver Inconvenience

The cost-effectiveness of RBT derives in part from its ability to process large numbers of drivers in a relatively short period of time. Once stopped, drivers are typically asked to provide a breath sample without any preliminary discussion, observation or review of the driver’s documents. The driver remains seated in the car, and the breath test itself takes approximately 30 seconds. A Finnish study reported that drivers undergoing RBT were detained on average for just seconds and that a team of ten officers could test 500 drivers in half an hour.⁸⁶ More recently, a 2004 New Zealand study indicated that drivers were usually waved through when lineups developed, resulting in a total delay of two minutes or less for most drivers who did not require evidentiary testing.⁸⁷ Thus, on average, RBT will result in detentions of about the same, or perhaps even shorter, duration as the detentions that currently result from Canadian SBT processing.⁸⁸

(g) RBT and the *Charter*

As with any expansion of police enforcement powers, RBT will inevitably be challenged under the *Charter*. The most likely challenges will be under section 8 (the right to be free from unreasonable search and seizure), section 9 (the right to be free from arbitrary detention) and section 10(b) (the right to counsel). We have provided a comprehensive assessment of these

Charter arguments elsewhere,⁸⁹ and have received the endorsement of Canada's leading constitutional law scholar, Peter Hogg, QC. As we summarize below, given RBT's important legislative objective and minimally intrusive nature, it should pass *Charter* scrutiny.

(i.) Section 9

Like the existing sobriety checkpoint programs in Canada, RBT will be found to constitute an arbitrary detention. In *R v Hufsky*,⁹⁰ the Supreme Court of Canada found that a driver who was stopped in an organized spot check was arbitrarily detained for the purposes of the *Charter*. Although the stop was "of relatively brief duration," the key factor was that "the police officer assumed control over the movement of the [accused] by a demand or direction that might have significant legal consequences, and there was penal liability for refusal to comply with the demand."⁹¹ The element of coercion was sufficient to make the stop a "detention" under section 9. The detention was found to be arbitrary because "there were no criteria for the selection of drivers to be stopped and subjected to the spot check procedure."⁹² Following *Hufsky*, there is little doubt that RBT will be found to involve an arbitrary detention. However, like the spot check in *Hufsky*, RBT should also be upheld under section 1 of the *Charter*.

(ii.) Section 10(b)

Similarly, RBT will undoubtedly be found to violate the right to counsel under section 10(b) of the *Charter*, which is triggered whenever a person is "detained." The Canadian courts have unanimously held that the right to counsel is triggered when a driver is directed to provide a breath sample on an ASD,⁹³ to answer police questions,⁹⁴ or to submit to physical coordination testing⁹⁵ for the purposes of determining impairment. Requiring drivers to submit to these tests without the opportunity to consult counsel infringes section 10(b). However, the Supreme Court of Canada has upheld these infringements of section 10(b) under section 1 of the *Charter*. As discussed below, RBT should be similarly upheld.

(iii.) Section 8

The most vigorous challenge to RBT will come under section 8 of the *Charter*, which protects the right to be free from unreasonable search and seizure. The Canadian courts have taken the position that any warrantless search or seizure is presumptively unreasonable,⁹⁶ and will need to be justified in accordance with the three-part test laid out in *R v Collins*: (i) Was the search or seizure authorized by law? (ii) Is the law itself reasonable? (iii) Was the search or seizure carried out in a reasonable manner?⁹⁷ Since RBT would be enacted through amendments to the *Criminal Code*, it would be "authorized by law." The main debate will centre on the reasonableness of the law itself.⁹⁸

While the case law on what constitutes an unreasonable search or seizure under section 8 is quite complex, it is essentially reduced to balancing the individual's right to privacy against the relevant government interest. The Canadian courts have consistently found that there is an expectation of privacy with respect to one's breath and bodily fluids.⁹⁹ However, this is a qualified expectation of privacy, particularly in situations involving a regulated activity, like driving, and where there is a significant risk to public safety.¹⁰⁰ Thus, for example, the courts

have upheld warrantless strip searches¹⁰¹ and so-called “bedpan vigils”¹⁰² at Canada’s airports, and random screening of all courthouse entrants,¹⁰³ as reasonable in the interests of public safety.

On the spectrum of bodily intrusions that have been upheld by the Canadian courts, RBT is relatively innocuous. It seems even less intrusive than having hair samples or buccal swabs taken for DNA analysis, which were found not to violate section 8 in *R v SAB*.¹⁰⁴ A breath test on an ASD takes only seconds, and does not involve pain or discomfort. There is no intrusion into the driver’s body, nor an exposure of any body parts that are normally concealed. It reveals no information about the driver apart from his or her BAC.¹⁰⁵ Finally, given that every driver passing through an RBT checkpoint is asked to provide a breath sample, there is nothing humiliating or stigmatizing about being tested.¹⁰⁶

In many respects, RBT is comparable to the random screening procedures used at airports, the borders, courthouses, and many government buildings, where every passenger or entrant is required to pass through metal detectors and have his or her baggage and/or person searched. In 2008, over 109 million passengers were subject to random screening and search procedures at Canada’s airports, and an additional 67 million travelers were subject to random screening and search at Canada’s borders.¹⁰⁷ Moreover, in recent years, airport searches in particular have become far more extensive. It is not uncommon for passengers to be swabbed for explosives’ residue, scanned for weapons and explosives concealed under their clothing, subject to thorough pat-down searches, and required to empty their pockets into a tray and remove their shoes, belts and jewellery.

While the Supreme Court has reasoned that more intrusive searches are justifiable at borders because of state security interests,¹⁰⁸ we would question whether these interests are fundamentally different or any greater than the state interest in road safety. To put it bluntly, many more people are killed in alcohol-related crashes every year than by terrorist attacks on airplanes or, for that matter, throughout all of Canada. Thus, while it is politically easy to justify invasive searches in the name of national security, we are not convinced that sharp distinctions can be drawn in Canada between the state interest in random breath testing of drivers on our roads and random searches at our courts, borders and airports. Further, we would venture to say that, for many people, it is a much greater intrusion on privacy to have one’s purse, briefcase and luggage searched, and much more humiliating to be patted down in public or strip-searched in private at a busy airport, than it is to provide a breath sample while sitting in one’s car for two minutes at roadside like every driver passing through an RBT checkpoint.

In our view, a compelling case can be made that RBT does not amount to an unreasonable search under section 8 of the *Charter*. However, even if it is found to violate section 8, we believe it can be justified under section 1.

(iv.) Section 1

In all likelihood, RBT will be found to violate sections 9 and 10(b) of the *Charter*. As a result, it will need to be justified under section 1 as being a reasonable limit “prescribed by law [that] can be demonstrably justified in a free and democratic society.” We believe that, like other comparable impaired driving countermeasures, RBT will be upheld. This requires analysis of the five elements set out in *R v Oakes*: (i) Is the infringement prescribed by law? (ii) Does it respond

to a pressing and substantial legislative objective? (iii) Is the measure rationally connected to the objective? (iv) Does it infringe the *Charter* right in issue as little as possible (also known as the “minimum impairment” or “least drastic means” test)? and (v) Do its positive effects outweigh its deleterious effects?¹⁰⁹

We have discussed at length elsewhere why any *Charter* violations entailed in RBT would be upheld as justifiable under section 1.¹¹⁰ Experience shows that nearly all section 1 cases turn on the minimum impairment test, and this is likely where the challenge to RBT will be most robust. Consequently, rather than replicating our earlier analysis in full, we have focused the following analysis on the minimum impairment test.

Should the courts rule that RBT infringes section 8 of the *Charter*, the government would need to show that RBT impairs a driver’s constitutional rights as little as necessary (ie, that it is the least drastic means of achieving the government’s objective). The overarching argument at this stage would be that Canada’s previous attempts to reduce impaired driving have not had a sufficient impact. The research on the relative effectiveness of RBT indicates that there is no lesser infringement on *Charter* rights that will significantly increase the deterrent impact of the impaired driving law.

For section 8 purposes, the bulk of the “minimum impairment” debate will likely centre on the relative effectiveness of RBT and Canada’s existing SBT provisions.¹¹¹ Some will argue that SBT is just as effective as RBT and is preferable because it involves a lesser infringement of constitutional rights. Thus, to be successful, the government will have to demonstrate that the existing SBT provisions are insufficient to achieve its objective of deterring impaired driving. Canada’s poor impaired driving record alone is sufficient to establish this. Moreover, when Queensland, Western Australia, New Zealand and Ireland replaced SBT with RBT, they experienced significant and sustained declines in impaired driving and related crashes.

With respect to sections 9 and 10(b) of the *Charter*, the minimum impairment test should be satisfied with relative ease. The Supreme Court has already upheld the detention involved in random spot checks as a minimum impairment of section 9. As Cory J remarked in *Ladouceur*:

Surely the preventive medication of requiring drivers to stop... is preferable to the incurable terminal tragedy represented by the fatal accident victim and the permanently disabled victim. Surely it must be better to permit the random stop and prevent the accident than to deny the right to stop and repeatedly confirm the sad statistics at the morgue and hospital.¹¹²

As discussed, the duration of the detention involved in RBT will be comparable to current roadside checkpoints. Moreover, because all drivers will be tested, no one will be stigmatized by being “singled out” or “targeted” for testing. Accordingly, pursuant to the reasoning in *Ladouceur*, RBT should be found a minimum impairment of section 9.

Similarly, the denial of the right to counsel under section 10(b) of the *Charter* has already been upheld for various roadside screening measures. In *R v Thomsen*,¹¹³ for example, LeDain J explained that the need to conduct the ASD test quickly at roadside simply did not allow for a prior opportunity to consult counsel. This logic applies with even more force to RBT. The effectiveness of RBT depends on the police being able to process the maximum number of

drivers in a minimum amount of time. The deterrent purpose of RBT would be frustrated if every driver were able to consult counsel.¹¹⁴ Further, RBT is used as a preliminary screening tool only and its results do not directly attract any criminal consequences. If the results indicate that a driver has a BAC above the *Criminal Code* limit, the driver will be given the right to retain and instruct counsel prior to any evidentiary breath tests. Therefore, section 10(b) is infringed as little as possible.¹¹⁵

II. ENACTING A .05% BAC OFFENCE

The current *Criminal Code* .08% BAC limit allows individuals to drive after consuming very large quantities of alcohol. Given the margin of error accepted by our courts, most police will not lay criminal charges unless a driver's evidentiary BAC readings are above .10%.¹¹⁶ Thus, an average 200-pound man can drink over six bottles of regular-strength beer (12 ounces at 5% alcohol by volume) in two hours, on an empty stomach, and then drive largely immune from criminal sanction.¹¹⁷ Indeed, it is unlikely that he would even be charged.

Since Canada enacted its current .08% BAC limit in 1970, numerous laboratory, driving simulator, and closed access roadway studies have established that even small amounts of alcohol adversely affect driving skills and performance.¹¹⁸ For example, a comprehensive 2004 study concluded that there is no evidence of a threshold BAC below which impairment does not occur, and no category of drivers who are not impaired by alcohol.¹¹⁹ Research has also established that the relative risk of crash death rises sharply starting at BACs of .05%, particularly for young males.¹²⁰ More recent American studies, using improved epidemiological methods, have established that the relative risks of a fatal crash at BACs above .05% are far higher than what Parliament believed when it enacted Canada's .08% BAC limit.¹²¹

In response to the research, the vast majority of countries have made it an offence to drive with a BAC of .05% or higher (see Table 2).¹²² Virtually every jurisdiction that lowered its permissible BAC limit has experienced significant reductions in impaired driving deaths and injuries.¹²³ For example, a long-term study of the Netherlands' .05% BAC law, introduced in 1974, suggested that it contributed to a broad and sustained decline in the total number of drinking drivers.¹²⁴ In Belgium, where the BAC limit was reduced to .05% in 1994, there was a 10% decrease in traffic fatalities in 1995, and a further 11% decrease in 1996.¹²⁵ Positive results were also reported in France,¹²⁶ Austria,¹²⁷ Sweden,¹²⁸ Germany,¹²⁹ and Denmark.¹³⁰

Perhaps the best documented effects of lowering the BAC limit from .08% to .05% occurred in the various Australian states. For example, after Queensland reduced its *per se* BAC limit to .05% in December 1982, there was a 14% reduction in serious collisions and an 18% reduction in fatal collisions.¹³¹ Similarly, the .05% BAC restriction in New South Wales was estimated to have reduced serious collisions by 7%, fatal collisions by 8%, and single-vehicle nighttime collisions by 11%.¹³² This translated into the prevention of 605 serious, 75 fatal, and 296 single-vehicle nighttime collisions per year.¹³³

It is particularly noteworthy that lower BAC limits in Australia had a substantial effect on drivers with high BACs (above .15%). For instance, a study in the Australian Capital Territory examined

RBT data for the 12 months prior to and after the .05% BAC limit was enacted.¹³⁴ The researchers found a 34% decrease in the percentage of drivers with BACs between .15% and .199%, and a 58% decrease in the percentage above .20%. Given that drivers with high BAC levels are at the greatest relative risk of crash,¹³⁵ such reductions would have a substantial impact on the number of alcohol-related deaths and injuries. Thus, even though a .05% BAC limit would appear to be aimed at drivers with moderate BACs, its potential impact on high-BAC drivers has important traffic safety implications.

