SHINE LAWYERS

Inquiry into concussions and repeated head trauma in contact sports

Submission of Shine Lawyers
Prepared by Jamie Shine - General Manager of Head Trauma Litigation
February 2023

Shine Lawyers Pty Ltd
ABN 86 134 702 757

1. Executive Summary

Persistent post-concussion symptoms, or mild trauma brain injuries, are highly misunderstood, undiagnosed, and often left untreated in Australia, resulting in many struggling in silence until they can take it no more.

Shine Lawyers has a Head Trauma division which act for hundreds of plaintiffs suffering from mild traumatic brain injuries. By working with these individuals, we have identified that: -

a. There is a significant lack of understanding by many medical professionals, insurers, right through to the public when it comes to mild traumatic brain injuries. For this reason, greater education and awareness is urgently required, such as those educational programs offered by Connectivity and Concussion Legacy Foundation. These should also be introduced at school level and to parents.

b. There is a lack of treatment options and providers working in the mild traumatic brain injury space in Australia. Given the serious and varying nature of each brain injury, they cannot be treated by one medical discipline alone. Rather, multi-disciplinary clinics need to be established in each State and Territory, as available in other countries.

c. There is little understanding about the massive impact a brain injury, even when classified as 'mild', has on an individual and their family. The burden is too great. People often cannot work and require frequent supervision, prompting, support and assistance with activities of daily living.

Additionally, there is decades of evidence about the effect of repeat head injuries and concussions having permanent impacts on an individual's mental capacity. CTE exists in Australia and, applying the Bradford Hill Criteria, repeat head injuries are the only cause of this progressive brain injury.

Despite the seriousness of the injury, the legal landscape in Australia has been stacked against players, meaning not only can they not afford access to treatment or to support their families; there is also little by way of consequence for sporting bodies to reform, inform, warn, or make the sports safer for Australians at all levels. The law has allowed bodies to focus only on the short-term issues, with little regard for long term consequences. The common law rights of Australians need to be preserved. Sporting bodies should be motivated to research, learn, implement consistent, meaningful protocols and be concerned for the long-term health of those involved.

2. Background

By way of background, my name is Jamie Lee Shine, General Manager and Special Counsel of the Head Trauma Division at Shine Lawyers, and I make these submissions to assist the Committee into this inquiry on behalf of Shine Lawyers and our clients suffering with traumatic brain injuries.

Shine Lawyers has a specialised team of lawyers dedicated to running personal injury claims for plaintiffs who have suffered varying degrees of traumatic brain injuries ('TBI'), known as our Head Trauma team. Members of this division historically ran catastrophic injury claims for Queenslanders, which included many moderate and severe TBI victims, however over time, many clients presented to the firm struggling with a constellation of symptoms consistent with a TBI yet with unremarkable neuro-imaging results. These individuals felt lost and unheard after their lives had been turned upside down by mild traumatic brain injury ('mTBI') and persistent symptoms following concussion. The firm undertook investigations to better understand the complexities of concussion and mild traumatic brain injury ('mTBI') and as a result set up the Head Trauma team who now advocate of hundreds of Queenslanders suffering with varying degrees of TBI from tortious acts including motor vehicle accident, workplace accidents, assaults, slips and falls and sporting incidents etc. The team now, in addition to pursuing compensation claims for TBI victims, advocates to create awareness around persistent post-concussion syndrome ('PPCS'), mTBI and chronic traumatic encephalopathy ('CTE') and the issues faced by those suffering with these debilitated injuries.

Qualifications and conflicts

I am a solicitor of the Supreme Court of Queensland, holding a Bachelor of Laws (LLB), Master of Laws (LLM), Master of Business Administration (MBA) and am a Graduate of the Australian Institute of Company Directors (GAICD).

I am currently a volunteer director for the following not for profit organisations

a. YoungCare Ltd;

b. Connectivity – Traumatic Brain Injury Australia;

c. Concussion Legacy Foundation Australia.

3. Concussion and mild Traumatic Brain Injury in Australia

Whilst we defer to the leading medical experts in relation to concussion and mild traumatic brain injury ('mTBI'), our experience is that far too many Australians are suffering long term from the consequences of persisting post-concussion symptoms and mild traumatic brain injury. Many are undiagnosed and untreated.

