Concussion: An Issue of Negligence in Sport?

GREY MATTER, GREY AREA

The Legal Issues Arising From the Management of Concussion in Sport

On 18 September 2015 the Rugby World Cup will kick off with England playing Fiji. During the course of the 48 games that will take place, a number of players will, undoubtedly, be concussed. The focus on concussion in the forthcoming World Cup compared to the previous World Cup in 2011 will be marked. In the last 4 years elite sport has spent much time debating the management of concussion and the short and long term effects. What has caused the spotlight to be shone so brightly on this issue over the last 4 years?

In 2001 the National Football League Player Association partnered with the Centre for the Study of Retired Athletes to look at the consequences of the impacts sustained through playing American Football. Around the same time, in November 2001, the governing bodies for football (FIFA), the Olympics (IOC) and ice hockey (IIHF) convened the 1st International Consensus Conference on Concussion in Sport which took place in Vienna.

Whilst elite sport debated the issue, Ben Robinson, aged 14 years, is playing rugby for Carrickfergus Grammar School in Ireland on 29 January 2011[1]. Early in the second half Ben suffers two concussive blows to the head. He can't remember the score and is unsteady on his feet but continues playing. With a minute to go Ben collapses and, in the arms of his mother, dies on the pitch. At the subsequent inquest, the coroner ruled that Ben had died from second impact syndrome. Since Ben's death, his father, Peter, has channelled his grief into campaigning and raising awareness about the dangers of concussion.

18 months later, in November 2012, and 11 years after the Vienna conference, the 4th International Consensus Conference on Concussion was taking place in Zurich. There was significant disagreement at that meeting as to the protocols to be implemented for concussions in sport. Dr Barry O'Driscoll, who had been a medical advisor to the IRB for 15 years, was anxious that player welfare was not being protected through the interpretation of the recommendations arising from the Zurich conference. He resigned his post.

[1] http://www.theguardian.com/sport/2013/dec/13/death-of-a-schoolboy-ben-robinson-concussion-rugby-union

By August 2013, following months of court ordered mediation, a $765m (£490m) settlement was reached between the NFL and former players. The basis of the settlement being grave concern about the prevalence of neuro-cognitive disorders among former American Football players having been caused by repeated concussions sustained whilst playing in the NFL and the players having been misinformed about this over their careers.

The culmination of the above events over the last 4 years has generated such momentum that the profile and commentary on the issue of concussion has risen exponentially. In the 2015 RBS 6 nations, the experiences of George North, Mike Brown and Jonny Sexton – to name only three of the highest profile players – demonstrated a sea change in the recognition of and reaction to concussion injuries. All 3 players have had periods of time out of the game to allow their head injuries to recover.

So, will we see the concussion debate move into the Court environment and be explored through litigation in our Jurisdiction? This paper considers the legal issues surrounding concussion injuries in sport and assesses who, if anyone, is liable in law for such injuries. Having defined concussion we will look at the fundamental legal principles that underpin liability when injuries arise; from there we will analyse the current protocols designed to manage concussions when they arise; before concluding with an analysis of what litigation might arise and how such litigation might be determined.

Understanding the way in which liability will be assessed should assist in improving the way in which concussions are managed and improve player welfare.

Concussion

A concussion is a traumatic brain injury that alters the way the brain functions. A concussion of the brain alters the state of consciousness, most commonly due to a blow to the head causing white matter damage in the brain. Effects are usually temporary but can include lasting headaches and problems with concentration, memory, balance and coordination. Although concussions are usually caused by a blow to the head, they can also occur when the head and upper body are violently shaken. Therefore, whilst concussions are more likely in contact sports such as football or rugby, they also arise in sports that, technically speaking, are non-contact: e.g. horse racing, motor sport or cricket. A concussion injury may cause a loss of consciousness, but most do not. Because of this, some people have concussions and don't realise it which reinforces the doctor's responsibility for diagnosis.

Whilst some concussions may be immediately apparent, the appearance of symptoms or cognitive deficit might be delayed several hours and thus concussion should be seen as an evolving injury in the acute stage. Guidelines implemented by sports governing bodies provide that assessments are taken at pitchside or on the field of play itself. With concussion being one of the most complex injuries in sports medicine to diagnose and with the likelihood of a delayed onset of a cognitive deficit, the difficulty in undertaking pitchside assessments is apparent.

