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SPORTS MEDICINE and the LAW

Presented by Montgomery McCracken

'Sled Head' Symptoms and a 'No-Head-Contact Drill' Gone Wrong: Chronic Traumatic Encephalopathy and Concussion go to the Olympics

By Kaspar Kielland, of Montgomery McCracken

When discussing concussion and chronic traumatic encephalopathy ("CTE") related sports injuries and their potential lingering effects, the average person (depending on their country of origin) usually thinks of a popular contact sport like football, hockey, rugby, boxing, or soccer. But these "higher risk" sports are not the only sports where players sustain head injuries. Cheerleading, gymnastics, motor sport racing, equestrian actives, and any other sport where players collide or that pose a potential for head injuries can be dangerous, and lawsuits involving injuries sustained outside of the contact sport world are on the rise.

Recent cases against the USA Bobsled and Skeleton Federation and the USA Taekwondo Inc., the two national governing bodies for the respective U.S. Olympic Committees, highlight how concussion and CTE cases can reach well beyond the headlines of mainstream contact

See OLYMPICS on Page 10

Concussion "Diagnostic" Tools - Technologies Generate Buzz, But Experts Urge Caution

By Jessica Rizzo and Dylan Henry, of Montgomery McCracken

We've come a long way . . .

As a society, we have made tremendous cultural and scientific progress over the last few decades in the prevention, identification, and treatment of concussion. In the not-so-distant past, when a concussed and disoriented athlete walked to the wrong sideline after a collision, he may have been told to "shake it off" and return to play immediately. Fortunately, we have heightened our collective awareness about the severity of concussion and the risks associated with not taking this type of traumatic brain injury seriously. We now appreciate that athletes suspected of suffering a concussion should be immediately removed from play, promptly examined, and treated by a physician.

But identifying and diagnosing a concussion is not a particularly straightforward process. "Concussions aren't binary," says Dr. Steven Broglio, Professor of Neurology at the University of Michigan. "A concussion diagnosis is really a cluster of diagnoses," he explains, "and the gold standard still involves a symptom

See CONCUSSION on Page 11

IN THIS ISSUE

SPORTS MEDICINE and the LAW

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New South Wales Supreme Court Dismisses Controversial Concussion Lawsuit

Just days before a controversial concussion lawsuit was set to be heard, the New South Wales Supreme Court dismissed the claim.

The litigation involved former Newcastle Knights star James McManus, who sued the National Rugby League team in 2017 for $1 million, claiming it was negligent in its handling of the repeated concussions he suffered during his playing career.

McManus, who retired in 2015 after playing in 166 games, alleged in the lawsuit that he suffers from chronic traumatic encephalopathy (CTE).

His complaint alleged that "CTE and other injuries are progressive and degenerative. Therefore, the plaintiff's capacity to engage in paid employment, and his ability to compete in the open market, will diminish over time. The plaintiff is presently aged 35 years. But for his injuries, the plaintiff would have worked to the age of 67 years."

It further charged that "as a consequence of his injuries the plaintiff's earning capacity has been reduced, so that now he can only generally work 3-4 days per week on a regular basis."

Predictably, the NRL was pleased with the ruling, issuing the following statement: "The claim brought by James McManus against the Newcastle Knights, which was managed by the NRL, has been finalised with the NSW Supreme Court ordering judgment for the Knights."

"The NRL is pleased that this long-running matter has been resolved in the Knights' favour.

"The NRL was confident in its defence of the claim under the Civil Liability Act and we are pleased that the matter could be resolved without further cost and expense for all parties."

Court Rules for Iowa School District and teacher in Concussion Lawsuit

A federal judge from the Southern District of Iowa has granted a motion for summary judgment to Des Moines Public Schools and a teacher, holding that it was not obligated to protect a student who was attacked and injured, suffering a concussion, by her classmates at a 2019 school dance.

Plaintiff Kristy Mitchell, the mother of 15-year-old Nevaeh Osorio, sued a teacher and the district for negligent supervision and a failure to protect her daughter in violation of state and federal law.

The district argued in its motion that "Iowa federal courts have ... refused to find a duty exists between an educational institution and a non-student who enters the boundaries of its campus." Further, it claimed the plaintiff "has not and cannot prove (the teacher) or the district owed any duty to Plaintiff whatsoever."

In considering the first claim, the court found that the plaintiffs failed to show that the defendants, the teacher and district, assumed a duty to protect the girl. Notably, it concluded that the teacher did not increase the risk for the girl.

In the second claim, it found that the teacher was entitled to qualified immunity.

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Qualified Immunity Shields Public High School Coach and Athletic Trainer from Liability

By Kacie Kergides and Kimberly Sachs, of Montgomery McCracken

On August 20, 2021, the Kentucky Court of Appeals held that a public high school coach and athletic trainer were entitled to qualified immunity—a doctrine that shields government employees from individual liability in lawsuits alleging violations of a clearly established right. The case involved the tragic death of Star Ifeacho, a former basketball player at Paul Laurence Dunbar High School in Lexington, Kentucky. Peace Ifeacho, his bereaved mother, brought a lawsuit against several coaches and administrators of Dunbar and Fayatte County Public Schools (FCPS), including Coach Chris Armstrong and athletic trainer Cody Begley, alleging violations of FCPS policies and negligence. Both Armstrong and Begley argued they were entitled to qualified immunity because they used their discretion in good faith when deciding how to respond to an emergency involving Star. Though the trial court found only athletic trainer Begley was entitled to qualified immunity, the case eventually reached the Kentucky Court of Appeals, where both Armstrong *and* Begley were found to be immune from suit on any and all tort claims involving Star.