Shine Lawyers Head Trauma team currently represent hundreds of Australians suffering with mTBI and ongoing post-concussion symptoms. More often than not, these individuals report a very similar story:-

- They had a very short period of being "blacked out" or period of feeling "dazed and confused" but when asked about a loss of consciousness most would deny this, even though there is a period of no recall;
- No altered Glasgow Coma Scale ('GCS') recorded in their ambulance records;
- No documented evidence of post traumatic amnesia ('PTA'), even when the individual could not recall conversations or events after the injury, demonstrating a lack of investigation when it comes to mTBI patients;
- Where CT or even MRI was undertaken, the majority of clients had normal imaging;
- In most cases, hospitals did not provide the individual with information on concussion or mTBI. If the individual was informed, they were often given a brochure on concussion and told they would be fine with time and to present to the General Practitioner ('GP') with ongoing concerns;
- In most cases where the individual continued to suffer symptoms, most were advised by their GP that there was nothing wrong, relying on the normal neuro imaging. In other cases, the individuals were referred to a physiotherapist and/or psychologists, and at best a neurologist. This was often the extent of the treatment referrals, despite numerous other symptoms being reported.
- In most cases, individuals could not afford treatment and rely on insurance to fund their rehabilitation. Most are motivated to get well and all wished they had not been injured;
- In most cases the individuals report a constellation of symptoms including, for example, one or more of the following:-
    - Vision difficulties – blurred vision, depth perception deficits, light sensitivity, black spots/ floaters, missing fields of vision, co-ordination difficulties, dizziness, nausea, vomiting;
    - Hearing difficulties – ringing in the ears, noise sensitivity, decreasing hearing.
    - Damage to one or more of the cranial nerves – including impaired smell or taste;
    - Head pain and feeling of pressure in the head, facial numbness, leaking fluid from nose;
    - Cognitive deficits – short term memory difficulties, concentration difficulties, slower speed of processing information, poor recall, poor executive functioning, increased impulsivity, decreased motivation or drive, confusion, difficulties multi-tasking or prioritising, poor decision making abilities and money management issues, forgetfulness.
    - Significant issues with fatigue, energy, drive, motivation;
    - Psychological sequalae – changes in mood and behaviour, depressed moods, social anxiety and withdrawal, suicidal ideation etc
- In most cases the GP, and the individual, did not know who to consult in relation to their ongoing symptoms.

This is consistent with the leading research in relation to TBIs. The World Health Organisations states that 90% of all TBIs are "mild" in classification meaning there was a loss of consciousness between 0-30mins, a GCS of 13-15 and a PTA of up to 24 hours. Of this 90%, only 10% will reveal anything on neuro-imaging. That leaves the majority of brain injured victims fighting to prove their symptoms, just to get a diagnosis and appropriate treatment.

Whilst concussion and mTBI cannot be detected, in most cases on CT or MRI, research shows that microscopic damage to the brain does in fact occur.[1] [2]

This makes diagnosing mTBI and concussion extremely difficult and explains why it is easier overlooked.

The experience of many of our clients is that if they do report their symptoms, very few people believe them, let alone provide appropriate referrals to providers who specialise or understand mTBI symptomology. The experience of these individuals is one of being unheard, gaslit and exhausted. GPs who identify the symptoms after often at a loss as to who to send their patients to for treatment.

Despite medical publications stating that you no longer require a loss of consciousness, altered GCS or an abnormal scan to have suffered a mTBI, many specialists and GPs still provide medical opinions in line with previous research and do not support the existence of mTBI or PPCS.

There is an urgent need for greater education in relation to concussion and mTBI, starting with hospital staff and general practitioners.

Connectivity[3] and Concussion Legacy Foundation (USA & Australia[4]) are organisations which both provide education on understanding concussion, mTBI and CTE.

Additionally, the greatest concern for our clients is the lack of treatment options available when they are desperate for help. There is an urgent need for multi-disciplinary TBI centres to be set up in all States and Territories in Australia in order to provide assessment, treatment and support to Australians suffering with the various symptoms of mTBI and concussion, through to the very severe symptoms associated with CTE. This treatment, support and validation are crucial in allowing people to feel heard and can save lives.