Every concussion injures the brain to some extent and the white matter damage in the brain is irreversible. Following the injury, the brain needs time and rest to heal properly. Concussions should be managed with physical and cognitive rest until the acute symptoms resolve and then a graded programme of exertion prior to medical clearance. Although the majority, 80–90%, of concussive symptoms will have worn off after 7 days and most concussive traumatic brain injuries are mild there are issues around:

1. Second Impact Syndrome[2];
2. An undiagnosed concussion leading to another serious injury in the same game[3];
3. Failure to recognise/treat concussion following a match leading to on-going training/playing and repeated further concussions;
4. The long term cumulative effect of repeated concussive trauma – dementia/alzheimers[4].

Taking these issues into account, it is incumbent upon those responsible for player welfare to understand concussion fully and draft policies and protocols which protect the players from both immediate and long term problems.

Legal Principles

So, how does the law approach player welfare and those responsible for it? At any one time, a sportsman/woman will be a player, an employee, a patient. Such status confers duties and obligations on those involved in the relationship but particularly onto those who are responsible for player welfare.

[2] http://www.sportsmd.com/concussions-head-injuries/second-impact-syndrome/
[3] http://www.telegraph.co.uk/sport/rugbyunion/international/wales/11397863/Wales-under-fire-over-George-North-concussion.html
[4] http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11264856

The law of negligence as applied to sports injuries is the same as is applied to determine negligence in any other area. The club/governing body/doctor must be found to owe a *duty of care* to the player; the club/governing body/doctor must have *breached that duty* by falling below the standards of behaviour acceptable for that particular activity; and that reasonably *foreseeable harm must have been caused* to the player as a result of the breach of duty.

The player as an Employee - Employers Liability

If a participant in a particular sport is paid by their club to play, it is likely that the club will be considered to be the player's employer. This relationship is an obvious one in professional sports, but the principle will also extend and apply to those who receive very modest sums (perhaps expenses only) for playing in what may otherwise be considered amateur teams. The absence of any pay at all and the fact that the player may have another day job, does not preclude the existence of an employer/employee relationship and thus a duty of care being owed. Whether such a relationship exists will depend on the precise circumstances, but where a club, coach or manager exercises a degree of control over the activities of the player, the legal relationship is likely to be established - at least for the duration of the sporting activity concerned.

The existence of such a duty is fundamental to any potential claim based on the principles of employer liability. Broadly speaking an employer must ensure that an employee has a safe place to work; is properly trained; has the correct equipment in good working order; that his fellow employees are competent; and that a safe system of work is adopted.

Here "work" would encompass the playing of the sport and the training associated with it. "Equipment" may include any item used when playing or training, it may also include the place/ surface where the sport is played. "Fellow employees" would include team mates and non-playing club staff. "System of work" may include a training regime or a particular tactical approach to the game. Consider a player who is concussed on a Saturday and then trains the following week whilst suffering from headaches together with balance and coordination problems. Would an employer be able to say that there is a safe system of work in place were an injury to occur to the same or a fellow player?

It is not within the contemplated scope of this paper to provide a detailed analysis of the archives of employer liability law. However, in summary terms, after the passing of s69 of the Enterprise and Regulatory Reform Act 2013, an employer can be found liable in respect of a claim made by an employee, if they have been negligent. If the employee can

establish that such a duty has been breached, and that the breach has caused him a loss which is foreseeable, then the claim by the employee will succeed.

Whether or not there is a duty and a breach of duty will be a matter to be determined in each case, though in most cases, these questions will be determined in part by reference to relevant health and safety regulations. There are no regulations specific to sport, but employers should be aware of, in particular;

- Management of Health and Safety at Work Regulations 1999;
- Personal Protective Equipment at Work Regulations 1992; and
- Provision and Use of Work Equipment Regulations 1998.

In addition, it is of course a legal obligation for any employer to ensure that liability insurance is in place. An employer can be held to be liable for the negligent acts and omissions of their employees. Hence, if the negligence of one employee causes injury and loss to another employee, the employer club or organisation will be held liable, provided that the incident giving rise to the loss, arose during an activity that was part of, or sufficiently connected to the "employment". Liability can arise for an employer even if one employee injures another in the course of horseplay or a prank in the workplace.