Background

On April 26, 2017, Star, a sophomore at Dunbar, attended an after-school basketball "open gym," where Chris Armstrong, a teacher and assistant boys' basketball coach, was supervising and coaching the students. During the open gym, Star complained to other students that he was having trouble breathing. After it was not getting better, Star went to the athletic trainers' office to speak with Cody Begley, an athletic trainer who worked at Dunbar pursuant to a contract with FCPS. Star specifically complained to Begley that his heart was racing. As Star turned to leave the athletic trainers' office, he turned back to Begley, stated "it's doing it," and then collapsed. Begley immediately went to Star's side, rolled him onto his back, checked his breathing and pulse, and, while doing so, instructed a football player in the office to call 911. Begley then began applying CPR and instructed another student to go find a coach. Thereafter, Armstrong came into the office and began to assist Begley.

During this time, Begley also instructed another nearby student to call another athletic trainer, Gabrielle Sombelon, who had taken the only automated external defibrillator ("AED") with her to an in-season baseball practice. According to the FCPS policy concerning the placement of AEDs in a building, "[t]he optimal response time is three (3) minutes or less . . . Survival rates decrease by 7-10% for every minute defibrillation is delayed."

When Sombelon did not initially answer her phone, Begley instructed two other students to retrieve another AED located in the school's foyer, approximately 325 feet from the athletic trainers' office. Once the students arrived with the AED, Begley applied the AED's leads to Star and delivered a shock when prompted by the AED. Before Begley could deliver a second shock, the Lexington Fire Department arrived and assumed resuscitation efforts. Star was transported to the University of Kentucky Emergency Department, but they were unable revive him and he passed away.

The Trial Court Case

Star's Estate and Star's mother, in her individual capacity, brought an action in Fayette Circuit Court against several Dunbar and FCPS coaches and administrators, including coach Armstrong and athletic trainer Begley, in both their individual and official capacities. The trial court dismissed all official capacity claims against Armstrong and Begley, leaving only the individual claims.

The complaint alleged that Armstrong was required under FCPS policies to immediately retrieve an AED. Similarly, the complaint claimed that Begley was negligent in having a student attempt to contact Sombelon to bring the portable AED to the athletic training room rather than immediately sending a student to obtain the other AED in the foyer.

Armstrong moved for summary judgment, claiming he was entitled to sovereign immunity, but the Fayatte Circuit Court denied Armstrong's motion, finding the claims against Armstrong were based on ministerial facts, and therefore, sovereign immunity was not applicable. Additionally, the court found that Armstrong was not immune under Kentucky's AED and Good Samaritan statutes because he was not engaged in Star's medical treatment. Begley's summary judgment motion was granted. Both Armstrong and the Estate filed timely appeals.

Qualified Immunity

The Kentucky Supreme Court has held that when an officer or employee of the state or county is sued in his or her individual capacity, that officer or

employee is often entitled to qualified official immunity, "which affords protection from damages liability for good faith judgment calls made in a legally uncertain environment." Yanero v. Davis, 65 S.W.3d 510, 522 (Ky. 2001). The application of qualified immunity "rests not on the status or title of the officer or employee, but on the function performed." Id. at 51. Specifically, "the analysis depends upon classifying the particular acts or functions in question in one of two ways: discretionary or ministerial." Haney v. Monskey, 311 S.W.3d 235, 240 (Ky. 2010). A duty is ministerial "when the officer's duty is absolute, certain, and imperative, involving merely execution of a specific act arising from fixed and designated facts." Patton v. Bickford, 529 S.W.3d 717, 724 (Ky. 2016).

The Appeal

In finding that Armstrong was ww to qualified immunity, the Appellate Court analyzed whether the FCPS Protocol imposed a ministerial duty on Armstrong to retrieve the AED or whether his decision was a good faith judgment call made in a legally uncertain environment. The Protocol instructs that certain actions must be taken when presented with an unresponsive victim: confirm the unresponsiveness of the victim, call 911, alert athletic and/or supervising staff, retrieve an AED, and follow CPR and AED procedures until EMS arrives. The court concluded that it was mandatory and ministerial that those tasks be completed.

When Armstrong entered the training room, Begley, an athletic trainer and certified-EMT, was already taking emergency care of Star. Armstrong responded to an in-progress situation already being managed in which appropriate care was being rendered. The court held that so long as Begley's aid was appropriate, Armstrong cannot be faulted for using his discretion in declining to take control from an individual with superior training and experience.

As it related to Begley, in noting that the negligence claims were dropped against him, the court found that Begley's decision-making process in determining how to retrieve the AED in this emergency situation was clearly discretionary in nature. Further, the court stated that although the Emergency Action Plan in place at the time made it mandatory for Begley to designate someone to retrieve the AED, his exercise of that discretion in who to designate, which AED to instruct that designee to retrieve, and how long to wait prior to designating someone else to retrieve an alternate AED were not specified by the EAP and instead remained in Begley's discretion. Therefore, because Begley's actions were discretionary, he was entitled to qualified immunity.

Takeaways

A school official's primary concern when it comes to saving a student's life should be just that: saving a student's life. Emergency situations require quick thinking and action, and coaches and athletic trainers should feel comfortable assessing the emergency circumstances and responding as they deem necessary given their expertise and training. Of course, every organization should have a protocol in place to ensure that coaches, athletic trainers, and athletic staff are taking the appropriate steps when a student-athlete's life is in danger. But, in an uncertain environment where every second counts, the focus should be on how to save a life and keep everyone safe—*not* on potential liability.