As a result of this evidence on the benefits of lower BAC limits, nearly every reputable traffic safety, injury prevention and public health organization supports BAC limits of .05% or lower.¹³⁶ Thus, Canada's federal .08% BAC limit is out of step with the driving laws in much of the world, particularly the leaders in traffic safety.

Table 2: BAC Driving Limits in High and Middle Income Countries

BAC	Countries
.00%	Azerbaijan, Bahrain, Czech Republic, Hungary, Iran, Kuwait, Libyan Arab Jamahiriya, Micronesia, Qatar, Romania, Saudi Arabia, Slovakia, and Ukraine.
.01% - .04%	Algeria, Bosnia and Herzegovina, Brazil, China, Colombia, Congo, Estonia, Georgia, Japan, Lithuania, Norway, Panama, Poland, Russia, and Sweden.
.05%	Albania, Argentina, Australia, Austria, Belarus, Belgium, Bulgaria, Chile, Costa Rica, Croatia, Cyprus, Denmark, El Salvador, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Latvia, Lebanon, Macedonia, Mauritius, Moldova, Mongolia, Montenegro, Nauru, Netherlands, Nicaragua, Peru, Philippines, Portugal, San Marino, Serbia, Slovenia, South Africa, South Korea, Spain, Suriname, Swaziland, Switzerland, Syria, Taiwan, Thailand, Tunisia, Turkey, and Turkmenistan.
.08% - .10%	Armenia, Bahamas, Belize, Botswana, Brunei, Cameroon, Canada, Ecuador, Fiji, Guatemala, Guyana, Honduras (.07%), Iraq, Jamaica, Jordan, Luxembourg, Malaysia, Malta, Mexico, Namibia, New Zealand, Oman, Paraguay, Puerto Rico, Saint Lucia, Seychelles, Singapore, Sri Lanka, Trinidad and Tobago, United Kingdom, United States, Uruguay, and Venezuela.

Sources: WHO, *Global Status Report on Road Safety: Time For Action* (Geneva: WHO, 2009), Table A.5; and International Center For Alcohol Policies (ICAP), *Blood Alcohol Concentration Limits Worldwide* (Washington: ICAP, 2009) at 3.

MADD Canada has previously called for the creation of a federal .05% offence to supplement the current .08% BAC offence, creating a tiered approach based on the driver's BAC.¹³⁷ For instance, the .05% offence could include more streamlined procedures, such as ticketing provisions, and lower penalties.¹³⁸ Further, offenders without a subsequent *Criminal Code* impaired driving conviction within two years could be deemed not to have a criminal record for the .05% offence, and the related information could be automatically destroyed. Bills incorporating these features have already been drafted and introduced in both the Senate and House of Commons.¹³⁹

Unfortunately, the federal government rejected proposals to introduce a .05% BAC offence. Thus, while we remain supportive of this measure, it is apparent that MADD Canada's federal law reform efforts should be focused elsewhere. Some of the traffic safety benefits associated with a federal .05% BAC limit could be achieved at the provincial level, where legislators seem more receptive to such reforms. To this end, MADD Canada developed model provincial administrative licence suspension legislation for drivers with a BAC above .05%. The model called for immediate seven-day administrative licence suspensions, vehicle impoundments, \$150-\$300 licence reinstatement fees, and the recording of all suspensions on the driver's record. Heavier sanctions and mandatory remedial measures were set out for subsequent suspensions within specified time periods. The Canadian Council of Motor Transport Administrators (CCMTA) adopted a modified version of the model.¹⁴⁰

Provincial developments on administrative .05% BAC limits are promising. In recent years, several provinces have increased the sanctions for driving with a BAC of .05% and above, and have improved record-keeping procedures for those who routinely drive at these BAC levels.¹⁴¹ However, as is generally the case with provincial countermeasures, there is a patchwork of .05% BAC provisions in place across the country. The relevant legislation does not make it an offence to drive with a BAC above .05%, but instead empowers the police to issue a short-term licence suspension at roadside. In several provinces, the consequence of driving with a BAC above .05% is simply a 24-hour roadside suspension, and no record of such suspensions is kept. Moreover, Québec has no short-term licence suspension program at all. Thus, the deterrent effect of the provincial .05% BAC laws is not comparable to that of a uniform federal .05% BAC offence.

III. TAKING BLOOD SAMPLES FROM HOSPITALIZED DRIVERS

Although impaired driving is the leading criminal cause of death in Canada, there are relatively few charges and convictions for the most serious impaired driving offences. While there were 1,074 deaths attributable to impaired driving in 2009,¹⁴² there were only 120 charges¹⁴³ and 53 convictions for impaired driving causing death.¹⁴⁴ Similarly, there were an estimated 63,338 impaired driving injuries in 2009, but only 804 charges and 313 convictions for impaired driving causing bodily harm. Even discounting for multi-casualty crashes and impaired drivers who kill or injure only themselves, the fact remains that relatively few impaired drivers who kill and injure others are charged, let alone convicted, of impaired driving causing death or bodily harm.

In large part, this is because of difficulties in gathering BAC evidence from impaired drivers who are taken to hospital following a crash. As outlined below, the *Criminal Code* provisions that allow police to demand or seize blood samples from hospitalized drivers are technically complex, and create complicated interactions between healthcare professionals and police. This results in a very low conviction rate for hospitalized impaired drivers. For instance, a 2004 British Columbia study reported that only 11% of drivers with BACs above .08% who were hospitalized following a crash were convicted of any *Criminal Code* impaired driving offence.¹⁴⁵ It is worth noting that the mean BAC of the alcohol-positive drivers was .15%. By contrast, in Sweden, where the police have broader powers to demand blood samples, it was reported that 85% of hospitalized drinking drivers were convicted of impaired driving.¹⁴⁶

It is tragically ironic that those impaired drivers who cause the most serious crashes are the least likely to be convicted of a criminal impaired driving offence. Perhaps more importantly, these drivers have high rates of recidivism and pose an ongoing risk to the public. For example, a British Columbia study indicated that 30.7% of impaired drivers who were hospitalized following a crash had a subsequent alcohol-related crash, impaired driving conviction or alcohol-related administrative licence suspension within 4½ years.¹⁴⁷ Consequently, MADD Canada supports *Criminal Code* amendments that would make it easier for the police to gather BAC evidence from suspected impaired drivers who have been taken to hospital following a crash.

(a) Authority to Conduct ASD Tests at Hospital

Police can demand an ASD test from a driver who they reasonably suspect has any alcohol in his or her body.¹⁴⁸ However, the *Criminal Code* requires that breath samples on an ASD be provided “forthwith,” which the courts have interpreted as meaning “immediately” and typically at roadside.¹⁴⁹ Thus, for example, an ASD demand was found to be invalid when the officer had to wait 30 minutes for it to be delivered to the scene.¹⁵⁰ Similarly, a demand was held to be invalid where the suspect was required to walk four minutes to the “checkstop bus” where the ASD was located.¹⁵¹

The requirement that ASD tests be conducted “forthwith” means that it is effectively impossible for police to demand an ASD test at the hospital. Consequently, the police are deprived of an important screening tool that would be available with respect to other impaired driving suspects. There is no reason, in terms of logic or trial fairness, for hospitalized impaired driving suspects to be treated differently than suspects on the road. The *Criminal Code* should thus be amended to grant police authority to demand an ASD test at the hospital from a driver who they reasonably suspect has any alcohol in his or her body. As with ASD tests conducted at roadside, a suspect who registers a “fail” should be subject to a demand for evidentiary samples, at which time he or she would be allowed to exercise the right to counsel.

(b) Evidentiary Blood Testing of Hospitalized Drivers

Where there are grounds to demand evidentiary tests from a hospitalized driver (whether because of a “fail” on an ASD or other reasons to believe that the driver was impaired by alcohol), MADD Canada recommends that the police be authorized to demand blood samples rather than breath samples taken on an approved instrument.

Under the current provisions of the *Criminal Code*, the police can only demand blood samples if, by reason of the suspect’s physical condition, he or she is incapable of providing breath samples or it is “impracticable” to obtain them.¹⁵² As we have explained elsewhere,¹⁵³ the courts have not consistently defined these prerequisites. While some judges have taken a realistic view of when a suspect’s medical treatment makes it impracticable to obtain breath samples,¹⁵⁴ others have insisted that the police demand breath samples unless it is “impossible in practice” to obtain them.¹⁵⁵ For example, it has been held that a police officer’s concerns about obtaining breath samples within the *Criminal Code*’s time constraints are not alone sufficient to justify a demand for blood samples,¹⁵⁶ and that a police officer should not make a decision about the suspect’s ability to provide breath samples without consulting medical personnel.¹⁵⁷

Thus, the *Criminal Code* provisions, as interpreted by the Canadian courts, often preclude police from demanding blood samples from hospitalized suspects. Instead, they must arrange for an approved breath-testing instrument and a qualified technician¹⁵⁸ to be brought to the hospital, find an appropriate room in which to conduct the tests (which may be difficult in crowded hospitals), set up and calibrate the instrument, provide the accused with an opportunity to consult with legal counsel, and conduct two breath tests at least fifteen minutes apart. All this must be done within a three-hour time limit,¹⁵⁹ during which time the suspect may also be receiving treatment.

By comparison, drawing a blood sample at the hospital would be relatively quick and simple. MADD therefore recommends that the *Criminal Code* be amended to remove the “preference” for breath samples in situations where an impaired driving suspect has been taken to hospital. Police should be authorized to demand blood samples instead.¹⁶⁰

(c) Demanding or Seizing Blood Samples Under Other Warrant Provisions

Two other provisions currently allow the police to obtain blood samples from suspected impaired drivers. First, in certain limited circumstances, police can obtain a special judicial warrant for the taking of blood samples from a suspect who is unable to respond to a demand for a blood test. Among other things, the officer must have reasonable grounds to believe that: the suspect committed an impaired driving offence in the previous four hours;¹⁶¹ the suspect was involved in a motor vehicle crash resulting in death or bodily harm; and a medical practitioner is “of the opinion” that, by reason of the crash or alcohol consumption, the suspect is unable to consent to a blood test.¹⁶² Typically, these warrants are sought when the suspect has been rendered unconscious or has suffered an injury, such as a serious concussion, that prevents him or her from responding to a demand. These provisions are technically complex and require the police to obtain what seems to be confidential medical information about the suspect.¹⁶³ Consequently, they are of limited use to police.

Second, under the general search warrant provisions of the *Criminal Code*, police may seize blood samples that have already been taken by medical personnel. However, the admissibility of blood samples seized under general search warrants is not guaranteed, and will depend on whether the court finds that hospital staff were acting as agents of the police or improperly released the suspect’s confidential health information.

Typically, blood samples will be admissible if they were originally taken for medical purposes, and were later seized by police who had formed an independent belief that the suspect was impaired by alcohol at the time of a crash.¹⁶⁴ By contrast, it will be considered an unreasonable search and seizure if medical personnel take a blood sample specifically for the purposes of assisting in a criminal investigation.¹⁶⁵ A search will also be viewed as unreasonable if medical personnel disclose confidential information, including the results of a toxicology screen, to the police in the absence of a warrant. For example, in *R v Dersch*,¹⁶⁶ the Supreme Court of Canada excluded blood samples that were seized under a general search warrant after a doctor disclosed the suspect’s BAC (.178% to .193%) to police. Major J stressed the “importance of guarding against a free exchange of information between health care professionals and police.”¹⁶⁷ The charges of impaired driving causing death and bodily harm were accordingly dropped.¹⁶⁸

The existing *Criminal Code* provisions place both police and hospital personnel in a difficult position. Police may not be able to obtain special or general warrants without obtaining information about a suspect's medical condition or treatment. However, it may be a breach of the healthcare professionals' confidentiality obligations to disclose such information to police in the absence of a court order, *subpoena*, or statutory reporting obligation.¹⁶⁹

For enforcement purposes, the ideal amendment would be a provision requiring medical personnel to take a blood sample from anyone brought to hospital after being involved as a driver in a motor vehicle crash, and to turn the blood sample over to police for BAC testing. Such provisions already exist in New Zealand and most Australian states,¹⁷⁰ and maximize the likelihood that impaired drivers will be detected and appropriately prosecuted.