[1] 'Concussion, microvascular injury, and early tauopathy in young athletes after impact head injury and an impact concussion mouse model.', *APA PsycNet* (February 2018) <https://psycnet.apa.org/record/2018-05455-014>;

[2] 'Microscopic lesions in the brain following head injury.', *Semantic Scholar* (1 August 1968) <https://www.semanticscholar.org/paper/Microscopic-lesions-in-the-brain-following-head-Oppenheimer/ea3ca6a78f1481c938a20e04f0426f5bd737282e#:~:text=Microscopic lesions in the brain following head injury.,lesions which are not apparent on naked-eye inspection.>.

[3] 'Connectivity Traumatic Brain Injury Australia', *Connectivity Traumatic Brain Injury Australia* (2023) <https://www.connectivity.org.au/>.

[4] 'Fighting Concussions & CTE', *Concussion Legacy Foundation* (2023) <https://www.concussionfoundation.com.au/>.

4. The History of Chronic Traumatic Encephalopathy

It has been understood for over a hundred years that repeat knocks to the head result in dulling of the brain and/or brain injury. Research undertaken by medical historian, Stephen Casper, found that since 1872 the director of the West Riding Lunatic Asylum, in England, had warned that concussions, and especially repeated concussions, could result in long term injuries[5]. Further research was published in relation to boxers in 1928 by Dr Harrison Martland[6] within which he stated,

"*"..nearly one half of the fighters who have stayed in the game long enough develop this condition, either in a mild form or a severe and progressive form which often necessitates commitment to an asylum*.."

The research work undertaken by Casper leads him to opine that the science on repeat head injuries/concussions resulting in long terms damage, including progressive brain injury, was convincing enough long ago.

Over the decades, further medical research has been undertaken yielding the same results with little being done to prevent or warn of these injuries. Casper's research goes on to show that brain injury specifically connected to football has been around since the sport existed. Despite the ongoing medical findings, it was not until 2002 that Dr Bennet I Omalu identified this condition which led to the medical publication in 2005 entitled 'Chronic Traumatic Encephalopathy in a National Football League Player[7]'.

This paper enlivened previous discussion and research in repeat head injuries in contact sports.

The CDC has published a Fact Sheet on CTE wherein it defines CTE as,

"*CTE is a brain disease that can only be diagnosed after death. It has been linked to specific changes in the brain that affect how the brain works. The research to-date suggests that CTE is caused in part by repeated traumatic brain injuries, including concussions, and repeated hits to the head, called subconcussive head impacts.[1] However, understanding among researchers about the causes of CTE is currently limited. Researchers do not know the number and types of head impacts that increase the risk for CTE. It is possible that biological, environmental, or lifestyle factors could also contribute to the brain changes found in people with CTE diagnosed after death.[2,3] More studies are needed to learn about the causes of CTE, its symptoms, and how it affects the brain.[4] In addition, research on the role of genetics, a person's medical history, and other factors (such as environmental or lifestyle factors) is needed to better understand the risk factors for CTE."*[8]

[5] Chen, I. 2023 'The Forgotten History of Head Injuries in Sports', The New Yorker, 11 Feb 2023. The Forgotten History of Head Injuries in Sports | The New Yorker

[6]Dr Harrison Martland and the history of punch drunk syndrome', *Oxford Academic* (1 January 2018) < https://academic.oup.com/brain/article/141/1/318/4774567>.

[7] 'Chronic traumatic encephalopathy in a National Football League player', *National Library of Medicine,* (July 2005) < https://pubmed.ncbi.nlm.nih.gov/15987548/>.

[8] 'Answering Questions About Chronic Traumatic Encephalopathy (CTE)', *CDC Heads Up* (January 2019) <https://www.cdc.gov/traumaticbraininjury/pdf/CDC-CTE-FactSheet-508.pdf>.

5. CTE in Australia

We defer to the internationally renowned work of Dr Michael Buckland, Neuropathologist, and his team at the Sports Brain Bank[9] in relation to their findings on CTE in the Australian sporting population.

The research shows that CTE is a neuropathological diagnosis. The defining lesion is the accumulation of abnormal tau protein in nerve cells at the depths of the cortical sulci with a perivascular distribution. CTE exists in Australia and the only known risk factor is exposure to repetitive head injuries.

The Sports Brain Bank was launched in March 2018 published its first findings in relation their investigations on 21 donated brains in early 2022[10]. They concluded that the clinical features of CTE are nonspecific and cannot be confidently diagnosed during life only on autopsy post mortem; advance stages of CTE often mimic Alzheimer's disease, less advanced cases presented with symptoms of depression, mood swings, explosivity, loss of attention, and concentration, short term memory loss, headache etc and that some people with CTE received a diagnosis of Post-Traumatic Stress Disorder.