Still, discretionary decision making should be avoided when the circumstances so permit. Schools and athletic organizations have safety protocols and procedures in place for a reason, and coaches, athletic trainers, and athletic staff should adhere to these protocols and procedures to the extent possible to ensure a safe environment for student-athletes. There should always be an emergency action plan in place, and school personnel should host quarterly trainings throughout the year for their athletic department to make sure the coaches, athletic trainers, and athletic staff responsible for the safety and well-being of student-athletes are well-versed in the steps they must take in an emergency situation.

Here, Armstrong and Begley were clearly familiar with the FCPS policies, and they tried to follow them as best they could. But, they both recognized that the emergency situation required them to make quick discretionary decisions about the policies in order to administer Star the best care in the safest and most efficient way. Though Star's tragic death was an unfortunate event, Armstrong and Begley did everything they could, within reason, to save his life.

In today's litigious society, the number of lawsuits against school personnel for student-athlete related injuries and deaths are increasing. Organizations must protect not only themselves, but the lives of their student-athletes, by having strict guidelines in place for medical emergencies. But, these protocols are not always a one-size-fits-all approach, and there should be some leniency in the law for spur-of-the-moment discretionary decision-making. The Kentucky Court of Appeals recognized this, and we anticipate future courts' ruling on qualified immunity in the medical emergency sports context will reach similar conclusions.

Kacie Kergides

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Kimberly L. Sachs

CSMAS Supports Comprehensive Student-Athlete Well-Being Survey, Review of Cannabinoid Policy

In its September meeting, the NCAA Committee on Competitive Safeguards and Medical Aspects of Sports approved actions around a comprehensive well-being survey, drug testing operational and policy issues, and a new mental health advisory group. The moves were made in support of the committee's mission "to promote a healthy and safe environment for student-athletes across the Association."

Comprehensive well-being survey

CSMAS approved the development of a comprehensive student-athlete well-being survey to streamline and better prioritize topics from the NCAA quadrennial surveys and other student-athlete health and well-being surveys.

Historically, NCAA research has conducted multiple surveys to gain insight into the student-athlete experience. This comprehensive effort would harvest health and safety content out of those surveys to create a single, robust well-being survey. The new survey is expected to be distributed in fall 2022.

New drug testing subcommittee and review of cannabinoid policy

CSMAS also approved the development of a drug testing subcommittee to address drug testing operational and policy issues.

This subcommittee will include CSMAS members from all three divisions and will include a representative from one of the national Student-Athlete Advisory Committees. It will be chaired by the CSMAS member designated as the committee's drug testing expert.

In consideration of the evolving landscape regarding cannabis use, CSMAS charged the drug testing subcommittee to explore possible changes to Association cannabinoid policy that would recenter the identification and deterrence of problematic cannabis use. The subcommittee recommendations are expected to be drafted by early 2022. Further, CSMAS directed the development of a summit to solicit input from membership stakeholders and industry experts related to the well-being and performance aspects of cannabis use.

New mental health advisory group

As an initial effort to respond to outcomes from the 2020 Diverse Student-Athlete Mental Health and Well-Being Summit, CSMAS approved broader membership socialization of the concepts developed at the summit and supported suggestions related to the review and update of the NCAA Mental Health Best Practices document. CSMAS also approved the creation of a Mental Health Advisory Group that would work under the direction and oversight of the committee to lead the review of best practice materials and be responsible for advising the Association on emerging developments in mental health science and policy.

Study Examines How Marching Band Kids Are at Risk from Heat Illness

Published in The International Journal of BiomTteorology, a study led by Andrew Grundstein, a professor in the University of Georgia's Franklin College of Arts and Sciences, has analyzed news reports of band members suffering heat-related illnesses from 1990 to 2020. The study found that almost 400 band students who overexerted themselves and became ill due to heat exposure. About half of these students were treated on site and didn't require hospitalization, but 44 percent wound up in the hospital for treatment before being released the same day. The others suffered from heat stroke, requiring more than just one day in the hospital. "Think about what they do," said Grundstein, corresponding author of the paper. "They go out there, and they often wear these really heavy wool uniforms. They practice many times for hours and hours outside. Some of them are carrying heavy instruments, and they're moving around a lot. There are a lot of risk factors that come into play for marching band members that people generally don't really think about."

Serious Injury Risk Higher for Horse Riding Than for Football, Motor Racing, or Skiing

The risk of an injury, requiring hospital admission, is higher for horse riding than for other potentially risky sporting activities, such as football, motor racing, or skiing, finds research published in the online journal Trauma Surgery & Acute Care Open.

While the most common site of injury was the chest, both head and neck injuries were the most lethal, the findings show.

Data from the US Centers for Disease Control and Prevention show that more than 30 million people participate in equestrian leisure and sporting activities every year in the USA. But relatively little is known about the prevalence and consequences of injuries sustained while horse riding.

To plug this knowledge gap, the researchers drew on data supplied from level I and II trauma centers to the US National Trauma Data Bank (NTDB), on injuries sustained by adults while horse riding between 2007 and 2016.

The most common site of injuries recorded was the chest: 9189 (37%). Injuries to the arms and legs occurred in 6560 (26.5%), while 5689 (23%) sustained head injuries.

Riders with head and neck injuries were 44 times as likely to die as those with arm/leg injuries, while those with chest and abdominal injuries were around 6 times as likely to do so.