However, it is unlikely that such provisions would pass *Charter* scrutiny in Canada. Taking blood samples without consent or prior suspicion that an offence has been committed, and then handing them over to the police, will most likely be considered an unreasonable search and seizure. Further, unlike RBT, which is used for screening purposes only, a blood sample taken at hospital would essentially be an evidentiary test, taken in violation of the right to counsel. Thus, the following is a more moderate set of legislative amendments, which are consistent with the *Charter*.

First, if a driver is taken to hospital following a crash, hospital personnel should be required to take and store a blood sample, unless this poses a danger to the patient. The sample should not be turned over to police (which would make hospital personnel police "agents" and possibly implicate them in a breach of section 8 of the *Charter*). Rather, the sample should be stored and only released to the police with the driver's consent or if they have a general search warrant to seize it. This would ensure that credible BAC evidence is available in crash situations, even if police cannot demand it within the *Criminal Code*'s time constraints. This would allow police to attend to the crash scene, assist other victims, and take the time to thoroughly investigate whether there are reasonable grounds to believe that the driver was impaired.

Second, the *Criminal Code* should clarify the obligations of medical professionals by requiring them to answer specific, limited questions that are necessary to assist police in investigating an alcohol-related crash, namely: whether they have taken a blood sample from the patient, and whether they have performed a BAC test. Such provisions would make any disclosure of the patient's personal information "required by law," and thus not in breach of the healthcare professionals' confidentiality obligations. Further, the disclosure of this minimal, relatively neutral information presents only a modest intrusion into patient privacy, and does not amount to an exchange of incriminating information between hospital staff and the police.

The above recommendations should substantially increase the likelihood that BAC evidence is available and admissible in cases involving hospitalized impaired drivers. These drivers will then be subject to appropriate charges and sanctions for their conduct, especially when it has led to death or serious personal injury.

Nevertheless, there are still gaps in the ability of police to gather evidence against suspected impaired drivers who are taken to hospital. In particular, if a driver is unconscious beyond the allowable period for making blood sample demands, and police are unable to independently form

the reasonable grounds necessary to seize an existing blood sample under a general search warrant, the driver may well be insulated from criminal liability. Although it is beyond the scope of this Review, MADD Canada may wish to explore whether this enforcement gap can be addressed by provincial driver licensing laws; for example, by providing implied consent for drivers to be tested if involved in a crash.

IV. TESTING FOR IMPAIRMENT BY DRUGS OTHER THAN ALCOHOL

Under section 253(1)(a) of the *Criminal Code*, it is an offence to operate a motor vehicle when one's ability to do so is impaired by alcohol or a drug. While drug-impaired driving has been an offence since the 1920s, the police were not given the means of enforcing the prohibition until 2008. This enforcement gap became a matter of growing concern when survey data indicated that driving after drug use had become more common.¹⁷¹ For example, several regional and national surveys indicated that more young Canadians reported driving after using cannabis than after consuming alcohol.¹⁷² It has been estimated that one-third of fatally-injured drivers in Canada had been using drugs.¹⁷³ The issue of drug-impaired driving is complicated, however, because not all drugs impair a person's ability to drive and because many drugs remain in a person's system long after their impairing effects have worn off.¹⁷⁴ In addition, some drivers may be impaired by more than one drug or by a combination of drugs and alcohol.¹⁷⁵ Thus, it is difficult to establish a standard threshold of impairment that is comparable to the per se .05% and .08% BAC limits for alcohol.

The 2008 amendments to the *Criminal Code* included two new measures aimed at enforcing the prohibition on drug-impaired driving. First, section 254(2)(a) authorizes the police to demand that a driver participate in a physical coordination test if they have reason to suspect that he or she has any alcohol or drugs in his or her body. Similar to breath tests on an ASD, the threshold for demanding physical coordination tests is relatively low. As in the case of ASD tests, the results of the physical coordination test can provide grounds for demanding an evidentiary breath test or a formal drug evaluation. It is an offence to refuse to comply with an officer's demand to perform a physical coordination test, without a reasonable excuse.¹⁷⁶

Second, the 2008 amendments authorize police to demand a drug evaluation test from a driver who the police have reasonable grounds to believe has, within the preceding three hours, driven while impaired by a drug or a combination of drugs and alcohol.¹⁷⁷ The results of this test, which is commonly known as a Drug Recognition Evaluation or DRE, are admissible in evidence at a criminal trial for impaired driving, as long as it was conducted in accordance with the relevant regulations and the driver was afforded the right to counsel.¹⁷⁸

Developed and widely used in the United States since the 1980s, DRE is designed to determine if an individual's ability to drive is impaired by one of seven classes of frequently abused drugs.¹⁷⁹ DRE is conducted by trained and certified "evaluating officers" and includes two major components. The first component includes 11 separate steps, including: an interview with the suspect and the arresting officer; various eye examinations; checking the suspect's temperature, pulse, blood pressure and muscle tone; and several divided attention tests to confirm that the

suspect's ability to drive is impaired. If the evaluating officer concludes, after the first component, that the suspect is impaired, the officer must identify the class of drugs involved.

It is only at this point that the officer can undertake the second component of the DRE, which entails demanding a sample of the suspect's blood, urine or saliva for analysis.¹⁸⁰ These chemical test results do not provide evidence of impairment, but rather, simply confirm if the class of drugs the officer identified was present in the suspect's body. A drug-impaired driving charge will only proceed to trial if the analysis of the suspect's bodily sample confirms the evaluating officer's conclusion about the class of drugs involved. Studies indicate that DRE is highly accurate in identifying the class of drugs that is present in a suspect's body.¹⁸¹

Physical coordination testing and the DRE are important first steps in the move to greater enforcement of the *Criminal Code's* prohibition of drug-impaired driving. However, DRE is complex, technical and time-consuming,¹⁸² and the process of training and certifying "evaluating officers" is rigorous and expensive.¹⁸³ While it is difficult to quantify, it is likely the case that drug-impaired driving is still significantly under-enforced in Canada.¹⁸⁴ Accordingly, the federal government should continue to pursue other, more effective methods of testing for drug-impairment, particularly for the most commonly used drugs.

Various jurisdictions have introduced other methods of defining and enforcing the prohibition against driving after drug use. Several European countries¹⁸⁵ and American states¹⁸⁶ have established *per se* limits for certain drugs, or prohibit driving with *any* amount of a given drug in one's system (also known as zero tolerance). An outright prohibition on driving with any drugs in one's system may not garner public or political support in Canada, given that drugs do not necessarily or consistently cause impairment, and that non-active metabolites of some drugs will result in drivers testing positive long after the drug's effects have worn off. Moreover, such a prohibition may be perceived as a back door attack on drug use, rather than on drug-impaired driving.¹⁸⁷ This would be particularly controversial if the *Criminal Code* were amended to allow for random roadside drug screening.

However, where it can be established that a given level of a drug can impair one's ability to operate a vehicle safely, establishing a *per se* limit in the *Criminal Code* would provide the most objective and efficient system of drug-impaired driving enforcement. At this stage, it would be prudent to target those drugs that are used most frequently prior to driving and whose impairing effects are best documented. Once such limits are established, the *Criminal Code* should provide authority for conducting preliminary screening tests (most likely saliva tests) at roadside, with more formal evidentiary testing, if warranted, conducted at a police station. These procedures would parallel those that already exist for alcohol-impaired driving.

To facilitate the enforcement of drug *per se* laws, the federal government should work to obtain a reliable, efficient and easy-to-use screening test that could be used for certain drugs at roadside. Like the ASDs used for alcohol, this roadside drug-screening test does not have to provide a precise or detailed toxicological result. Rather, it need only provide the officer with reasonable grounds to believe that the driver's drug level exceeds the *per se* limit. Such tests have already been used to conduct random roadside drug screening in some Australian states.¹⁸⁸ A driver who tests above the *per se* level at roadside could then be taken to an appropriate facility for evidentiary testing (through blood, saliva or urine, depending on the best means of identifying

the given drug). The results of such evidentiary testing would be admissible in evidence at a criminal trial, providing that procedures were correctly followed and the driver was given the right to counsel.

The drug-impaired driving legislation in the Australian state of Victoria may provide a useful model. The *Road Safety (Drugs Driving) Act, 2003* and *Road Safety (Drugs) Act, 2006* prohibit drivers from operating a motor vehicle with any level of methamphetamine, THC or MDMA in their systems. The legislation authorizes police to randomly demand an oral fluid (saliva) screening test from any driver at roadside. This initial screening test takes approximately five minutes.¹⁸⁹ If the driver tests positive for any of the three target drugs, he or she is required to accompany police to a testing vehicle where a second saliva sample is taken. The second sample is tested by a specially trained and qualified police officer. If it also shows the presence of a targeted drug, it is sent on to a laboratory for confirmatory analysis, and the driver is immediately prohibited from driving for a specified time. The driver will only be charged if the laboratory analysis confirms the presence of a targeted drug.

Preliminary analysis of Victoria's drug testing framework has shown positive results. All of the 489 drivers who were prosecuted pursuant to the legislation were convicted.¹⁹⁰ Another 17 were convicted for refusing to provide a sample. Drivers were processed relatively quickly (5 minutes for first test and 30 minutes for second test), which is considerably quicker than the roughly two hours needed for a complete an SFST and DRE in Canada.¹⁹¹ Further, the saliva tests provided an accurate indication that a targeted drug was in the driver's system. The Victorian legislation thus provides a model of efficient, accurate and relatively user-friendly drug testing. With appropriate modifications (using *per se* limits instead of zero tolerance, and providing an opportunity to consult counsel prior to evidentiary testing), the Victorian approach could be adopted by Canadian law enforcement.

Drug-impaired driving is a growing problem, and the related research and technology is evolving rapidly. While the 2008 amendments were an important first step in drug-impaired driving enforcement, the federal government should not assume that the problem has been appropriately addressed. Instead, the government should strive to find more accurate and efficient means of detecting drug-impaired drivers and subjecting them to appropriate criminal charges. Random roadside drug screening would provide police with an efficient, cost-effective tool for these purposes.

The provisions outlined above would complement MADD Canada's proposals for RBT, as they would allow for random drug screening at roadside, to be confirmed by subsequent evidentiary testing. Like RBT, random drug screening would allow police to process a large number of drivers with minimum inconvenience, and those testing negative would be free to return to the road in minutes. Taken together, RBT and random drug screening would significantly increase the perceived and actual risk of detection for drivers impaired by either alcohol or drugs (or both), and greatly enhance the deterrent effect of the existing law.

V. REDUCING THE “HARD” SUSPENSION FOR OFFENDERS WHO PARTICIPATE IN AN ALCOHOL INTERLOCK PROGRAM

In 1999, the *Criminal Code* was amended to allow the one-year federal driving prohibition for first impaired driving offenders to be reduced to three months if the offender participated in a provincial interlock program.¹⁹² Two years later, the *Criminal Code* was amended to permit the federal driving prohibitions for second and subsequent offenders who enrolled in an interlock program to be reduced to six and twelve months, respectively.¹⁹³ This amendment recognized that alcohol interlocks are an effective means of reducing recidivism among all impaired driving offenders, and was intended to encourage all offenders to participate in these programs.

Unfortunately, in most provinces, less than a quarter of impaired driving offenders enroll in the interlock program.¹⁹⁴ Clearly, an additional incentive is required to encourage the use of interlocks. MADD Canada therefore recommends that the minimum period of “hard” suspension or prohibition be reduced to 30, 60 and 90 days for first, second and subsequent offenders, respectively, who participate in a provincial interlock program.

In the past decade, research has indicated that the traffic safety benefits associated with alcohol interlock programs are worth the trade-off of having a shorter “hard” suspension period.¹⁹⁵ Indeed, a large percentage of suspended drivers continue to drive, and are at increased risk of crash when they do.¹⁹⁶ Moreover, suspended (and therefore uninsured) drivers expose all road users to significant risks of uncompensated losses.¹⁹⁷ The high rates of unlicensed driving undermine the deterrent and traffic safety benefits of lengthy licence suspensions.¹⁹⁸

Accordingly, it is justifiable to reduce the period of “hard” suspension for drivers who participate in an interlock program. While these offenders would still be on the roads, at least they would be required to drive sober. Research indicates that, when installed, alcohol interlocks can reduce impaired driving recidivism by approximately 65%.¹⁹⁹ Given that the first six months following an impaired driving conviction hold the highest likelihood of recidivism,²⁰⁰ it is worthwhile to install an interlock device sooner, rather than later.

The interlock program can be an important aspect of an offender’s overall remedial program. The provinces should develop integrated programs, in which the offender’s performance on the interlock is used to monitor his or her progress in alcohol treatment and in determining whether he or she is ready for full relicensure.²⁰¹ MADD Canada believes that such comprehensive programs are the most promising way to reduce the likelihood of recidivism. The federal government can take a leadership role by promoting early entry into provincial interlock programs.