The player as a patient - Clinical Negligence

When a player is injured or consults with a club doctor, the player's status as a "patient" as well as a player conveys a duty of care onto the player/patient from the club doctor. The club doctor's standards will be judged in the same way as a doctor operating in a hospital or a clinic. That duty of care owed by a doctor to his/her patient has long been established by the case of Bolam –v- Friern Hospital Management Committee[5]. Namely, a patient seeking to prove medical negligence needs to show that the doctor acted in a way that no other reasonable, responsible practitioner would have done in those circumstances.

Upon a concussion injury occurring, the club doctor will be required to exercise his skills immediately on the field of play but also on an on-going basis as he monitors the player following the injury. Whilst the standard of care by which a club doctor will be judged are the same as a doctor of similar standing, the environment and dynamics in which a club doctor operates are very different. In a hospital environment the doctor decides what is in his patient's best interests and the hospital environment supports those decisions.

[5] [1957]2 All ER 118

Compare that to the pressures from coaching and management staff to ensure that players are kept on the pitch, to maximise the team's chance of winning. The basic requirements of assessing the patient, listening to the history but also with the benefit of having witnessed the incident, and an importance on note taking remain paramount. A failure to perform a proper medical examination and reach a clinical decision that would be supported by a reasonable, responsible body of practitioners would render the doctor negligent. Note that in reaching this decision the doctor's judgment should not be influenced by any sporting protocol or wider sporting considerations; the decision is simply based on what is in the patient's/player's best interests. A hypothetical but reasonable thought process would seem to be *"I have witnessed a clash of heads, my patient lost consciousness or is at least dazed and confused, is it safe for my patient to remain on the field of play?"*[6]

If it is determined that a club doctor is, or may have been, negligent, it is necessary to establish who bears responsibility for the doctor's actions. As explained above, vicarious liability is a legal doctrine that assigns liability for an injury to a person who did not cause the injury but who has a particular legal relationship to the person who acted negligently. If the doctor is employed by the club, the starting position is that the club will bear responsibility for the doctor's actions. However, the club may have retained the doctor as an independent contractor in which case the doctor bears responsibility for his own actions. The contract between the club and the doctor will determine this point.

Referees and officials

Whilst the referee or umpire may not be everyone's friend, there would be no sport without them. At the very top of professional sports, there are professional referees but the vast majority of officials are part time or volunteers.

A referee takes on the responsibility of enforcing the rules of the sport during the game, which have been drawn up to ensure fair competition, allowing for a physical contest within the spirit of the game and in keeping with the competitive nature of the sport.

The referee has a duty to the players to ensure that the rules are applied. He must also ensure that violent and/or dangerous play is sanctioned. The referee must have an eye on player welfare during the game and should intervene if he considers that a player is unfit to continue or needs treatment. Play should be stopped to allow for treatment. The demands on referees differ from sport to sport. In Rugby Union, the referee must manage

[6] http://www.dailymail.co.uk/sport/concussion/article-2642211/Brian-ODriscolls-doctor-uncle-blasts-IRB-concussion-rules-Florian-Fritz-injury.html

a game with a high degree of physical contact and also technical areas such as a scrum or line-out, each having their own particular dangers.

Failing to take control and not enforcing the rules can result in the referee being liable if an injury is sustained by a player as a result of his failings. Consider the circumstances of a head collision between two players that is witnessed by the referee. Following treatment by the medical officer, the referee is advised that the player will be remaining on the field of play. The player continues to play on but is clearly groggy and not at full capacity – is the referee liable in full or in part if he does not direct that the player leaves the field of play and, in determining this, how does the referee's assessment rank alongside the medical officer's opinion?[7]

The player's responsibility - Contributory Negligence

But what of the players' involvement in managing their concussion. Contributory negligence is a doctrine of common law that if a person was injured in part due to their own actions then a proportion of the damages will be reduced to account for this.