New Study Analyzes Concussion Rates and Closed Head Injuries in HS-Aged Female Athletes Over Past 20 Years

The epidemiology of sports-related concussions (SRCs) and closed head injuries (CHIs) in high school females remains largely undefined at the national level, especially for unorganized sports and recreational activities such as equestrian and snow-related sports.

A new study presented at the 2021 Annual Meeting of the American Academy of Orthopaedic Surgeons (AAOS) took a closer look at sports-related head injuries in female patients over a 20-year period to identify national estimates, demographic characteristics, and trends. The findings show a dramatic increase — more than 200 percent — in sports-related head injuries among female athletes ages 14-18 and demonstrates that this increase is not always directly correlated to increased participation.

According to studies investigating sex differences in SRC epidemiology, female athletes face concussion rates nearly twice as high as their male counterparts when participating in sex-comparable sports. Female athletes may also be more likely to sustain recurrent concussions, experience atypical symptoms, and require longer recovery times before returning to sport. ,

"In addition to concussions, we made sure to include closed head injuries as part of our analysis because, in both cases, we wouldn't want athletes to return to play without an evaluation," said lead researcher Kevin Pirruccio, MD, orthopaedic surgery resident at Yale New Haven Hospital. "CHI is the most common type of traumatic brain injury; it is a blunt, non-penetrating head trauma that doesn't create a break in the skull. While there is a lot of overlap between SRCs and CHIs, concussion refers to the symptoms (dizziness, nausea, blurry vision, etc.) and CHI is the mechanism of the injury."

The study, "Sports-Related Concussions in High School Females: An Epidemiologic Analysis of 20-Year National Trends," retrospectively identified a study population of female patients, ages 14 to 18, who sustained SRCs and CHIs across 56 sports or recreational activities from 2000 to 2019. Dr. Pirruccio and his team used the Consumer Product Safety Commission's National Electronic Injury Surveillance System (NEISS), which documents activity-associated injuries presenting to emergency departments (EDs) in the United States.

"We used the NEISS database because

it captured injuries occurring in sports and activities outside of a school setting, such as horseback riding, snowboarding, and rugby, providing a more accurate look at data outside of what is typically studied among high school athletes," said Dr. Pirruccio.

The national weighted estimate of female patients ages 14 to 18 presenting to U.S. EDs with SRCs or CHIs increased significantly between 2000 (9,835 cases) and 2019 (31,751 cases). On average, 39.1% of annual SRCs and CHIs presenting to U.S. EDs occurred in this patient cohort. Over one quarter (26.2%) of these injuries occurred in patients 15 years of age.

Among this group, the five sports and recreational activities most commonly associated with SRCs and CHIs were soccer (20.6%), basketball (18.5%), cheerleading (10.4%), softball (10.1%), and volleyball (6.5%).

As the number of girls participating in sports continues to rise, the research team also studied the direct correlation of increased participation to concussion rates over the 20-year period in high school-aged female athletes. They determined that concussion rates cannot be attributed to increases in participation rates alone. While the primary influence behind increasing concussion trends in these patients may well be increased participation rate for certain sports, such as soccer and volleyball, variations in annual SRCs and CHIs presenting to U.S. EDs associated with softball, cheerleading, and basketball were not strongly correlated with participation.

Dr. Pirruccio and his team hope to further investigate the potential causes of these annual SRC and CHI variations, which could include factors such as concomitant changes in practice rules or training regimens, cultures within a sport, or reporting differences between individual athletes. They also hope this study will encourage other research teams to further investigate the topic.

"While concussions can be classified as an epidemic, it's important to consider that 96.7% of patients who were admitted to the emergency department with an SRC or CHI were treated and went home," said Dr. Pirruccio. "Sustaining a concussion shouldn't necessarily preclude our youth from participating in the sports and physical activities they love. Instead, we hope this study encourages mindfulness among athletes, coaches, and parents and stimulates the adoption of comprehensive return to play protocols to prevent further harm. This is especially important with non-school sanctioned sports and activities, which may lack a dictated return-to-play guideline."

Dent v. NFL Lives On as the Court Considers the Latest Machinations in the Painkiller Litigation

By Jeff Birren, Senior Writer

Soon after the NFL Concussion Case Litigation entered settlement discussions, another NFL class action was filed in federal court in San Francisco, (*Richard Dent et al v. NFL,* ("*Dent*") N.D. Cal. Case No. C 14-02324 WHA). It was assigned to Judge Alsup. *Dent* was based on the theory that the NFL, and not the clubs, gave pain medication to players to allow them to continue to play. Sports Litigation Alert, a sister publication to SML, has followed its progress (*SLA,* "Former NFL Football Players Sue League over Use of Prescription Drugs" (5-30-14)). After the District Court dismissed *Dent, (SLA*, "Judge Grants NFL Motion to Dismiss Prescription Drug Claims" (12-26-14)), the same counsel, but different plaintiffs, filed similar claims not against the NFL but against the member clubs, *Etopia Evans et al v. Arizona Cardinals et al.* That case was filed in Maryland but was transferred to Judge Alsup. Much of *Evans* was tossed on a motion to dismiss (*SLA, "*Court Dismisses Claims Brought by Ex-NFL Players in Pain Medication Litigation" (3-17-17)). The final claims were dismissed on summary judgment, based on workers compensation exclusive remedy statutes (*SLA,* "Judge Grants Summary Judge on the Few Remaining Claims in NFL 'Painkiller' Case" (9-1-17)). The Ninth Circuit affirmed (761 F. App'x 701 (9th Cir. 2019)).