CONCLUSION

Canada continues to have a very poor impaired driving record by international standards. The federal legislative amendments over the past decade have helped to close loopholes and

rationalize sentencing, but have not had a significant impact on the number and percentage of alcohol-related crash deaths and injuries. Given recent trends in alcohol consumption and availability, and the survey data on driving after drinking, it is unlikely that Canada's record will significantly improve without a substantive change in the federal law. In this review, we have suggested that the enactment of comprehensive RBT legislation and a federal .05% BAC offence are the most promising measures for significantly reducing impaired driving and alcohol-related crashes in Canada. Other measures, such as expanding authority to take blood samples from hospitalized impaired drivers, enhanced enforcement of drug-impaired driving, and greater incentives to participate in alcohol interlock programs, will also improve the enforcement and prosecution of existing impaired driving laws, and enhance public safety.

Given the lack of political will to introduce a lower BAC limit, MADD Canada's focus for federal reform should be on the introduction of comprehensive RBT legislation and programs. RBT has been proven effective around the world at deterring impaired driving and reducing its tragic consequences. It enjoys high levels of public support, which generally increase following its implementation. It has been shown to be highly cost-effective and causes minimal inconvenience to drivers. Without question, RBT will be subject to *Charter* challenges. However, we believe that, like current traffic enforcement powers and the over 160 million random searches undertaken at courthouses and other government buildings, airports and border crossings, RBT will be upheld under the *Charter*. RBT's proven traffic safety benefits far outweigh the minimum intrusion on *Charter* rights that it entails.

Appendix I: Technical Notes for Figures 1 and 2

Sources of Crash Data

- Canadian alcohol-related crash data are taken from D Mayhew, S Brown & H Simpson, *The Alcohol-Crash Problem in Canada: 2008* (Ottawa: Transport Canada, 2010) at 14.
- European alcohol-related crash data are taken from G Jost et al, *Road Safety Target In Sight: Making up for lost time – 4th Road Safety PIN Report*, online: European Transport Safety Council <<http://www.etsc.eu/docuemtns/ETSC%204th%20PIN%20Report%2010.pdf>> at 97 (Table 15).
- Australian alcohol-related crash data are taken from Australian Transport Council, *National Road Safety Strategy: 2011-2020*, online: Australian Transport Council <http://www.atcouncil.gov.au/documents/files/NRSS_2011_2020_20May11.pdf> at 4, 11 and 25. The Australian crash data is for the year 2010.
- Japanese alcohol-related crash data are taken from Facts and Details, *Automobile Accidents in Japan*, online: Facts and Details <<http://factsanddetails.com/japan.php?itemid=850&catid=23&subcatid=153>>. The Japanese crash data are for the year 2007.
- New Zealand alcohol-related crash data are taken from Ministry of Transport, *Road Toll*, online: Ministry of Transport, New Zealand <<http://www.transport.govt.nz/research/Pages/Road-Toll.aspx>>.
- American alcohol-related crash data are taken from Fatality Analysis Reporting System (FARS), *Persons Killed, by STATE and Highest Driver Blood Alcohol Concentration (BAC) in Crash – State: USA, Year: 2009*, online: National Highway Traffic Safety Administration <<http://www.fars.nhtsa.dot.gov/States/StatesAlcohol.aspx>>.

Sources of Population Data

- Canadian population data are taken from Statistics Canada, *CANSIM Table 051-0001, Estimates of population, by age group and sex for July 1, Canada, provinces and territories, annual (persons)* (Ottawa: Statistics Canada, 2011). The population data are for 2008.
- Population data are taken from Department of Economic and Social Affairs, Population Division, *World Population Prospects: The 2010 Revision – File 1: Total Population... 1950-2100 (thousands)*, online: United Nations, Department of Economic and Social Affairs <<http://esa.un.org/unpd/wpp/Excel-Data/population.htm>>. Unless otherwise specified, population data are for 2008.
- Irish population data are for 2005.
- Japanese population data are for 2007.

Classifying Crashes as “Alcohol-Related”

- In Denmark, Finland and France, the term “alcohol-related” was defined as a crash in which any active participant was found to have a BAC above .05%.

- In Canada, the term “alcohol-related” is defined in terms of one or more of the parties having a positive BAC.
- In Great Britain, an “alcohol-related fatality” was defined as a traffic death in which a driver or rider blew over 35 micrograms of alcohol per 100 millilitres of breath, refused a breath test, or died and was found to have had a BAC in excess of .08%. Department for Transport, *Reported Road Casualties Great Britain: 2008 Annual Report*, online: Department for Transport <<http://www2.dft.gov.uk/adobepdf/162469/221412/221549/227755/rrcgb2008.pdf>>.
- In Sweden, the term “alcohol-related fatality” was limited to fatally-injured drivers who tested positive for alcohol in postmortem testing.
- In Ireland, the term “alcohol-related” was defined in terms of a driver having a BAC of .02% or more. In some circumstances, the BACs of pedestrians may have been obtained and considered in the total alcohol-related fatalities. D Bedford, *Drink Driving in Ireland*, online: Alcohol Ireland <<http://alcoholireland.ie/wpcontent/uploads/2011/02/drink-driving-in-ireland-dr-declan-bedford-oct-2008.pdf>>, Table: Deaths in Alcohol Related Crashes.
- In The United States, the term “alcohol-related” was defined in reference to a driver having a BAC of .01% or more.
- In New Zealand, “impairment-related” refers to a death resulting from a crash in which at least one driver was affected by alcohol/drugs. Research and Statistics, Ministry of Transport, *Alcohol/drugs: Crash Statistics for the Year Ended 31 December 2009*, online: Ministry of Transport, New Zealand <<http://www.transport.govt.nz/research/Documents/Alcohol-drugs-crash-fact-sheet-2010.pdf>>.
- In Australia, the alcohol-related crash deaths, or “drink-driving” fatalities as they are called, appear to refer to crash deaths in which one of the drivers had a BAC above .05%.
- In Germany and the Netherlands, drivers killed “on the spot” might not have been tested.

Appendix II: Technical Notes for Figure 3

- Per capita alcohol consumption is measured in litres/capita (age 15+). Organization for Economic Co-operation and Development (OECD), *Non-Medical Determinants of Health: Alcohol Consumption*, online: OECD <http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT>.
- Per capita alcohol consumption for Great Britain included the entire United Kingdom.

ENDNOTES

¹ The minimum sentence for driving while one's ability is impaired, driving with a BAC above .08%, and failing to provide a breath or blood sample is now a \$1,000 fine for a first offence, and 30 and 120 days' imprisonment for second and subsequent offences, respectively. *Criminal Code*, RSC 1985, c C-46, s 255(1). The maximum penalties for impaired driving causing bodily harm and impaired driving causing death are now ten years' and life imprisonment, respectively (section 255(2) and (3)). See *An Act to amend the Criminal Code (impaired driving causing death and other matters)*, SC 2000, c 25.

² *An Act to amend the Criminal Code (conditional sentence of imprisonment)*, SC 2007, c 12.

³ *An Act to amend the Criminal Code and to make consequential amendments to other Acts*, SC 2008, c 6, ss 18-26 [2008 Amendments]. For a more detailed discussion of these amendments, see R Solomon, E Chamberlain & C Lynch, "Canada's New Impaired Driving Legislation: Modest Gains and Missed Opportunities" (2010) 56 *Crim LQ* 51 [Modest Gains].

⁴ *Criminal Code*, *supra* note 1, ss 259(1.1-1.2).

⁵ See 2008 Amendments and the related discussion in Modest Gains, *supra* note 3 at 66-72.

⁶ See Modest Gains, *ibid* at 54-55. A national survey of police found that it took an average of 2.8 hours to process a simple charge of impaired driving and an additional 4.4 hours if the case went to trial. See B Jonah et al, "Front-line police officers' practices, perceptions and attitudes about the enforcement of impaired driving laws in Canada" (1999) 31 *Accid Anal and Prev* 421 at 429-30 and 432. Similarly, in a recent survey of Crown counsel, 53% agreed or strongly agreed that their caseloads made it difficult to adequately prepare for an impaired driving trial. R Robertson, W Vanlaar & H Simpson, *National Survey of Crown and Defence Counsel on Impaired Driving* (Ottawa: Traffic Injury Research Foundation, 2009) at 49. This has led to a growing police reluctance to lay impaired driving charges, and helps to explain why Canada's 2007 charge rate for impaired driving offences was only 40% of the American rate (1 for every 358 licensed drivers compared to 1 for every 139 licensed drivers). See Transport Canada, *2007 Canadian Motor Vehicle Traffic Collision Statistics* (Ottawa: Transport Canada, 2010) at 7; and National Centre for Statistics and Analysis, *Traffic Safety Facts, 2007 Data* (Washington: National Highway Traffic Safety Administration, 2008) at 5.

⁷ D Mayhew, D Beirness & H Simpson, "Trends in Drinking-Driving Fatalities in Canada – Progress Continues" in H Laurell & F Schlyter, eds, *Alcohol, Drugs and Traffic Safety – T'2000: Proceedings of the 15th International Conference on Alcohol, Drugs and Traffic Safety*, CD-ROM (Stockholm: International Council on Alcohol, Drugs and Traffic Safety (ICADTS), 2000) [ICADTS 2000].

⁸ These included: the new offences of impaired driving causing death and bodily injury; provisions permitting the police to demand blood samples in certain limited circumstances; mandatory minimum driving prohibitions; and significantly increased minimum and maximum penalties. *Criminal Law Amendment Act, 1985*, SC 1985, c 19.

⁹ The measures introduced at the provincial level included: 90-day administrative licence suspensions for drivers with BACs of .08% or above; lengthier minimum licence suspensions for drivers convicted of a federal impaired driving offence; mandatory education, assessment and treatment programs; and graduated licensing programs for young and novice drivers.

¹⁰ For a general discussion of these developments see M Asbridge et al, "The Criminalization of Impaired Driving in Canada: Assessing the Deterrent Impact of Canada's First Per Se Law" (2004) 65 *J Studies on Alcohol and Drugs* 450 at 456-58; and R Mann et al, "Drinking-Driving Fatalities and Consumption of Beer, Wine and Spirits" (2006) 25 *Drug and Alcohol Review* 321 at 324.

¹¹ S Pitel & R Solomon, *Lives Saved* (Oakville: MADD Canada, 2012); D Mayhew, D Beirness & H Simpson, "Trends in Drinking-Driving Fatalities in Canada – Progress Stalls" in P Williams & A Clayton, eds, *Proceedings of the 17th International Conference on Alcohol, Drugs and Traffic Safety*, CD-ROM (Glasgow: ICADTS, 2004).

¹² See *supra* notes 1-5.

¹³ Most provinces have enacted several progressive programs in the last ten years, including: comprehensive graduated licensing programs; zero BAC limits for young and novice drivers; increased short-term licence

suspensions for driving with a BAC of .05% or more; mandatory alcohol interlock programs for federal impaired driving offenders; vehicle impoundment programs; and comprehensive assessment and treatment programs. These measures have been effective and, in our view, have prevented increases in impaired driving deaths. For a review of the provincial reforms see R Solomon et al, *Rating the Provinces and Territories: The 2009 Report* (Oakville: MADD Canada, 2009).

¹⁴ S Pitel & R Solomon, *Estimating the Number and Cost of Impairment-Related Traffic Crashes in Canada: 1999 to 2009* (Oakville: MADD Canada, 2012) at 7-8.

¹⁵ Given certain inherent limitations in the coroners' data upon which this estimate is based, it likely significantly understates the total number of impairment-related deaths in Canada. For example, if an impaired driver crashes into a vehicle, killing its sober driver and two occupants, it is only the dead driver's BAC that would be reported in the coroner's fatality data. Unless the police recorded the crash as being due to the surviving driver's impairment, all three deaths would be recorded as being non-alcohol-related. Similar problems arise when intoxicated drivers survive crashes in which they kill sober passengers, pedestrians or bicyclists. See H Simpson, *Drinking-Driving Statistics in Canada: Does Anyone Really Know How Big the Problem Is?* (Ottawa: Traffic Injury Research Foundation, 1997) at 53-56.

Moreover, research indicates that police frequently fail to detect and report the presence of alcohol. See for example E Vingilis, E Adlaf & L Chung, "Comparison of Age and Sex Characteristics of Police-Suspected Impaired Drivers and Roadside-Surveyed Impaired Drivers" (1982) 14 *Accid Anal and Prev* 425; and E Vingilis & V Vingilis, "The Importance of Roadside Screening for Impaired Drivers in Canada" (1987) 29 *Can J Crim* 17 at 22-25. Although these sources are dated, police under-reporting remains problematic, particularly in Québec.