Their publication related to their first 21 donated brains, 12 were found to have evidence of CTE lesions. 8 of those were from professional sportspeople and 4 played at amateur/representative levels. 6 of the 12 donors had died by suicide. 6 of the 12 donors played AFL and 5 played union or league.

The Brain Bank concluded that CTE is present in the Australian population and has been here for quite some time, however it was only after making specifics investigations that it was found, and it was easy to find in the at risk population. They noted that before the Australian Sports Brain Bank, no one was specifically looking for it in Australia. Despite the history of repeat head knocks reported in the section above. They concluded that CTE affects both professionals and amateur sportspeople and that the disease wrecks lives and destroys families but is completely preventable.

Causal link between repeat head Injuries and CTE

A defence relied upon by sporting organisations, defendants and insurers is that there is no causal link between CTE, repeat head injuries and contact sports such as football, hockey, boxing, horse racing etc. Analogous to the history of causation between cancer and smoking or dust exposure, millions of dollars have been invested in restoring the publics' and players' trust in the product of contact sport and in particular football. With sporting bodies demanding that evidence be produced conclusively linking repeat head knocks to CTE before they are willing to take appropriate action to warn, inform and prevent. Whilst we strongly disagree that this is the appropriate test, standard or burden of proof when dealing with issues of public health and safety, it is the way codes have been allowed to get away with arguably negligent inaction and preventative measures.

In 2022 the international publication 'Applying the Bradford Hill Criteria for Causation to Repetitive Head Impacts and Chronic Traumatic Encephalopathy[11]' explored the question of causation of CTE to repeat head injury exposure through the nine viewpoints used in the Bradford Hill Criteria and found convincing evidence of a causal relationship between repeat head injury and CTE as well as no other explanation for the presence of CTE. We support the submissions of the Australian Sports Brain Bank and Concussion Legacy Foundation.

[9] 'Diagnosis and Research', *Sports Brain Bank* (2023) <https://www.brainbank.org.au/diagnosis-research/>.
[10] 'Chronic traumatic encephalopathy in Australia: the first three years of the Australian Sports Brain Bank', *Wiley Online Library* (10 February 2022) <https://onlinelibrary.wiley.com/doi/10.5694/mja2.51420>.

[11] 'Applying the Bradford Hill Criteria for Causation to Repetitive Head Impacts and Chronic Traumatic Encephalopathy', *National Library of Medicine,* (July 2022) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9355594/#:~:text=The%20Bradford%20Hill%20criteria%20include,coherence%2C%20experiment%2C%20and%20analogy>.

6. The Legal Landscape – TOR H: workers, or other, compensation mechanisms for players affected by long-term impacts of concussions and repeated head trauma;

Despite the incredibly serious; life altering; career changing nature of these injuries, there is a simple reason why only a couple of cases have been commenced in Australia to date. The legal landscape in Australia is heavily stacked against an injured sportsperson suffering from a brain injury.

The objective of torts law is to provide financial support to an injured plaintiff to cover their loss of income earning capacity and to fund their care, treatment, and support. Additionally, these claims are important as they create consequences for defendants and act as a deterrent[12]. These consequences seek to ensure that defendants take health and safety issues seriously, act proactively to assess risks, and take steps to minimise the likelihood of harm to others. They also seek to spread the loss, so it is not all borne by the government.

Yet, those living with a TBI as a result of their sporting involvement will face the following hurdles should they seek to bring a claim. It should be noted that in Australia, each State and Territory has their own separate legislations, case law and procedures relating to their claims, however often similar principles or concepts are replicated throughout the states:-

Barriers to obtaining financial support

A. Exclusion from Workers' Compensations Schemes

For those pursuing a career as a professional footballer, the legislation in most states and territories has been set up to specifically exclude football players from being considered "employees" and from having the benefit of access to statutory benefits afforded by these schemes.