The Ninth Circuit revived the *Dent* claims that had been dismissed based on preemption (902 F. 3d 1109 (9th Cir. 2018)). Judge Alsup later granted the NFL's motion for summary judgment, but the Circuit reversed as to one cause of action (*SLA*, "Richard Dent v. NFL: The Ninth Circuit Revives a Single Dismissed Claim in Workers Comp Case" (9-11-20)). The NFL filed a motion to dismiss, but perhaps to the surprise of all, Judge Alsup denied the motion (*SLA*, "Dent v. NFL: The Plaintiffs Survive a Motion to Dismiss" (4-23-21)).

Dent Continues

The sole remaining cause of action was a common law claim for negligent voluntary undertaking for a supposed failure to ensure the proper recordkeeping, administration and distribution of painkillers and other prescription medications. The purported class included all NFL players who played between January 1, 1973, and December 31, 2008, and who received various medications from an NFL club including opioids, non-steroidal anti-inflammatory drugs, corticosteroids, or

local anesthetics.

The plaintiffs recently sought class certification. The Court held the hearing on the motion on 8-5-21 and ruled 26 days later ("Order Denying Class Certification ("*Order")* (8-31-21). (The first six pages recites in vastly greater detail the history of the litigation summarized above).

The Court's "Analysis"

The plaintiffs sought certification under FRCP 23(b)(c), which requires showing that "the questions of law or fact common to class members predominate over any questions affecting only individual members, and that a class action is superior to other available methods for fairly and efficiently adjudicating the controversy" (Id. at 8). The court "must do a rigorous analysis to determine if the requirements" are satisfied.

The Court stated that even after two Ninth Circuit opinions, "the precise nature of plaintiffs' theory of the NFL's liability remains elusive." Originally the theory was that the NFL "itself illegally distributed controlled substances and therefore its actions directly injured players" (quoting *Dent I,* 902 F3d. at 1118). The plaintiffs later "admitted those allegations were incorrect." They then asserted a voluntary undertaking theory. The Ninth Circuit articulated that theory as: the NFL voluntarily undertook a duty to ensure proper recordkeeping, administration, and distribution of the medications; that it created a drug oversight program; audited clubs' compliance with federal drug laws; mandated procedures to control the drug distribution system; oversaw the administration of that system; and it was within the NFL's control to "promulgated rules or guidelines that could improve safety for players across the league" (Order at 8/9).

To determine whether the NFL breached that duty, the Court "must by definition looks at the actions of the clubs." Class counsel asserted at oral argument that *Dent II* "precluded consideration of the conduct of the clubs." The Court responded that this was not so, as the items listed above support a duty by the NFL, but those "items necessarily turn in part of the propriety of the conduct of the clubs."

Common Questions of Law?

The class included all NFL players who played "at any time during the 35-year period from 1973 to 2008 and who received any drugs from his team." Class counsel argued that New York should apply to all claims, or, if not New York, then the law of the named plaintiffs' states, California, Arizona, and Illinois, should apply to the entire class. At oral argument class counsel "misstated that plaintiffs' briefing had done a comprehensive survey" of the law and "virtually all 50 states follow" the *Restatement (Second) of Torts.* In fact, counsel had only compared the law of those four states. The Court responded that it could not "rely merely on the assurances of counsel" (Id. at 10). "Plaintiffs' counsel has simply assumed away the problem and provided an inadequate record for certification."

In California, "the situs of the injury remains a relevant consideration." Here, "at least 23 states are implicated." The putative class includes "thousands of current and former NFL players spanning 35 years of plays, 32 different teams, and medications administered and distributed (and injuries suffered) in at least 23 different states." (Note that eight of the clubs have permanently moved from jurisdiction to another during the relevant time frame.)

Plaintiffs' brief admitted that the class was "harmed in dozens of different cities during the course of their NFL careers." Therefore the "potentially affected jurisdictions" are the states where the class members sustained injuries and the states where they currently reside. California requires comparing each non-forum state's law with California law. Plaintiffs cited a Wyoming District Court opinion but that dealt with one medication. Here, the plaintiffs "have not met their burden to show that a single body of law can be applied to the entire class, or even that the differences among the states would be manageable" (Id. at 11). A case involving the laws of 23 different states could "become a sprawling trainwreck. Variation in the law from state to state might make the case unmanageable." Although it might work, plaintiffs "have not met their burden to show it."

Club by Club Factual Questions Predominate

The NFL developed its annual prescription drug audit system in the early 1970s based on widely publicized dispensing of controlled substances and practices among certain teams. A 1990 NFL report acknowledged that there was still "variations among the clubs in terms of recordkeeping" and this would "affect not only the lack of common proof but the substantiative lability of the NFL." If a club "maintained good drug records, the NFL did not breach its duty to the players of that club". Conversely, players of a club "who negligently maintained drug records might have claims" (Id. at 12). But even then, "we don't have a method of common proof to show that such failure caused injury to the player, given the lack of records."

A 1992 NFL report stated that the range of use of such drugs "is quite wide." In 1986 the "maximum number of controlled substances dispersed by a team was 15." In 2012 the average was 9.3 different types of NSAIDS and 13.6 different types of controlled substances per club." These differences continued over time. Moreover, there were wide differences in the use of the same drug. In 2005 the Jets dispensed 320 tablets of Toradol and 148 Toradol injections. The previous season the Colts dispensed

651 doses of Toradol and 249 Toradol injections.