Finally, the way that the provinces define an "alcohol-related" traffic death also contributes to under-reporting. Québec has a narrower definition of an "alcohol-related death" than the other provinces, excluding deaths among alcohol-impaired pedestrians, deaths in alcohol-related off-road crashes, and alcohol-related deaths involving snowmobiles, ATVs, bicycles and other non-principal vehicle types. See Traffic Injury Research Foundation, *Alcohol-Crash Problem in Canada: 2009* (Ottawa: Canadian Council of Motor Transport Administrators (CCMTA), 2011) at 133. Further, while the TIRF/CCMTA report indicated that the total number of alcohol-related crash deaths in Québec for 2009 was 142 (at 126), the Société de l'assurance automobile du Québec (SAAQ) reported the number in the same year to be 195 on its official website: www.saaq.gouv.qc.ca/en/accident_prevention/alcohol/index.php (accessed 28 November 2011).

¹⁶ Pitel & Solomon, *supra* note 14 at 3.

¹⁷ *Ibid* at 10.

¹⁸ In contrast to the 1,074 impairment-related crash fatalities in 2009, there were 610 homicides in Canada, which includes the separate offences of murder, manslaughter and infanticide. S Beattie & A Cotter, "Homicide in Canada, 2009" (Fall 2010) 30:3 *Juristat* (Statistics Canada Cat No. 85-002-X).

¹⁹ As the numerous technical notes in Appendices I and II illustrate, it is challenging to make subtle distinctions in the comparative data. Despite these concerns, Figures 1-3 provide an ample basis for concluding that Canada's impaired driving record is poor by international standards. This conclusion is wholly consistent with earlier comparative studies. For example, an international study published in 2000 reported that Canada had the second highest rate of alcohol involvement in fatal crashes of 16 comparable developed democracies. K Stewart et al, "International Comparison of Laws and Alcohol Crash Rates: Lessons Learned" in ICADTS 2000, *supra* note 7. Further, a 2001 Transport Canada study found that Canada had the highest rate of impairment among fatally-injured drivers of eight Organisation for Economic Co-operation and Development (OECD) countries. Transport Canada: *Canada's Road Safety Targets to 2010* (Ottawa: Minister of Public Works and Government Services, 2001) at 7.

²⁰ W Vanlaar & R Robertson, *The Road Safety Monitor 2010: Drinking and Driving In Canada* (Ottawa: Traffic Injury Research Foundation, 2010) at 2.

²¹ See Canadian Institute For Health Information (CIHI), "Frequency of drinking 5 or more drinks on one occasion in the last 12 months, by age group and sex, household population aged 12 or over who are current drinkers, Canada excluding territories, 1994/95-1998/99" (2001) 2001:3 *Health Indicators*, Catalogue No. 82-221-XIE; CIHI, "Frequency of drinking 5 or more drinks on one occasion in the last 12 months, by age group and sex, household population aged 12 or over who are current drinkers, Canada, 2000/01" (2001) 2001:2 *Health*

Indicators, Catalogue No. 82-221-XIE; and Statistics Canada, *CANSIM Table 105-0431, Frequency of drinking in the past 12 months, by age group and sex...peer groups, every two years, 2005* (Ottawa: Statistics Canada, 2005). The 15-24 age group also has the highest rates of weekly and monthly binge drinking, and of consuming five or more drinks on a typical drinking day. E Adlaf, P Begin & E Sawka, eds, *Canadian Addiction Survey (CAS): A National Survey on Canadians' Use of Alcohol and Other Drugs (Detailed Report)* (Ottawa: Canadian Centre on Substance Abuse, 2005) at 29 and 31.

²² Increased alcohol availability is associated with increased per capita consumption and binge drinking. In turn, both of these factors have been shown to be predictive of impaired driving deaths and injuries. See T Babor et al, *Alcohol: No Ordinary Commodity – Research and Public Policy*, 2d ed (New York: Oxford University Press, 2010) at 103-46.

²³ M Johnson & E Howard, *Road Safety Vision 2010: Mid-Term Review, Final Report* (Burnaby: Canadian Traffic Safety Institute, 2007).

²⁴ *Ibid* at 57.

²⁵ *Ibid* at 72-73.

²⁶ P Gutoskie, *Road Safety Vision 2010: 2006 Update* (Ottawa: CCMTA, 2008) at 36.

²⁷ Canada, House of Commons Standing Committee on Justice and Human Rights, *Ending Alcohol-Impaired Driving: A Common Approach* (Ottawa: House of Commons Standing Committee on Justice and Human Rights, 2009) at 13-16 [*Common Approach*].

²⁸ Department of Justice Canada, *Discussion Paper: Modernizing the Transportation Provisions of the Criminal Code* (Ottawa: Department of Justice Canada, 2010) at 10-13.

²⁹ See *R v Dedman*, [1985] 2 SCR 2 at 32-36; and *R v Orbanski*; *R v Elias*, [2005] 2 SCR 3 at para 41 [*Orbanski*].

³⁰ See for example, Ontario *Highway Traffic Act*, RSO 1990, c H.8, ss 216(1), 33(1) and (3), and 48(1); and British Columbia *Motor Vehicle Act*, RSBC 1996, c 318, ss 71 and 73(1)-(2).

³¹ *Criminal Code*, *supra* note 1, s 254(2).

³² The Swedish study is cited in Vingilis & Vingilis, *supra* note 15 at 22-23.

³³ J Wells et al, “Drinking Drivers Missed at Sobriety Checkpoints” (1997) 58 J Stud Alcohol 513 at 516.

³⁴ S Ferguson, J Wells & A Lund, “The Role of Passive Alcohol Sensors in Detecting Alcohol-Impaired Drivers at Sobriety Checkpoints” (1995) 11:1 Alcohol, Drugs and Driving 23; and I Jones & A Lund, “Detection of Alcohol-Impaired Drivers Using a Passive Alcohol Sensor” (1986) 14:2 J Police Sci Administration 153 at 157. .

³⁵ E Vingilis, EM Adlaf & L Chung, “Comparison of Age and Sex Characteristics of Police-Suspected Impaired Drivers and Roadside-Surveyed Impaired Drivers” (1982) 14 Accid Anal and Prev 425 at 427. See also E Vingilis et al, “Psychosocial Characteristics of Alcohol-Involved and Nonalcohol-Involved Seriously Injured Drivers” (1994) 26 Accid Anal and Prev 195 at 203.

³⁶ W Picton, “Legislation to Allow the Safe Release of Potentially Unsafe Drinking Drivers” (1978) 40 CRNS 30.

³⁷ *Common Approach*, *supra* note 27 at 13.

³⁸ See R Solomon et al, “Predicting the Impact of Random Breath Testing on the Social Costs of Crashes, Police Resources and Driver Inconvenience in Canada” (2011) 57 Crim LQ 438 at 457-58.

³⁹ R Homel, “Random Breath Testing the Australian Way: A Model for the United States?” (1990) 14:1 Alcohol Health and Research World 70 at 72.

⁴⁰ For example, evidentiary tests must be conducted by “qualified technicians” in accordance with the *Criminal Code*’s strict time limits and other procedural requirements. See *Criminal Code*, *supra* note 1, s 254.

⁴¹ Worldwide Brewing Alliance, *2008 Drinking and Driving Report*, 8th ed (London: Worldwide Brewing Alliance, 2009) at 13; K Stewart, *On DWI Laws in Other Countries* (Washington: National Highway Traffic Safety

Administration, 2000) at 40-48; and E Townsend, F Achterberg & T Janitzek, *Traffic Law Enforcement Across the EU: An Overview* (Brussels: European Transport Safety Council, 2006).

⁴² Worldwide Brewing Alliance, *ibid* at 13.

⁴³ World Health Organization (WHO) Regional Office for Europe, *European Status Report on Alcohol and Health 2010* (Geneva: WHO, 2010) at 74; and E Townsend, F Achterberg & T Janitzek, *supra* note 41.

⁴⁴ European Commission, Press Release, IP/03/1436, “Commission Calls for Better Enforcement of Road Safety Rules” (22 October 2003).

⁴⁵ T Janitzek & E Townsend, *Traffic Law Enforcement Across the EU: Time for a Directive* (Brussels: European Transport Safety Council, 2006) at 15.

⁴⁶ For a more detailed review of the research literature, see R Solomon et al, “The Case for Comprehensive Random Breath Testing Programs in Canada: Reviewing the Evidence and Challenges” (2011) 49 *Alta LR* 37 at 51-55.

⁴⁷ For instance, one author noted that, in the space of only 20 weeks, RBT had prevented some 200 fatalities and thousands of hospital admissions. G Paciullo, “Random Breath Testing in New South Wales” (1983) 1:1 *The Medical Journal of Australia* 620 at 620. Another report indicated that the introduction of RBT in New South Wales caused an immediate 90% decline in road deaths, which then stabilized roughly 22% below the average for the preceding six years. R Homel, “Random Breath Testing the Australian Way,” *supra* note 39 at 70. In fairness, these spectacular reductions were achieved at a time when the magnitude of the impaired driving problem in Australia significantly exceeded the current Canadian situation. The introduction of RBT in Canada would not likely generate such dramatic results.

⁴⁸ R Homel, *Policing the Drinking Driver: Random Breath Testing and the Process of Deterrence* (Canberra: Department of Transport, 1986) at 15.

⁴⁹ See for example, A Cavallo & M Cameron, *Evaluation of a Random Breath Testing Initiative in Victoria 1990 & 1991, Summary Report* (Melbourne: Transport Accident Commission, 1992) at 1; D Zaal, *Traffic Law Enforcement: A Review of the Literature* (Clayton: Monash University Accident Research Centre, 1994) at 67; and B Watson, G Fraine & L Mitchell, “Enhancing the Effectiveness of RBT in Queensland” in *Prevention of Alcohol Related Road Crashes: Social and Legal Approaches Conference* (Brisbane: Griffiths University, 1994) 31 at 34-38.

⁵⁰ J Henstridge, R Homel & P Mackay, *The Long-Term Effects of Random Breath Testing in Four Australian States: A Time Series Analysis* (Canberra: Federal Office of Road Safety, 1997). In conducting the study, the authors controlled for various confounding factors, including other impaired driving countermeasures, such as lowering the legal BAC limit to .05%.

⁵¹ R Homel, “Random Breath Testing and Random Stopping Programs in Australia” in R Wilson & R Mann, eds, *Drinking and Driving: Advances in Research and Prevention* (New York: Guilford Press, 1990) 159 at 162.

⁵² Specifically, Henstridge, Homel & Mackay recommend that “all states should increase highly visible stationary RBT to a level equivalent to one test per licence holder per year,” *supra* note 50 at 115. Based on New South Wales data, the authors calculated that increasing the daily testing rate by 1,000 roughly corresponded to a 6% decline in total crashes and a 19% decline in single-vehicle nighttime crashes. *Ibid* at 50.

⁵³ *Ibid* at 114-15.

⁵⁴ The program in New South Wales achieved an initial 15% reduction in the total number of fatal crashes, which remained relatively constant for nearly ten years despite significant increases in the population. *Ibid* at 44. However, the initial sharp declines in serious crashes and single-vehicle nighttime crashes were not as stable and could only be sustained by steadily increasing enforcement and publicity. *Ibid* at 50.

⁵⁵ G Casey, “Random Breath Testing – A Successful Policy Recipe” (2006) 7:4 *Journal of the Australian College of Road Safety* 29 at 30.

⁵⁶ J Grube, “Preventing Alcohol-Related Problems: Public Policy Strategies” in *Implementing Impaired Driving Countermeasures: Putting Research into Action* (Washington: Transportation Research Board, 2005) 93 at 104.