Nearly every Australian state excludes sports people from receiving compensation for the state's respective workers compensation scheme[13] for injuries they sustain while playing, or training for, their sport of choice.[14]

It is understood that the history behind this deliberate exclusion was due to financial considerations, with clubs and governing bodies unable to afford such workers compensation premiums. However, with the

---

[12] Pyrenees Shire Council v Day (1998) 192 CLR 330, [123]

[13] section 84 of the *Workers Compensation Act 1951* (ACT), In New South Wales, sports people are excluded from the definition of a 'worker' in section 4 of the *Workplace Injury Management and Workers Compensation Act 1998 No 86* (NSW) when they are a registered participant of a sporting organisation participating in an authorised activity of that organisation, engaging in training for their sport, or travelling in connection with their sport, and therefore cannot receive compensation in most circumstances (*Workplace Injury Management and Workers Compensation Act 1998 No 86* (NSW) s 4, *Sporting Injuries Insurance Act 1978 No 141* (NSW) s 4). in Queensland, the *Workers' Compensation and Rehabilitation Act 2003* (Qld) excludes a professional sportsperson the Acts definition of a 'worker' under the same circumstances the New South Wales Act does, with the addition of the individual also being excluded from the definition while they are performing promotional activities because of the individuals standing as a sportsperson (*Workers' Compensation and Rehabilitation Act 2003* (Qld) Sch 2, Prt 2 s 2(a)); In South Australia, a person employed to participate in a sporting activity (and to engage in training or preparation with a view to such participation, and other associated activities) is excluded from the application of the *Return to Work Act 2014* (SA) and will therefore not receive compensation in relation to any injury sustained during or in connection to their sport (*Return to Work Regulations 2015*). In Tasmania, the *Workers Rehabilitation and Compensation Act 1988* (Tas) excludes a person from receiving compensation under the Act when they are participating as a contestant in a sporting activity, engaging in training with the view of participating in a sporting activity, or travelling in connection with a sporting activity, if they are doing so pursuant to a contract under which they are not entitled to any remuneration other than remuneration for the doing of those things (*Workers Rehabilitation and Compensation Act 1988* (Tas) s 7

[14] The only state where a sports person may potentially be able to receive workers compensation is the Northern Territory, where a sports person will fall within the definition of a 'worker' under the *Return to Work Act 1986* (NT) section 3B if the sports person earns over 65% of the annual equivalent of average weekly earnings from their engagement in the sport (*Return to Work Act 1986* (NT) s 3B(15), *Return to Work Regulation 1986* (NT) r 5); In Victoria, under the *Workplace Injury Rehabilitation and Compensation Act 2013* (Vic), a person who is employed to participate as a contestant in a sporting activity will not receive compensation for an injury sustained while they are participating in the sport, while they are engaged in training or preparation with the view of participating, or while they are travelling between a place of residence and the place at which the person is engaged (*Workplace Injury Rehabilitation and Compensation Act 2013* (Vic) Sch 1, Prt 1 s 17) and in WA, the *Workers' Compensation and Injury Management Act 1981* (WA) excludes sporting contestants from falling within the Acts definition of a 'worker'.

commercialisation of today's clubs and bodies, it must be questioned whether this is still in keeping with the needs of today's society. It is recommended that investigation be undertaken about the affordability of sports people being allowed back into the schemes, including other sports such as horse racing where TBIs are found.

Most concerning is that employers have a non-delegable duty of care and by excluding players from workers compensation scheme, employers could seek to abrogate their responsibilities.

B. Legal Defences

Defendants are able to rely on legal defences such as:-

i. Obvious Risk

   a. At law there is no duty to warn of 'obvious' risk. Obvious risk is usually defined to be a risk that, in the circumstances, would have been obvious to a reasonable person in the position of the plaintiff. In many state legislations, the defendant does not need to take proactive steps to warn a plaintiff if the risk is obvious.

   b. Defendants argue that the risk of injury in most sports is obvious and therefore injuries are not compensable. However, they take a conflicting approach by also alleging that they did not know about the dangers of concussion, repeat head injuries and CTE.

   c. In some Civil Liability Acts, there are exemptions to this, such as when the plaintiff has requested advice or information about the risk.

ii. Voluntary assumption of the risk

   a. A defendant can avoid liability by establishing voluntary assumption of the risk by the plaintiff. Here the defendant needs to show that the plaintiff was fully aware of the risk involved with the activity, had a full appreciation and comprehension of the nature and extent of the risk and voluntarily accepted the whole of that risk. It is up to the plaintiff to prove otherwise.