Plaintiffs "would have us wave our hand at these inter-team differences as merely a question of damages, not liability, because, they say, the volumes were all unreasonable. At oral argument, plaintiffs' counsel brazenly compared the differences in volumes of medications dispensed by the NFL teams to the difference in the number of victims between 'a serial killer who killed 20 people and a murderer who committed 1.'" However, they "provided no reason or evidence, other than exaggerated rhetoric, to believe that the least volume of medications was equally unreasonable to the most and that such differences are immaterial." In fact, they "have made no showing whatsoever that the wide variety of painkillers and non-steroidal anti-inflammatory drugs (NSAIDSs) posed a uniform risk of injury in terms of excessive use. The inter-team differences in volumes and varieties of drugs cannot be ignored."

Furthermore, plaintiffs' evidence showed a substantial variation over time within a single team. In 2006 the Jets dispensed 511 Vicodin tables but in 2007 they dispensed 1275 Vicodin tablets. Plaintiffs have "provided no reason to believe that such differences are a matter of damages only rather than liability versus non-liability."

The NFL program did not and could not "provide a unform standard of medical care for the team" physicians and trainers. A 1986 report emphasized that it did not "dictate how physicians should practice medicine. That was controlled by state law in the place of the practicing physicians." Consequently, a court would "need to look at the reasonableness of the conduct of the club physicians and trainers" and that is "governed by state law."

Moreover, "the NFL has frequently modified the audit program over time. Plaintiffs alleged that by voluntarily undertaking the program, the NFL assumed a duty to conduct the audits with reasonable care for the benefit of the players." The relevant factors, however, "have changed significantly over the 35-year period from 1973-2008" (Id. at 13). In a 2011 study, 48% of the retired players "reported using no prescription opioids during the NFL careers." The cited study also "shows that a significant number of putative class members received opioids from sources other than their clubs" such as a teammate or family member. Plaintiffs admitted that this "factor would have to be accounted for" but "there is no practical way to do so on a class-wide basis. For the foregoing reasons, a *Rule 23(b)(3)* class will not be certified."

The Class Seeks Large Damages

One class certification factor in *FRCP 23(b)(A)* is the class members' interest in damages. Small individual damages weigh in favor of certifying a class, but relatively large damages weigh against class action. Several putative class members "claim damages created than two million dollars" (Id. at 14). Thus, "individual class members have substantial incentive to pursue individual claims weighing against the class action."

FRCP 23(c)(4) Class?

The plaintiffs last assertion was that class status was appropriate for certification of the duty and breach elements of the negligence claim. The Court disagreed. In evaluating the NFL's conduct, "we would still need to have evidence concerning what the NFL itself knew about the extent of the problems, if any, at the club level." A club "by club probing of the NFL's knowledge would still devolve into a myriad set of club issues." Even if that happened, the "state courts would have a devil of a time trying to dovetail that finding into the specifics of a follow-up trials by individual players in state courts."

Consequently, the "most effective and efficient way to litigate this case is to proceed to trial on a non-class basis." Should plaintiffs win, that "would have collateral estoppel effect that would benefit their teammates" while a loss "would not prejudice other class members suing on their own." Plaintiffs cited a case that the Court thought was inapposite because all the properties at issue were in a single state. Finally, the duties related to the distribution and administration of medications is "governed by a professional standard of care" and not ordinary negligence (Id. at 15). The "complexities raised by the differences in law are compounded" by "the necessity of examining both the NFL's conduct towards the clubs under 23 different bodies of law, and the clubs' conduct towards the players under the medical professional standards of 23 different jurisdictions." FRCP 23(c)(4) class status was denied.

Conclusion

A California workers compensation firm started the case, and in that venue, applicants have a massive home field advantage. *California Labor Code §3202* states that the code "shall be liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment." Things do not work that way in federal court. The annual drug audit was a voluntary undertaking created to help the players. It led to this lawsuit, proving again that no good deed goes unpunished. It is now on to summary judgment before heading back to the Ninth Circuit.

Chronic Traumatic Encephalopathy and Concussion go to the Olympics

Continued from page 1

sports. Despite the exceptional commitment of the practicing athletes driven by the dream of representing their country at the Olympics, it is unfortunate how many Olympic disciplines receive attention from the general public only during the actual Olympic games. But the risks of brain-related injuries in many of those sports are as serious as those occurring in the big leagues' arenas, and unlike the Olympic games themselves, the risk is ever present, and not just every four years. And the liabilities for the regulating sports associations who might fail - or failed - to take proper actions to prevent and mitigate those risks can potentially be substantial.

'Sled Head' – The Bobsled Class Action

William Person, a member of the US Olympic team between 1999 and 2007, filed a proposed class action against the USA Bobsled and Skeleton Federation ("USABS") in the Los Angeles Superior Court at the end of last September. Person decided to take action against the USABS after noticing that many former bob sledding athletes are dealing with the consequences of brain injuries allegedly caused by practicing the sport, including living with "depression, dementia and sometimes taking their own lives."

Person claims that as early as 1983 the USABS knew that head impacts and sub-concussive blows inherently associated with bob sledding had the potential of causing serious brain damage to the athletes. However, the USABS did not advise them about those risks. Person further alleges that while practicing the sport, he was suffering symptoms of "sled head." To this day, little research has been conducted on "sled head," which is a condition that causes the athletes to experience headaches, fogginess and disequilibrium as a result of multiple bumpy and fast track runs. The former Olympian claims that the USABS did not medically evaluate whether or not he was still fit to practice, notwithstanding having been made aware of those symptoms. The lawsuit seeks compensation for the potential class of athletes in both the form of implementing preventative measures, through the creation of a fund that will pay for the monitoring of the condition and symptoms of former bobsledders, as well as remedial measures, through the establishment of a Court Supervised Compensation Program for those athletes that have already been diagnosed with both neurodegenerative and behavioral brain injuries.