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- ⁵⁷ A Erke, C Goldenbeld & T Vaa, “The Effects of Drink-Driving Checkpoints on Crashes – a Meta-Analysis” (2009) 41 *Accid Anal & Prev* 914 at 919 (Table 2).
- ⁵⁸ M Mathijssen, “Drink Driving Policy and Road Safety in the Netherlands: A Retrospective Analysis” (2005) 41 *Transportation Research Part E: Logistics and Transportation Review* 395 at 395.
- ⁵⁹ J Dunbar, A Penttila & J Pikkarainen, “Drinking and Driving: Success of Random Breath Testing in Finland” (1987) 295:6590 *British Medical Journal (Clinical Research Edition)* 101 at 102.
- ⁶⁰ European Transport Safety Council, “Road Safety Performance Index” (Brussels: European Transport Safety Council, 2008).
- ⁶¹ Road Safety Authority, *Road Safety Strategy 2007-2012* (Ballina, Ireland: Road Safety Authority, 2007) at 7.
- ⁶² D Bedford, “Drink Driving in Ireland” (paper presented at the Road Safety Authority Conference, Dublin, 13 October 2008) [unpublished], online: Road Safety Authority <http://www.rotr.ie/conference/presentations/Declan_Bedford_rsa-131008.pdf>.
- ⁶³ T O’Brien, “Irish road deaths ‘Fall By 42%’” *Irish Times* (19 May 2010).
- ⁶⁴ T Miller, M Blewden & J-f Zhang, “Cost savings from a sustained compulsory breath testing and media campaign in New Zealand” (2004) *Accid Anal & Prev* 783 at 793.
- ⁶⁵ Erke, Goldenbeld & Vaa, *supra* note 57 at 919.
- ⁶⁶ Henstridge, Homel & Mackay, *supra* note 50 at 102 (Table 6.9).
- ⁶⁷ See also Homel, “Random Breath Testing and Random Stopping Programs in Australia,” *supra* note 51 at 187, discussing similar results in Western Australia.
- ⁶⁸ Homel, “Random Breath Testing the Australian Way,” *supra* note 39 at 74.
- ⁶⁹ Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (UK), 1982*, c 11 [Charter].
- ⁷⁰ C Peek-Asa, “The Effect of Random Alcohol Screening in Reducing Motor Vehicle Crash Injuries” (1999) 16:1S *Am J Prev Med* 57 at 65; R Shults et al, “Reviews of Evidence Regarding Interventions to Reduce Alcohol-Impaired Driving” (2001) 21(4S) *Am J Prev Med* 66 at 76; and R Elder et al, “Effectiveness of Sobriety Checkpoints for Reducing Alcohol-Involved Crashes” (2002) 3:4 *Traffic Inj Prev* 266.
- ⁷¹ See Solomon et al, “The Case for Comprehensive Random Breath Testing,” *supra* note 46 at 55-57.
- ⁷² I Jones & A Lund, “Detection of Alcohol-Impaired Drivers Using a Passive Alcohol Sensor” (1986) 14:2 *J Police Sci Administration* 153 at 157. See also R Voas, “A New Look at NHTSA’s Evaluation of the 1984 Charlottesville Sobriety Checkpoint Program: Implications for Current Checkpoint Issues” (2008) 9:1 *Traffic Inj Prev* 22 at 25, which reported that the introduction of PAS devices in Virginia’s SBT checkpoints increased arrests threefold.
- ⁷³ K Beck, “Lessons Learned From Evaluating Maryland’s Anti-Drunk Driving Campaign: Assessing the Evidence for Cognitive, Behavioral, and Public Health Impact” (2009) 10 *Health Promotion Practice* 370 at 375.
- ⁷⁴ J Lacey, R Jones & R Smith, *Evaluation of Checkpoint Tennessee: Tennessee’s Statewide Sobriety Checkpoint Program* (Washington: National Highway Traffic Safety Administration, 1999), Executive Summary.
- ⁷⁵ *Ibid*, chapter 2.
- ⁷⁶ B Watson & J Freeman, “Perceptions and Experiences of Random Breath Testing in Queensland and the Self-Reported Deterrent Impact on Drunk Driving” (2007) 8 *Traffic Inj Prev* 11 at 14. Similarly, in a 2006 Irish survey, 87% of the participants strongly endorsed RBT. *Alcohol in Ireland: Time for Action – A Survey of Irish Attitudes* (Dublin: Alcohol Action Ireland, 2006) at 14.
- ⁷⁷ For example, prior to its introduction in New South Wales, public support for RBT stood at 63.8%. By mid-1983, six months after RBT was introduced, support had increased to 85.3%. By 1987, it stood at 97%. I Kearns et al, “An Overview of the Random Breath Testing Trial in New South Wales” (1987) 86 *Alcohol, Drugs and Traffic Safety* 429 at 431; and Homel, “Random Stopping Programs in Australia,” *supra* note 51 at 177. See also W Harrison et al, *Drink-Driving Enforcement: Issues in Developing Best Practice* (Sydney: Austroads, 2003) at 5-6.

⁷⁸ Ipsos Reid, *Canadian Attitudes Toward Random Breath Testing (RBT)* (Oakville: MADD Canada, 2010) at 11 and 16-17.

⁷⁹ *Ibid* at 8-9.

⁸⁰ For a more detailed discussion, see Solomon et al, “Predicting the Impact of Random Breath Testing,” *supra* note 38.

⁸¹ Homel, “Random Breath Testing the Australian Way,” *supra* note 39 at 70.

⁸² M Mackay et al, *Cost Effective EU Transport Safety Measures* (Brussels: European Transport Safety Council, 2003) at 27. See also M Peden et al, eds, *World report on road traffic injury prevention* (Geneva: WHO, 2004) at 130.

⁸³ Miller, Blewden & Zhang, *supra* note 64 at 788.

⁸⁴ Solomon et al, “Predicting the Impact of Random Breath Testing,” *supra* note 38 (Table 4).

⁸⁵ *Ibid* at 452-59.

⁸⁶ Dunbar, Penttila & Pikkarainen, *supra* note 59 at 101.

⁸⁷ Miller, Blewden & Zhang, *supra* note 64 at 788.

⁸⁸ This depends on how detailed the officer’s questions are at current SBT checkpoints. If the officer simply asks, “Where are you coming from?” or “Have you had anything to drink?”, then the SBT stop could be of slightly shorter duration than an RBT stop. But if the officer asks for a driver’s licence and other documents, attempts to scrutinize the driver for signs of alcohol consumption, or closely questions the driver, then the SBT stop will take much longer than a typical RBT stop.

⁸⁹ See Solomon et al, “The Case for Comprehensive Random Breath Testing,” *supra* note 46 at 60-77.

⁹⁰ [1988] 1 SCR 621.

⁹¹ *Ibid* at 632.

⁹² *Ibid* at 633. The random of stopping of vehicles by police engaged in routine patrol activities (as opposed to organized spot checks) has also been found to constitute arbitrary detention: *R v Ladouceur*, [1990] 1 SCR 1257 at 1277.

⁹³ *R v Thomsen*, [1988] 1 SCR 640; and *R v Seo* (1986), 54 OR (2d) 293 (CA).

⁹⁴ *Orbanski*, *supra* note 29.

⁹⁵ *Ibid*; and *R v Saunders* (1988), 41 CCC (3d) 532 (Ont CA).

⁹⁶ *Hunter v Southam*, [1984] 2 SCR 145 at 161.

⁹⁷ [1987] 1 SCR 265 at 278.

⁹⁸ The third element, whether the search was carried out in a reasonable manner, depends on the way that the police conduct the search in the particular case, and cannot be analyzed in the abstract.

⁹⁹ *R v Pohoretsky*, [1987] 1 SCR 945; *R v Dymont*, [1988] 2 SCR 417; *R v Colarusso*, [1994] 1 SCR 20; and *R v Haas* (2005), 76 OR (3d) 737 (CA).

¹⁰⁰ See the reasons of L’Heureux-Dubé J in *R v Bernshaw*, [1995] 1 SCR 254 at 307-8.

¹⁰¹ *R v Simmons*, [1988] 2 SCR 495.

¹⁰² See *R v Monney*, [1999] 1 SCR 652 at 681-82, where the use of a “drug loo” facility at an airport was found to be a reasonable search. While the court found that the compelled production of a bowel movement was an embarrassing process, it did not interfere with bodily integrity.

¹⁰³ *R v Campanella* (2005), 75 OR (3d) 342 (CA).

¹⁰⁴ [2003] 2 SCR 678. Admittedly, that case involved DNA samples seized under a special warrant for forensic analysis. It does, however, reveal the Supreme Court's current views on the intrusiveness of bodily searches.

¹⁰⁵ In *SAB, ibid*, the court was influenced by the fact that the special warrants authorized the collection of "non-coding" DNA (ie, a sample which only allowed for comparison with another sample), which would not reveal any medical, physical or mental characteristics about the individual.

¹⁰⁶ See *Simmons, supra* note 101 at 517, where the Supreme Court similarly noted that there was no stigma attached to being routinely searched at an airport.

¹⁰⁷ *Transportation in Canada 2008: An Overview* (Ottawa: Minister of Public Works and Government Services, 2008) at 18; and Canada Border Services Agency, "CBSA National Statistics: Trade and Traveller Statistics," online: Canada Border Services Agency <<http://www.cbsa-asfc.gc.ca/agency-agence/stats/trade-echange-eng.html>>.

¹⁰⁸ *Simmons, supra* note 101 at 528.

¹⁰⁹ *R v Oakes*, [1986] 1 SCR 103.

¹¹⁰ Solomon et al, "The Case for Comprehensive Random Breath Testing," *supra* note 46 at 71-77.

¹¹¹ Similar arguments may be made for breath screening using passive alcohol sensors (PAS), which are somewhat less intrusive than RBT tests, and thus involve a lesser infringement of section 8. However, while PAS devices improve impaired driving detection, they do not approach the 100% detection rates of RBT. The use of PAS devices would introduce its own set of legal challenges, particularly if there are passengers in the vehicle. Moreover, it would increase the current two-step process (ASD + evidentiary testing on an approved instrument) to a three-step process, and thus would lengthen the already time-consuming enforcement process. To be effective, the PAS must be held within inches of the drivers' mouth. Finally, although PAS devices have been approved for use in the United States, there is considerable police opposition to their use. In short, PAS devices are not a realistic alternative to comprehensive RBT. See generally JC Fell et al, "Why are Sobriety Checkpoints Not Widely Adopted as an Enforcement Strategy in the United States?" (2003) 35 *Accid Anal and Prev* 897; and Solomon et al, "The Case for Comprehensive Random Breath Testing," *supra* note 46 at 74.

¹¹² *Ladouceur, supra* note 92 at 1281-82.

¹¹³ [1988] 1 SCR 640 at 655.

¹¹⁴ This is particularly true given that the highest incidence of impairment occurs late at night and early in the morning, when the probability of a detained person immediately obtaining legal advice is very low. See *Seo, supra* note 93 at 316.

¹¹⁵ While the importance of the right to counsel should not be downplayed, the practical effect of any legal advice given at roadside would be minimal. Unless something is very amiss, drivers have an obligation to comply with the demand and the only advice counsel could provide would be to provide a breath sample. See *Criminal Code, supra* note 1, section 254(5), which makes it an offence to fail or refuse to provide a breath sample without a reasonable excuse.

¹¹⁶ B Jonah et al, *supra* note 6 at 429.

¹¹⁷ R Solomon & E Chamberlain, "Calculating BACs for Dummies: The Real-World Significance of Canada's 0.08% Criminal BAC Limit for Driving" (2003) 8 *Can Crim LR* 219 at 224 and 231-34.

¹¹⁸ See for example, A Liguori et al, "Alcohol Effects on Mood, Equilibrium and Simulated Driving" (1999) 23 *Alcoholism: Clinical and Experimental Research* 815; and H Moskowitz & D Fiorentino, *A Review of the Literature on the Effects of Low Doses of Alcohol on Driving-Related Skills* (Washington: National Highway Traffic Safety Administration, 2000).

¹¹⁹ E Ogden & H Moskowitz, "Effects of Alcohol and Other Drugs on Driver Performance" (2004) 5 *Traffic Inj Prev* 185.

¹²⁰ See for example, P Zador, S Krawchuk & R Voas, "Alcohol-Related Relative Risk of Driver Fatalities: An Update Using 1996 Data" (2000) 61 *J Stud Alcohol* 387; and D Preusser, "BAC and Fatal Crash Risk" in D

Mayhew & C Dussault, eds, *Proceedings of the 16th International Conference on Alcohol, Drugs and Traffic Safety*, CD-ROM (Montreal, Société de l'assurance automobile du Québec, 2002) [ICADTS 2002].

¹²¹ H Moskowitz et al, "Methodological Issues and Epidemiological Studies of Alcohol Crash Risk," and R Compton et al, "Crash Risk of Alcohol Impaired Driving" in ICADTS 2002, *ibid*.

¹²² International Center for Alcohol Policies (ICAP), *Blood Alcohol Concentration Limits Worldwide* (Washington: ICAP, 2005); E Wren, *Drunk Driving Blood Alcohol Limits Worldwide* (New York: Drive and Stay Alive Inc, 2005); and Eurocare, *Drinking and Driving in Europe: A Report to the European Union* (St Ives: Eurocare, 2003).

¹²³ For reviews of the research, see Shults et al, *supra* note 70 at 69-71; R Mann et al, "The Effects of Introducing or Lowering Legal Per Se Blood Alcohol Limits for Driving: An International Review" (2001) 33 *Accid Anal and Prev* 569; E Chamberlain & R Solomon, "The Case for a 0.05% Criminal Law Blood Alcohol Concentration Limit for Driving" (2002) 8 (Suppl III) *Inj Prev* iii1 at iii5-iii14; J Fell & R Voas, "The Effectiveness of Reducing Illegal Blood Alcohol Concentration (BAC) Limits for Driving: Evidence for Lowering the Limit to .05 BAC" (2006) 37 *J Safety Research* 233; and T Babor et al, *Alcohol: No Ordinary Commodity*, *supra* note 22 at 169-70.