iii. Dangerous Recreational Activity

   a. A defendant is not liable for harm suffered by the plaintiff caused by the materialisation of an obvious risk of a dangerous recreational activity, whether or not the plaintiff is aware of the risk[15].

   b. Dangerous recreational activity ('DRA') is usually defined to mean an activity engaged in for enjoyment, relaxation or leisure that involves a significant degree of risk of physical harm to a person. The case law in each state varies as to what activities are considered to be DRA.

iv. Exclusion clauses and waivers

   a. Defendants further seek to limit their exposure to claims by including or reducing their liability through contracts with the players;

   b. Indemnity waivers are also included in many club and grassroots registration forms in an attempt to limit the liability of clubs against claims for injury.

v. Causation

   a. In relation to CTE, the most common defence used to date has been that there is no conclusive evidence linking repeat head injuries to CTE. Despite the work from the Boston University, the position of the CDC and more recently the publication applying the Bradford Hill Criteria, this point is maintained by defendants. To this end, governing sporting bodies have in the past set up their own groups to advise them on issues of concussion and then deferred to these groups, such as the Concussion in Sports Group. However, risk is attached when considering the

[15] Civil Liability Act 2002 (NSW) s5L; Civil Liability Act 2003 (Qld) s19; Civil Liability Act 2002 (Tas) s20; Civil Liability Act 2002 (WA) s5H.

appropriateness of those appointed to those groups, the work that they choose to consider or reject when giving their opinions, and the way they choose to summarise literature put before the group. We hold concern around whether it is appropriate for bodies to police themselves when it comes to injuries impacting life and death.

b. Defendants can allege that the plaintiff's symptoms and/or loss is not caused by the repeat head knocks, but rather due to other factors such as use of drugs and alcohol (which many people suffering with injuries turn to for medicinal reasons), life style factors, or other illnesses such as dementia or PTSD, genetic disorders etc.

vi. Time Limitations

a. In all jurisdictions, plaintiffs have a small window of time from the tortious action in which to bring a claim. For many, particularly those suffering with CTE, the true extent of their symptoms will not be known for many years after the negligent act. For those with trauma induced epilepsy, they may experience their first episode decades after the traumatic incident. Whilst there are, in many states, ways to extend the limitation by virtue of new evidence, this is not without risk as further time windows in which to act often apply and issues, such as prejudice to the defendant given the lapse in time will often be considered in such applications.

vii. No objective evidence of a brain injury

a. TBIs are known as the invisible injury. This is especially true for concussions, mild traumatic brain injuries and CTE which can not be detected, in most cases, by CT or MRI. Whilst other diagnostic aids are being used to help health professionals, such as Transcranial Magnetic Stimulation; PET; fMRI; MEG; DTI; blood bio markers, at this stage they do not go as far as objectively proving the diagnosis;

b. This defence is commonly used by defendants in mTBI litigation, including motor vehicle accidents. Insurers frequently deny the existing of a mTBI stating that there is no objective evidence of a brain injury, therefore making claims lengthy and costly for plaintiffs.

c. Additionally, there is often little understanding or appreciation by defendants and insurers as to the life altering impacts mTBI have on and individual and their families. They frequently misunderstand the long-term impacts brain injury has on those suffering and their families.

d. Additionally, the diagnosis of CTE can currently only be made posthumously.

C. Private Insurance – TPD and Income Protection Insurance

In response to professional players being excluded from workers compensation benefits, many have been encouraged to seek their own private insurance over the years either as individuals or as collective players groups. However, further issues arise with these policies of insurance. Some issues may include

a. General superannuation products after often unsuitable for professional players as they do not appropriately meet their needs;

b. A broker would be required to properly negotiate the terms of the contract or product to ensure it included these injuries;

c. The policy needs to be current as at the time of the injury, it won't assist an individual if their policy has finished when they develop symptoms;

d. It adds an additional responsibility on the player to seek advice which many would not do or may not be able to afford

e. Tailored policies come at a cost which many may not be willing or able to afford;

f. Some policies now specifically seek to exclude CTE, most exclude mental health injuries from their policies;

g. In relation to income protection policies, these often apply for a period of 2 years and individual ones will only go to 65 years. This will not assist those with late diagnosis or with their treatment, care and

support beyond this age. Also if there is no wage or the person has retired there is no loss of income and no claim on the policy;

h. Many would not know to include a trauma policy and again would need advice on whether it specifically covered these injuries;

i. Disclosure about previous concussions may prevent future cover for this injury and failure to disclose could lead to benefits being denied at a later stage.

j. These policies do not cover children or those not working.