Players undertake an assessment at the beginning of each year which provides a baseline for cognitive responses going forward. Players who are found to have deliberately set the baseline below the genuine position will be exposed to an allegation of contributory negligence. Such an allegation may also arise where a player continues to play after suffering a concussion. However, this does not provide the club or the doctor with a defence. Primary liability will rest with the club and/or the doctor who must then argue that the payer should be found partially responsible. With the pressure on modern professional sportsmen it is likely that they will do all that is within their control to play for the team and most certainly be reluctant to leave the field of play[8]. Furthermore, any Defendant who wishes to advance an argument for contributory negligence will have to overcome the fact that a concussed player is unlikely to have full capacity at the time when he is asked to return to play. Primary responsibility for removal from the field of play and management of concussion thereafter remains with the doctor.

[7] http://www.theaustralian.com.au/sport/rugby-union/rugbys-concussion-test-under-review-following-george-smith-collision/story-e6frg7o6-1226681199974

[8] Daniel S Goldberg "Concussions, Professional Sports, and Conflicts of Interest" Ref: HEC Forum (2008) 20(4): 337-355

Governing Bodies

The basic principles established above demonstrate that an employer owes a duty of care to its employees and a doctor owes a duty of care to his/her patient. But does World Rugby or the RFU owe a duty of care to those playing the game?

The governing body determines how a sport is governed; how the rules are applied and modified; they will invest in and promote the sport; and, in most cases, they will also act as a disciplinary body. As such governing bodies have a significant say in the commercial activities of clubs and professional participants. Were a claim to arise, as explained earlier, an employee/employer relationship is established through one party paying another. Commercial contracts that create a payment relationship between player and governing body will, in all likelihood, establish the appropriate legal relationship to confer a duty of care.

As referenced in the opening paragraphs, the NFL have made $765m available to former players with concussion related health issues. World Rugby and the RFU will no doubt be considering whether similar liabilities may carry across to the game of rugby. So what have governing bodies in rugby and other sports done to limit their exposure in any potential future litigation?

The consensus statement on concussion in sport

As referred to above, the 1st International Consensus Conference on Concussion in Sport took place in Vienna in 2001. The aims of the conference were to provide recommendations for the improvement of safety and health of athletes who suffer concussive injuries. The 4th, and most recent, conference took place in Zurich in 2012. Building on the previous conference, the main considerations in Zurich were: making a diagnosis of concussion; best practice for evaluating an athlete on the field of play; management of and therapies for concussion; risk reduction strategies; long term problems and specifically Chronic Traumatic Encephalopathy ("CTE").[9]

Arising from the 2012 conference, guidelines governing management of a player showing any features of concussion have been drawn up. An assessment of the concussive injury should be made using clinical judgment with the aid of the Sport Concussion Assessment

[9] http://bjsm.bmj.com/content/47/5/250.full

Tool 3[10] and a player with diagnosed concussion should not be allowed to return to play on the day of injury.

Following the 2012 Consensus, the IRB (as "World Rugby" was known at the time) introduced the Pitchside Suspected Concussion Assessment (PSCA). The language used around the PSCA has not helped clubs and, specifically, doctors. The position seems to be that any player who has a "suspected" concussion must be removed from play. However, where a team doctor suspects that there is a *"potential"* concussion, the PSCA's stated aim was to provide a "quiet situation" for the doctor to make their assessment[11].

In 2012 this quiet situation was set at 5 minutes but increased to 10 minutes in 2014. Semantics, maybe, but by opening up a distinction between "potential" and "suspected" the clubs and the doctors have been presented with a scenario which is open to abuse/misinterpretation. A reasonable responsible body of doctors who believe a player has a *potential* concussion would, it is suggested, remove their patient from circumstances where a further impact is foreseeable. Having 5 or 10 minutes doesn't assist because the moment there is a potential concussion is the moment that the doctor demonstrates that concussion is in his differential diagnosis. The acknowledged difficulty in diagnosing concussion and the delayed onset of symptoms means that a 5 or 10 minute assessment does not add anything to the doctor's ability to diagnose.