¹²⁴ PC Noordzij, "Decline in Drinking and Driving in the Netherlands" in *The nature of and the reasons for the worldwide decline in drinking and driving. Transportation research circular number 422* (Washington: National Academy Press, 1994) 44-49.

¹²⁵ Institute of Alcohol Studies, *Drinking and Driving Fact Sheet* (St Ives: Institute for Alcohol Studies, 2000).

¹²⁶ C Mercier-Guyon, "Lowering the BAC limit to 0.05: results of the French experience," presented to Transportation Research Board 77th Annual Meeting, Washington (11-15 January 1998).

¹²⁷ G Bartl & R Esberger, "Effects of lowering the legal BAC limit in Austria" in ICADTS 2000, *supra* note 7.

¹²⁸ B Borschos, "An evaluation of the Swedish drunken driving legislation implemented on February 1, 1994" in ICADTS 2000, *ibid*; and T Norström & H Laurell, "Effects of lowering the legal BAC-limit in Sweden" in C Mercier-Guyon, ed, *Proceedings of the 14th International Conference on Alcohol, Drugs and Traffic Safety – T'97* (Annecy: Centre d'études et de recherche en médecine du trafic, 1997) 87-94.

¹²⁹ M Vollrath & H-P Krueger, "Long term changes in driving under the influence of alcohol and attitudes concerning DUI" in ICADTS 2000, *ibid*.

¹³⁰ IM Bernhoft, "Effect of lowering the alcohol limit in Denmark" in ICADTS 2000, *ibid*.

¹³¹ Henstridge, Homel & Mackay, *supra* note 50 at 113. These results were not confounded by the effects of random breath testing, as it was not introduced until eight years later.

¹³² *Ibid*.

¹³³ *Ibid*. See also CN Kloeden & AJ McLean, *Late night drink driving in Adelaide two years after the introduction of the .05 limit* (Adelaide: NHMRC Road Accident Research Unit, 1994).

¹³⁴ C Brooks & D Zaal, "Effects of a Reduced Alcohol Limit for Driving" in HD Utzelmann, G Berghaus & D Kroj, eds, *Proceedings of the 12th International Conference on Alcohol, Drugs and Traffic Safety, T'92* (Cologne: Verlag TÜV Rheinland, 1992) 1277-88. This included 92,000 tests in 1990 and 82,000 tests in 1991.

¹³⁵ An American study found that male drivers aged 21 to 34 with BACs of .15% and higher are 572 times more likely to be killed in a single-vehicle crash than sober drivers of the same age. PL Zador, SA Krawchuk & RB Voas, "Alcohol-related relative risk of driver fatalities and driver involvement in fatal crashes in relation to driver age and gender: an update using 1996 data" (2000) 61 *J Stud Alcohol* 387.

¹³⁶ These include the World Medical Association, American Medical Association, British Medical Association, the European Commission, the European Transport Safety Council, the Royal Society for the Prevention of Accidents, the World Health Organization, the International Transportation Safety Association, the Association for the Advancement of Automotive Medicine, the American College of Emergency Physicians, the Ontario Centre for Addiction and Mental Health, the Canadian Public Health Association, and the Australian Transport Safety Bureau. See Chamberlain & Solomon, *supra* note 123 at iii10.

¹³⁷ For a more detailed explanation of the proposed .05% offence, see R Solomon, E Chamberlain & S Usprich, “BAC to the Future: Modernizing the Criminal Drinking-Driving Threshold” (2006) 52 *Crim LQ* 35.

¹³⁸ *Ibid* at 61-63.

¹³⁹ In November 2005, Senator M Lebreton introduced Bill S-47, *An Act to Amend the Criminal Code (Impaired Driving) and Other Acts*, 1st Sess, 38th Parl, 2005. In October 2006, R Cannan, MP, introduced Bill C-376, *An Act to Amend the Criminal Code (Impaired Driving) And to Make Consequential Amendments to Other Acts*, 1st Sess, 39th Parl, 2006.

¹⁴⁰ See R Solomon et al, *Rating the Provinces & Territories: The 2009 Report*, *supra* note 13 at 6.

¹⁴¹ See for example, the enhanced .05% programs in British Columbia, Ontario, and Newfoundland and Labrador: *Motor Vehicle Act*, RSBC 1996, c 318, ss 215.41-215.46, 253(6) and (7), and 97.2; *Highway Traffic Act*, RSO 1990, c H.8, s 48; and *Highway Traffic Act*, RSNL 1990, c H-3, s 60.5(1)-(6).

¹⁴² See Pitel & Solomon, *supra* note 14.

¹⁴³ Statistics Canada, *CANSIM Table 252-0051 – Incident-based crime statistics, by detailed violations, annual (number)* (Ottawa Statistics Canada, 2011).

¹⁴⁴ Canadian Centre for Justice Statistics, *Number of Adult and Youth Cases Completed in Canada 1994/95 to 2009/10, for Select Impaired Driving Offences* (Ottawa: Statistics Canada, 2011). Unfortunately, while charges are reported on a calendar year basis, convictions are reported on a fiscal year basis. Further, given the length of time it takes for a serious impaired driving charge to work its way through the courts, it is most unlikely that the 2009 deaths strictly correlate to the 2009 charges and convictions. Nevertheless, these statistics provide a clear indication of the poor enforcement of Canada’s most serious impaired driving offences.

¹⁴⁵ R Purssell et al, “Proportion of injured alcohol-impaired drivers subsequently convicted of an impaired driving criminal code offence in British Columbia” (2004) 6:2 *Canadian Journal of Emergency Medicine* 80. Similarly, only 16% of injured alcohol-impaired drivers admitted to an Alberta tertiary care trauma centre between April 1, 1995 and March 31, 2003 were convicted of any federal impaired driving offence, even though their mean BAC was .19%. M Goecke et al, “Characteristics and conviction rates of injured alcohol-impaired drivers admitted to a tertiary care Canadian Trauma Centre” (2007) 30:1 *Clinical & Investigative Medicine* 26 at 26 and 29.

¹⁴⁶ S Mattsson, A Eriksson & H Sjögren, “Conviction rates among hospitalized DUI/DWI drivers” (2000) 28 *J Traffic Medicine* 21.

¹⁴⁷ R Purssell et al, “Proportion of Injured Drivers Presenting to a Tertiary Care Emergency Department Who Engage in Future Impaired Driving Activities” (2010) 11 *Traff Inj Prev* 35. See also E Vingilis et al, “Psychosocial Sequelae of Motor Vehicle Collisions: A Follow-up Study” (1996) 28 *Accid Anal and Prev* 637, which found that 40% of impaired drivers hospitalized after a crash acknowledged driving while impaired within the following year.

¹⁴⁸ *Criminal Code*, *supra* note 1, s 254(2)(b).

¹⁴⁹ See *R v Woods*, [2005] 2 SCR 205 at para 30. Although the *Criminal Code* does not stipulate that the tests must be conducted at roadside, the courts have routinely stressed the immediacy requirement of both the ASD demand and test. It is largely because tests are taken forthwith, at roadside, that justifies the ability to conduct them in violation of the suspect’s right to counsel.

¹⁵⁰ *R v Grant*, [1991] 3 SCR 139. The accused was accordingly acquitted of the offence of refusing to provide a breath sample. Similarly, in *R v Cote* (1992), 6 OR (3d) 667 (CA), an accused who was taken to a police detachment and waited a total of 14 minutes for the ASD to be ready was acquitted of refusing to provide a breath sample.

¹⁵¹ *R v Megahy* (2008), 432 AR 223 (CA). However, the subsequent evidentiary breath test results were admitted under section 24(2) of the *Charter*, as the court found that the breach of the accused’s rights was “minor and technical” and did not affect the fairness of the trial.

¹⁵² *Criminal Code*, *supra* note 1, s 254(3)(b). The police must also have reasonable grounds to believe that the person committed an impaired driving offence within the previous three hours.

¹⁵³ E Chamberlain & R Solomon, “Enforcing Impaired Driving Laws Against Hospitalized Drivers: The Intersection of Healthcare, Patient Confidentiality and Law Enforcement” (2010) 29 WRLSI 45 at 53-58.

¹⁵⁴ See for example, *R v Pearce* (1988), 56 Man R (2d) 77 (QB); *R v Wytiuk* (1989), 60 Man R (2d) 259 (QB); *R v Salmon* (1999), 141 CCC (3d) 207 (CA); and *R c Paradiso*, [2002] JQ No 7999 (CM) (QL).

¹⁵⁵ *R v Lipka* (1989), 20 MVR (2d) 298 (Ont Dist Ct) at 305. In that case, the suspect was strapped to a spinal board at the crash scene, was wearing a cervical collar and had his leg splinted. The officer accordingly made a blood sample demand. However, at the hospital, it was determined that the suspect’s only serious injury was to his leg, and was not life-threatening. The judge found that it would have been practicable to perform breath tests on an approved instrument while the suspect waited for x-rays. The accused was thus acquitted of the charge of refusing to provide a blood sample.

¹⁵⁶ *R v MacMillan* (1989), 19 MVR (3d) 137 at 140.

¹⁵⁷ *R v Brooke* (1999), 239 AR 339 at para 16 (Prov Ct).

¹⁵⁸ Qualified technicians are usually specially-trained police officers. They must be officially designated by the Attorney General of the province as being qualified to operate an approved instrument. *Criminal Code*, *supra* note 1, s 254(1).

¹⁵⁹ In practice, the time limit may actually be two hours. The 1999 amendments to the *Criminal Code* extended the time limit for demanding samples from two to three hours after the suspected commission of an impaired driving offence. However, the amendments did not make parallel changes to the time limits in sections 258(1)(c) and (d), which contain what is known as the presumption of temporality or identity. These sections presume that the accused’s BAC at the time of testing reflects his or her BAC at the time of the alleged offence, but only if they are taken within two hours. If the tests are taken after two hours, the Crown will lose the benefit of this evidentiary shortcut, and will be required to call a toxicologist to relate the suspect’s BAC at the time of testing back to the time of driving. This is time-consuming, expensive, and provides the defence with additional opportunities to raise technical challenges to the evidentiary breath or blood test results. Thus, for all intents and purposes, the police are still required to administer the evidentiary breath or blood tests within two hours of the alleged offence.

¹⁶⁰ As a complementary amendment, the *Criminal Code* should allow the blood sample to be drawn by anyone who is qualified to do so by his or her professional licensing body. Currently, section 254(4) of the *Criminal Code* only allows blood samples to be taken by “qualified medical practitioners” (ie physicians). However, many physicians do not regularly draw blood samples. Instead, this task is delegated to a nurse or other qualified technician. Such personnel draw blood on a regular basis, and are actually more skilled at the task than many physicians. In a busy hospital setting, these other qualified personnel are much more likely to be available to draw blood from impaired driving suspects.

For rare cases where the taking of a blood sample poses a danger to the patient, medical practitioners should be allowed to object to a blood sample demand on medical grounds. Given that only a small amount of blood is required for BAC testing, and that blood samples are often drawn for medical purposes when an accident victim comes into the emergency room, such cases will likely be very rare.

¹⁶¹ It may be particularly difficult for police to detect signs of impairment in an unconscious patient. Signs that are apparent might be attributed to other factors, such as a head injury or shock. See for example, *R v Clark* (1995), 135 Sask R 103 (QB), where the suspect was involved in an otherwise unexplained head-on collision which killed the other driver. Although an emergency medical technician had reported to the police that she could smell alcohol on the suspect’s breath, the judge held that this smell might have had another source, such as diabetes. Consequently, the judge ruled that there was insufficient evidence of impairment to issue a warrant, and the blood sample evidence was excluded. This meant that the accused was acquitted on the charge of driving with a BAC above .08%, and that there was little evidence left to support the charge of impaired driving causing death.

¹⁶² *Criminal Code*, *supra* note 1, s 256(1).

¹⁶³ Healthcare professionals are subject to a broad range of confidentiality obligations, stemming from common law, equity, professional governing bodies, various health statutes, and privacy legislation. Most provinces have privacy legislation specifically aimed at the health sector, which prohibits the disclosure of information about a patient without the patient’s consent or as required by law. See for example, *Health Information Act*, RSA 2000, c H-5, ss

34-35; and *Professional Misconduct*, O Reg 865/93, s 1(1), para 10. Healthcare professionals would be “required” to disclose information if presented with a warrant or *subpoena*; however, a mere request for information by police in the course of an investigation is not sufficient. This means that healthcare professionals who respond to a police inquiry about the patient’s condition or treatment, without the patient’s consent, may well be in breach of one or more of their confidentiality obligations. See *R v Lavoie* (2002), 205 NSR (2d) 252 (Prov Ct), and see generally Chamberlain & Solomon, *supra* note 153 at 75-80.