'No-Head-Contact Drill' – The Taekwondo Suit

From the steep and fast runs of sledding to the flats of a martial art mat, the Northern District of Ohio recently denied the motion by the USA Taekwondo Inc. ("USAT") seeking the dismissal of a complaint brought by former taekwondo Olympic prospect, Philip Vincent Ripepi. In 2018, Ripepi was selected by two USAT coaches to participate in a training camp organized by the USAT in England. Ripepi alleges that the aim of the camp was to acclimatize the participants to taekwondo at an Olympic level. During the second day of camp, Ripepi was allegedly coupled with an athlete outside of his weight class to perform what is known as a "no-head-contact drill." Notwithstanding the nature of the drill, Ripepi was almost immediately hit by a kick to the back of his head by his sparring partner. The blow knocked him to the ground for several minutes and he started to feel dizzy. The athlete claims that neither the coaches nor the athletes who were present provided him with assistance. He was pressured to continue his training - which he did - for the reminder of the day.

In the evening, his concussive symptoms, including nausea and vomiting, worsened. Ripepi spent the night in excruciating pain without being able to sleep. The following morning, the athlete informed the USAT of his deteriorating symptoms, but despite allegedly acknowledging the concussive nature of Ripepi's symptoms, the USAT decided to ignore them. The USAT allegedly not only failed to provide him with medical assistance but also discouraged him to go to the hospital. Ripepi decided to sit on the sidelines for the day but his symptoms, which included headaches, ringing in his ears, sensitivity to lights and sounds and double vision, kept getting worse. At that point, he was told he would be evaluated by the mother of another camp participant who was a surgeon. But according to Ripepi, the training day went by without him receiving any medical attention.

The following day, after another sleepless night, the USAT asked Ripepi to assist with "computer activities" while waiting to be evaluated by the doctor, to which Ripepi agreed. Once again, the doctor did not arrive during the training session. Ripepi was then again allegedly promised that he would have been evaluated in the evening in his hotel room, but he opted instead to return to the United States.

Ripepi's suit alleges that the USAT's failure to properly respond to his head injury was a breach of the USAT's duty of care towards the athlete and that such negligent behavior "destroyed his career and lifelong ambition of participating in the Olympics." The USAT moved to dismiss Ripepi's complaint on a primary assumption- of- risk defense theory claiming that, by agreeing to participate in the camp, Ripepi knew of the risks involved, and therefore he was not owed "any duty whatsoever."

In denying the USAT's motion to

dismiss, the court acknowledged how the USAT's defense of primary assumption of risk will "stand in the spotlight through the course of the litigation" but at this stage of the proceeding, Ripepi's allegations that the USAT breached its duty of care toward the athlete, "in a situation where harm is probable, and subsequently deliberately failed to provide him with medical care while appreciating the injury," are sufficient for the matter to go forward. Whether the USAT can successfully show that Ripepi assumed the "ordinary risk of the activities," that the assumption of risk defense is sufficient to overcome Ripepi's negligence claims, and whether Ripepi's accusations are true, "remains to be seen."

Takeaway

The bottom line is that concussion litigation and CTE failure-to-warn cases are no longer solely reserved for, or a hallmark of, the more popular contact sports. The athletic world is beginning to realize the potential serious, if not deadly, injuries that can result from the routine head and body contact that is associated as being part of a sport. This includes not only the one-off concussive impacts but also the repetitive sub-concussive impacts (such as the constant jostling of the head inside a bobsled). These sub-concussive blows are what makes it harder for a governing sport association to argue that the athlete was warned and made aware of, appreciated, and assumed the risk. Yes, a bobsledder may have assumed the risk of the sport, which includes high-force crashes and possible concussion, but was the bobsledder made aware of the long-term risks associated with the accumulation of repetitive sub-concussive blows?

Sports associations must do more than wave a flag and stand on the side, especially now that it is clear these associations are aware of the long-term effects of the sub-concussive blows. They must act proactively through guidelines, training and services aimed not only at ensuring the athletes' health and safety but also at avoiding the risks and negative attention drawn by litigation.

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Concussion "Diagnostic" Tools - Technologies Generate Buzz

Continued from page 1

evaluation, a cognitive screening, and a neurological screening" by a physician with experience handling concussions. It takes time and training to properly conduct that kind of thorough assessment, but based on recent headlines, one might think the possibility of *instant* (and physician-free) concussion diagnosis is just around the corner.

This article addresses the state of concussion "diagnostic" tools currently on the market and discusses why, despite recent advancements, we are still years away from being able to rely solely on any one technology for concussion diagnosis.

Biomarkers in Saliva and Blood

The University of Birmingham says it has identified a method of accurately diagnosing concussions by using saliva samples to evaluate changes in players' RNA.[1]

The healthcare company Abbott received Food and Drug Administration ("FDA") clearance for a rapid, handheld traumatic brain injury blood test this year.[2] Developed in collaboration with the Department of Defense ("DOD"), the test measures elevated concentrations of certain biomarkers in the blood plasma of those suspected of having a concussion. Abbott says it provides results within 15 minutes.