Looking at this more closely, the medic is required, *firstly, to suspect that the player has been involved in an incident which might have caused concussion*. If the medic satisfies him/herself of that then, *secondly, clinical judgment is exercised as to whether that player has potentially concussive features*. If the player has a suspected concussion they must leave the field of play. If they have *potential* concussion they are assessed as to whether they are fit to return to play. Given the pressure on medics from management and the intensity of the game situation, there are two opportunities to reach a conclusion which avoids the requirement to remove the player from the field of play. George North, for example, was allowed to play on having been knocked out against England on 7 February 2015 and there is currently sufficient wriggle room to justify questionable judgments. When challenged by World Rugby, the Welsh Rugby Union were able to defend their actions by saying that the mechanism of injury was unsighted [by the medical team] when it occurred on the field of play[12]. It is doubtful that such a response would provide a

[10] http://www.sportconcussionlibrary.com/content/sport-concussion-assessment-tool-3-scat3
[11] http://www.rugbydump.com/2013/07/3310/irb-reaffirm-commitment-to-concussion-management-best-practice
[12] http://www.theguardian.com/sport/2015/feb/12/breakdown-george-north-wales-concussion

defence to the medical team had this incident come before the Courts. The vast majority of incidents that require medical input occur outside of a hospital or GP surgery. Doctors are, therefore, required to reach clinical decisions and judgments without having witnessed the "mechanism" of injury. If the medical team did manage to satisfy a (hypothetical) judge that they had not witnessed the mechanism of injury, would they succeed in establishing that a reasonable responsible body of practitioners would have left George North on the field of play?

When first introduced, the PSCA was so highly criticised in Australia that the Chief Medical Officer of the Australian Rugby Union, Dr Warren McDonald, wrote a memo to all Member Unions stating:

> "The PSCA has been approved by the IRB for use in controlled Professional Rugby environment….. *Under NO circumstances* in domestic rugby competitions in Australia shall a PSCA Protocol be implemented …. If a player is suspected of having concussion that Player must be removed from play…"[13]

Were the PSCA to come before a Court in litigation proceedings, the evidential basis on which was founded would be analysed. The strength of any peer review would be an influential factor on how reliable it is as part of any Defence. It is likely that cross examination would take place around the comparable status of the NICE guidelines[14] which state that if a patient has been concussed, even if they seem to have recovered, the patient should be referred immediately to hospital[15].

In summary, as we stand, we have a team doctor who has a duty to exercise his clinical judgment taking into account the protocols he receives from his domestic governing body as well as guidance/directives from World Rugby. In assessing the liability of those who hold a responsibility for player welfare it will be the Court's role to work through the chain of passes to determine the status of the PSCA and return to play protocols; how they should be interpreted; and the clinical judgment exercised by the medics in the application of the protocols.

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[13] www.cnru.com.au/.../1393239429_pitch_side_**concussion**_assessment_ protocols.pdf

[14] https://www.**nice**.org.uk/**guidance**/.../information-for-the-public-the-early- management-of-head-injuries-pdf

Conclusion

The death of Ben Robinson; informed concern about World Rugby's PSCA and protocols; acceptance by the NFL that compensation must be paid to former players; and a growing medical evidence base about CTE has brought concussion to the centre of public consciousness. Those responsible for player welfare owe a duty of care to those players and must, therefore, understand where they are exposed to liability for any potential claims and implement systems and protective measures to protect players as far as is reasonably possible.

The claims that are foreseeable at the moment are:

- Second Impact Syndrome;
- An undiagnosed concussion leading to another serious injury in the same game;
- Failure to recognise/treat concussion following a match leading to on-going training/playing and repeated further concussions;
- The long term cumulative effect of repeated concussive trauma – dementia/alzheimers.

Those responsible for player welfare will assess their involvement in any or all of the above scenarios and consider how their actions will be judged on the basis of existing legal principles as set out throughout this paper. Governing bodies, clubs and club doctors must be aware of the evolving understanding and research in this area. As knowledge and understanding moves on, so must assessments of risk. Policies and protocols established in 2012 may not establish a defensible position in litigation arising from events in 2015.

It must be recognised that contact sports are a key part of our society with millions of participants, coaches, referees and spectators getting involved every week. Sport is beneficial to us in many ways and the issue of concussion, if properly researched and managed, should not drastically change the way our favourite sports are played, coached or refereed.

Much focus will be applied to club doctors. Ultimately the club doctor has a duty to treat his patient, despite the pressures exerted by management and created within a club environment. Doctors will come under increasing scrutiny not just on their judgment of permitting return to the field of play but also on their short, medium and long term management of players with concussion injuries.

Recognising the challenges in managing concussion and placing player welfare at the centre will do as much as is reasonable to avoid serious injury to players and reduce potential legal liabilities as far as possible.

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