¹⁶⁴ See for example, *R v Carter* (1982), 39 OR (2d) 439 (CA). After interviewing the suspect, police learned that he had been drinking prior to the crash. They also found full and empty beer bottles at the scene. The Ontario Court of Appeal therefore found that it was reasonable for police to obtain a warrant to seize blood samples that had been taken for medical purposes in the hospital emergency department. See also *R v Katsigiorgis* (1987), 62 OR (2d) 441 (CA), where the court found that it was reasonable for police to take steps to preserve the continuity of the blood sample in anticipation that it would be seized under a general search warrant.

¹⁶⁵ This includes blood samples taken by medical personnel at the direction of the police (*R v Pohoretsky*, [1987] 1 SCR 945) and those taken on the medical personnel’s own initiative (*R v Cochrane*, [1990] BCJ No 1411 (Co Ct) (QL)).

¹⁶⁶ [1993] 3 SCR 768.

¹⁶⁷ *Ibid* at para 29.

¹⁶⁸ See also *R v Dymont*, [1988] 2 SCR 417; and *R v Erickson* (1992), 125 AR 68 (CA).

¹⁶⁹ See *supra* note 163. But see *R v Porretta* (1995), 15 MVR (3d) 289 (Ont Gen Div), where Eberhard J suggested that a medical professional who answered the police questions that were necessary to obtain a search warrant was not in breach of confidentiality obligations.

¹⁷⁰ See for example, *Land Transport Act 1998* (NZ), 1998/110, s 73(5); *Road Safety (Alcohol and Drugs) Act 1970* (Tas), s 10A(1); and *Road Transport (Safety and Traffic Management) Act 1999* (NSW), s 20.

¹⁷¹ For example, in a national survey, the percentage of respondents who admitted to driving within two hours of using marijuana/hashish increased from 1.5% in 2002 to 2.4% in 2006. This represents over half a million Canadians driving after using those drugs in the past twelve months. H Simpson et al, *The Road Safety Monitor: Drugs and Driving* (Ottawa: Traffic Injury Research Foundation, 2006) at 9. See also GW Walsh & RE Mann, “On the high road: driving under the influence of cannabis in Ontario” (1999) 90 CJPH 260; EM Adlaf, RE Mann & A Paglia, “Drinking, cannabis use and driving among Ontario students” (2003) 168 CMAJ 565; and DJ Beirness & EE Beasley, “A Roadside Survey of Alcohol and Drug Use Among Drivers in British Columbia” (2010) 11 Traffic Inj Prev 215.

¹⁷² For example, in a survey of high school students in Atlantic Canada, 15.1% of respondents reported driving under the influence of cannabis, while 11.7% reported driving while under the influence of alcohol. M Asbridge, C Poulin & A Donato, “Motor vehicle collision risk and driving under the influence of cannabis: Evidence from adolescents in Atlantic Canada” (2005) 37 *Accid Anal and Prev* 1025 at 1029. See also DJ Beirness & CG Davis, *Driving Under the Influence of Cannabis: Analysis drawn from the 2004 Canadian Addiction Survey* (Ottawa: Canadian Centre on Substance Abuse, 2006); and F McGuire et al, “Driving under the Influence of Cannabis or Alcohol in a Cohort of High-frequency Cannabis Users: Prevalence and Reflections on Current Interventions” (2011) 53 *Can J Criminology and Criminal Justice* 247.

¹⁷³ EE Beasley, DJ Beirness & AJ Porath-Waller, *A Comparison of Drug- and Alcohol-involved Motor Vehicle Driver Fatalities* (Ottawa: Canadian Centre on Substance Abuse, 2011). Unfortunately, drug testing of fatally-injured drivers is not as routine as alcohol testing, so the estimate was based on a less-than-complete data set. The most commonly found drugs in fatally-injured drivers were depressants and cannabis. For comparable Australian data, see OH Drummer et al, “The involvement of drugs in drivers of motor vehicles killed in Australian road traffic crashes” (2004) 36 *Accid Anal and Prev* 239.

¹⁷⁴ For a thorough discussion of these and other problems related to the enforcement of the drug-impaired driving law, see DJ Beirness, P Swan & B Logan, *Drugs and Driving: Detection and Deterrence* (Washington: OECD Publishing, 2010) [OECD].

- ¹⁷⁵ Combining drugs or drugs and alcohol significantly increases crash risk. It has been suggested that, because marijuana and alcohol impair different sets of skills and capacities, their impairing effects may be additive or even multiplicative. See CJ O’Kane, DC Tutt & LA Bauer, “Cannabis and driving: a new perspective” (2002) 14 *Emergency Medicine* 296; RE Mann et al, *Impacts of cannabis on driving: An analysis of current evidence with an emphasis on Canadian data* (Ottawa: Road Safety and Motor Vehicle Regulation Directorate, Transport Canada, 2003); and E Kelly, S Darke & J Ross, “A review of drug use and driving: epidemiology, impairment, risk factors and risk perceptions” (2004) 23 *Drug and Alcohol Rev* 319 at 332.
- ¹⁷⁶ *Criminal Code*, *supra* note 1, s 254(5). The penalties are the same as that for refusing to provide a breath or blood sample. The minimum penalty is a \$1,000 fine and a one-year driving prohibition.
- ¹⁷⁷ *Ibid*, s 254(3.1).
- ¹⁷⁸ The Supreme Court of Canada has held that the results of physical coordination testing would only be admissible as evidence against the accused if he or she were first given the right to counsel: *Orbanski*, *supra* note 29.
- ¹⁷⁹ The seven classes of drugs are: depressants (eg barbiturates); inhalants (eg gasoline); phencyclidine (PCP); cannabis; stimulants (eg amphetamines and cocaine); hallucinogens (eg LSD and MDA); and narcotics (eg heroin and morphine). Department of Justice, *Drug Recognition Expert Testing* (Ottawa: Department of Justice, 2005).
- ¹⁸⁰ *Criminal Code*, *supra* note 1, s 254(3.4).
- ¹⁸¹ The DRE is accurate in predicting the presence of the class of drugs in over 90% of the cases. See for example, J Smith et al, “Drug recognition expert evaluations made using limited data” (2002) 130 *Forensic Sci International* 167; E Schectman & D Shinar, “Modeling drug detection and diagnosis with the ‘drug evaluation and classification program’” (2005) 37 *Accid Anal and Prev* 852; and D Beirness et al, “The Accuracy of Evaluations by Drug Recognition Experts in Canada” in B Logan, ed, *Proceedings of the 18th International Conference on Alcohol, Drugs and Traffic Safety – T-2007* (Seattle: International Council on Alcohol, Drugs and Traffic Safety, 2007) (CD-ROM).
- ¹⁸² It has been reported that a typical DRE in Canada lasts 30-45 minutes, with over 100 separate pieces of information being collected. AJ Porath-Waller, DJ Beirness & EE Beasley, “Toward a More Parsimonious Approach to Drug Recognition Expert Evaluations” (2009) 10 *Traffic Inj Prev* 513 at 517. This does not include the time necessary to conduct a preliminary roadside physical coordination test, transport the suspect to the police station, or allow him or her to consult with counsel. When these aspects are included, the process takes close to two hours from roadside testing to completion.
- ¹⁸³ In order to become evaluating officers, candidates must meet the rigorous training and testing standards established by the International Association of Chiefs of Police. Training of evaluating officers occurs in three stages: pre-school (16 hours), expert school (56 hours) and field certification (approximately 40-60 hours). The International Drug Evaluation & Classification Program, online: <www.decip.org/training> (accessed: 16 January 2012). See also *Drug Evaluation and Classification Training, Administrator’s Guide* (Washington: US Department of Transportation, 2007).
- ¹⁸⁴ Statistics Canada indicated that there were just over 1,400 arrests for drug-impaired driving in 2009. Statistics Canada, “Police-reported crime statistics” *The Daily* (20 July 2010). While this was roughly triple the number of arrests from the previous year (before DRE was introduced in the *Criminal Code*), it still falls far short of the estimated half million Canadians who reported driving within two hours of using marijuana or hashish in the *Road Safety Monitor*, *supra* note 171. Moreover, the half million figure does not include drivers who used other drugs that can impair a driver’s ability to operate a vehicle safely.
- ¹⁸⁵ These include Belgium, France, Germany, Sweden, Switzerland, and the United Kingdom. See OECD, *supra* note 174, Table 5.1.
- ¹⁸⁶ These include Arizona, Michigan, Iowa, Wisconsin, Delaware, Georgia, Illinois, Indiana, Minnesota, Nevada, Ohio, Pennsylvania, Rhode Island, Utah, and Virginia. See J Lacey, K Brainard & S Snitow, *Drug Per Se Laws: A Review of Their Use in States* (Washington: National Highway Traffic Safety Administration, 2010).
- ¹⁸⁷ On the other hand, establishing a legal limit above zero may give the impression that there is a “safe” or “acceptable” limit for using a given drug, which contradicts more general laws against drug possession.

¹⁸⁸ See M Boorman & K Owens, “The Victorian Legislative Framework for the Random Testing of Drivers at the Roadside for the Presence of Illicit Drugs: An Evaluation of the Characteristics of Drivers Detected from 2004 to 2006” (2008) 10 *Traffic Inj Prev* 16; and J Davey & J Freeman, “Screening for Drugs in Oral Fluid: Drug Driving and Illicit Drug Use in a Sample of Queensland Motorists” (2009) 10 *Traffic Inj Prev* 231.

¹⁸⁹ Boorman & Owens, *ibid* at 17.

¹⁹⁰ *Ibid* at 21.

¹⁹¹ See *supra* note 182.

¹⁹² *Criminal Code*, *supra* note 1, ss 259(1.1) and (1.2)(a).

¹⁹³ *Ibid*, s 259(1.2)(b) and (c).

¹⁹⁴ DJ Beirness & P Marques, “Alcohol Ignition Interlock Programs” (2004) 5 *Traffic Inj Prev* 299. In most provinces, less than a quarter of impaired driving offenders have installed an interlock.

¹⁹⁵ R Compton & J Hedlund, *Reducing Impaired-Driving Recidivism Using Advanced Vehicle-Based Detection Systems: A Report to Congress* (Washington: National Highway Traffic Safety Administration, 2007).

¹⁹⁶ A study of suspended and fatally-injured drivers in California found that 12.2% of all drivers were driving without a valid licence, and that unlicensed drivers were over-represented in fatal crashes by a factor of 4.9 to 1. D DeYoung, R Peck & C Helander, “Estimating the Exposure and Fatal Crash Rates of Suspended/Revoked and Unlicensed Drivers in California” (1997) 29 *Accid Anal and Prev* 17. Similarly, a 2003 study found that 20% of all fatal crashes in the United States between 1993 and 1999 involved at least one driver who was suspended or did not otherwise have a valid licence. R Scopatz et al, *Unlicensed to Kill: The Sequel* (Washington: AAA Foundation for Traffic Safety, 2003). See also JEL Malenfant, R Van Houten & B Jonah, “A Study to Measure the Incidence of Driving Under Suspension in the Greater Moncton Area” (2002) 34 *Accid Anal and Prev* 439; and J Suggett, *Fatal and Injury Crashes Among Unlicensed Drivers in Ontario: 1996-2003, Report to MADD Canada* (St Catharines: Synectics Transportation Consultants Inc, 2007).

¹⁹⁷ R Solomon et al, “Automobile Insurance, Impaired Driving and Victim Compensation Across Canada” (2005) 12 *MVR* 22.

¹⁹⁸ The recommendation to reduce the “hard” suspensions for drivers who participate in an interlock program is not meant to address the problem of unlicensed or prohibited driving. MADD Canada continues to advocate for provincial vehicle-based sanctions and better enforcement against those who drive while suspended or prohibited. See E Chamberlain & R Solomon, *The MADD Canada Model 2009* (Mississauga: MADD Canada, 2009) at 62-69.

¹⁹⁹ C Willis, S Lybrand & N Bellamy, *Alcohol ignition interlock programmes for reducing drink driving recidivism (Review)* (Oxford: The Cochrane Collaboration, 2009) at 20, 22.

²⁰⁰ PR Marques & RB Voas, *Key Features for Ignition Interlock Programs* (Washington: National Highway Traffic Safety Administration, 2010) at 22.

²⁰¹ In particular, the interlock data log can be an important source of information about the offender’s pattern of drinking and driving. For example, a pattern of early morning lockouts suggests that the offender has been engaged in heavy late-night drinking: PR Marques, RB Voas & AS Tippetts, “Behavioral measures of drinking: patterns from the Alcohol Interlock Record” (2003) 98 (Suppl 2) *Addiction* 13. The offender’s treatment counselor should use this information to target specific problem behaviours. Similarly, if an offender has repeated lockouts, it indicates that he or she is not yet ready to regain full licensure, and should remain in the interlock program. See P Marques, A Tippetts & R Voas, “The Alcohol Interlock: An Underutilized Resource for Predicting and Controlling Drunk Drivers” (2003) 4 *Traffic Inj Prev* 188.