Neurological Signals

A Canadian research team has developed portable, automated electroencephalography ("EEG") technology that can, they say, diagnose a concussion in 10 minutes by measuring brain vital signs.[3]

Ocular Screening Devices

In 2018, the neuro-diagnostic company Oculogica received FDA approval to market the EyeBox, a technology designed to detect traumatic brain injury by tracking eye movement and measuring cranial nerve function.[4] The DOD recently awarded Oculogica a $2 million grant for the development of a wearable version.[5] Rugby clubs in Australia and

1 University of Birmingham, *Rugby study identifies new method to diagnose concussion using saliva*, Science Daily, March 23, 2021 (https://www.sciencedaily.com/releases/2021/03/210323183823.htm).

2 Abbott, *Abbott Receives FDA 510(K) Clearance for the First Rapid Handheld Blood Test for Concussions*, Abbott, January 11, 2021 (https://abbott.mediaroom.com/2021-01-11-Abbott-Receives-FDA-510-k-Clearance-for-the-First-Rapid-Handheld-Blood-Test-for-Concussions).

3 Damian McNamara, *Portable EEG Makes 'Real Time' Call on Sports Concussions*, Medscape, January 29, 2019 (https://www.medscape.com/viewarticle/908383#vp_1).

4 Maria Rachal, *Concussion diagnostic tech on rise with FDA clearances*, MedTech Dive, January 3, 2019 (https://www.medtechdive.com/news/concussion-diagnostic-tech-on-rise-with-fda-clearances/545117/).

5 Oculogica, *Oculogica Receives De-*

New Zealand have already begun using the eye-tracking NeuroFlex device on a trial basis. Developed by a Québécois company to screen for head injuries using virtual reality technology, the device is being touted as capable of capturing all the data it needs for assessment in just 10 seconds.[6]

Impact Force Detection Devices

Philadelphia startup Tozuda now sells head impact indicators that can be affixed to a player's helmet. They change color when a potentially damaging hit has occurred, indicating that the player should be evaluated. Their catchphrase? "If it's red, check your head."[7]

. . . But we still have a ways to go.

To be sure, these are exciting developments. Many concussions evade detection because healthcare providers must rely on self-reporting to detect key symptoms, and players are not always reliable narrators of their own experiences. "I've had high-school athletes lie to my face," says Broglio. Athletes often downplay their symptoms because they are overeager to get back in the game. An objective diagnostic test would make it more difficult for patients to evade an unwanted diagnosis. Non-invasive tests like those in development could also spare patients the exposure to radiation that comes with undergoing a full CT scan.

Even so, experts urge caution. "We're still a long way away" from any of these technologies being ready to supplant the human element, says Broglio.

Dr. Jeffrey Kutcher, a neurologist, agrees. "I get asked all the time about blood tests for concussion," he says. "People ask, 'this is a concussion marker, right? We can use these little handheld blood tests on the sidelines at football games, right?' That's not the correct way to think about it. The correct way is to understand that if a neuron experiences enough biomechanical force, it will excrete certain proteins into the blood, and you can pick thosew up with testing. However, that's a marker for whether the neuron experienced force. It's not necessarily a marker for an underlying physiological injury. As such, you might use this kind of tool when you're not sure if the patient experienced brain trauma and you want to know if you need to expose them to the radiation of a CT scan. You might use this kind of test to efficiently triage patients in ED setting."

Jessica Rizzo

Dylan Henry

Much about concussions remains medically mysterious, and while the impulse to solve that mystery with technologies that promise clarity and objectivity is understandable, there is still no substitute for subjective interpretation. Each concussion is unique, and while a particular diagnostic technology may one day work for some people, that is no guarantee that it will work for everyone. The American Medical Society for Sports Medicine has recently found that combining tests of different functions to form a multimodal concussion assessment can result in more accurate diagnoses, but a single test used in a vacuum cannot be trusted, at least for the foreseeable future.[8]

For purposes of avoiding legal liability, there is no question that schools and athletics associations should never rely solely on any diagnostic technology. Players suspected of having suffered a concussion should be immediately removed from play and examined by someone trained to administer a cognitive screening, neurological screening, and symptom evaluation. Never rely on a negative saliva, EEG, blood, eye movement, or impact indication reading to put a player back in the game if she is exhibiting other telltale concussion symptoms.

Burgeoning interest in concussion diagnostic technologies coincides with growing optimism about the possibility of diagnosing chronic traumatic encephalopathy ("CTE") in living patients.[9] A definite determination of CTE is still considered to require postmortem neuropathologic diagnosis, though researchers are hopeful that identifying the disease earlier will lead to better outcomes for patients. We will explore the legal issues raised by these developments in an upcoming issue of SML.

partment of Defense Grant to Develop Wearable Concussion Diagnostic with Pre-eminent Partners, Global Newswire (https://www.globenewswire.com/news-release/2021/05/18/2231788/0/en/Oculogica-Receives-Department-of-Defense-Grant-to-Develop-Wearable-Concussion-Diagnostic-with-Pre-eminent-Partners.html).

6 Gerry Thornley, *Eye-tracking technology trialled in bid to diagnose concussion*, The Irish Times, May 18, 2021 (https://www.irishtimes.com/sport/rugby/eye-tracking-technology-trialled-in-bid-to-diagnose-concussion-1.4567663).

7 https://www.tozuda.com/.

8 Kimberly G. Harmon, et. al., *American Medical Society for Sports Medicine position statement on concussion in sport*, Br. J. Sports Med. 2019; 53: 213-225.

9 Daily Briefing, *We're one step closer to diagnosing CTE in living patients*, Advisory Board, March 29, 2021 (https://www.advisory.com/en/daily-briefing/2021/03/29/cte-criteria).