D. NDIS

The National Disability Insurance Scheme is only eligible for those who apply under the age of 65 years. Should the individual not develop symptoms, or their symptoms not be progressed to a debilitating level, before the age of 65 years, they will be precluded from accessing NDIS benefits.

7. Other Issues

a) A commonly observed and confusing issue is the lack of consistent concussion protocols in sport when it comes to identification and management of concussions. These should be consistent in all sports from profession to grassroots levels.

b) The Scat 5 testing has limitations including who can administer it, the time it takes to test, that it does not test for long term or sub concussive damage. Best testing options are required.

c) Long term – Focus of sporting bodies is often short sighted and motivated by short term gains. A conflict therefore arises when it comes to player injury management. A concern about who is making decisions for players which are interested in their long term health, when players are currently lacking the required advice, information and education to make those decisions themselves.

8. Amateurs at high risk

We know from the medical research that amateurs are at the same risk of suffering persistent concussion symptoms and CTE, as professional players, yet they are often exposed to even greater likelihood of injury and risk because of the poor controls available at grassroots levels. Some of the issues faced at school and club level include:-

- Coaches, or those making a call about safe play, are often volunteers with little to no understanding or education around concussion or concussion management;
- Little to no formal training and inconsistent training;
- Limited access to doctors, medical professionals at the game;
- Limited number of referees to witness head injuries, stop play or intervene;
- Players will self report that they are fine to play, when clearly concussed, and suffer second impact syndrome
- There is little by way of support for these players after the game. Individuals are left to their own devices to identify the issues, seek out medical help and fund the often lifelong rehabilitation journey.
- The risks extend to numerous sports such soccer, hockey, gymnastics, horse riding, motorcycle sports etc.

Currently the power sits with the defendants at all levels of these sports.

9. Recommendations

Shine Lawyers supports the submissions of the Australian Sports Brain Bank and Concussion Legacy Foundation Australia.

1. There needs to be greater transparency, accountability, and consistent education and training by governing sporting bodies. Not just in football codes, but in other areas such as gymnastics etc, particularly when it comes to designing and enforcing appropriate concussion protocols;
2. Reduce exposure to repeat head injuries. CTE is completely avoidable. By reducing exposure over the years it leads to reduced number of CTE cases, as such the following measures would reduce exposure: -
    a. No headers in soccer under the age of 14;
    b. No unnecessary collisions in training;
    c. Remove tackling from sports until the age of 14;
    d. Learn consistent safe play practices;
    e. Consider weight divisions when tackling to avoid unnecessary injuries;
    f. Push for flag, tag or reduced contact methods of sports for a long as possible to limit the number of concussions an individual suffers in their lifetime.
3. There should be a positive obligation by bodies to research the issue. To inform, warn and make the games as safe a possible;
4. Education on mTBI, concussion and CTE should be compulsory from schools and beyond. Delivered especially to both children and their parents so they understand that repeat head injuries expose their children to the significant risk of progressive brain degeneration.
5. There needs to be consistent concussion protocols across all sports which are understood and enforced from the top to grassroots sports. The protocols need to be set with consultation with concussion experts without conflicts of interest or association with the governing bodies. These should be legislated and penalties imposed for failing to comply.
6. The health and welfare of the player needs to be the paramount priority in any decision making process.
7. Education – there needs to be greater education by medical practitioners, schools, children, parents, sporting bodies about concussion, mild traumatic brain injury and CTE. Organisations like Connectivity and Concussion Legacy Foundation provide free and fee for certification education courses. Without correct identification and diagnosis, individuals are left feeling isolated, unheard and in pain whilst their worlds are falling upside down.
8. Better treatment options – currently there are very few people or places that individuals can go to (or that GPs know to refer to) for concussions, mTBI or CTE rehabilitation. These injuries are complex with a constellation of symptoms and require wholistic treatment by a range of specialists. For this reason, it is **strongly** recommended that multi-discipline concussions or TBI centres be set up in all capital cities in Australia.
9. Ongoing research into all factors relating to concussion/mTBI and CTE. Including the impact on women in sport and why they are more likely to suffer greater effects and for longer when it comes to concussion and that this research be used to implement changes in the sport and in concussion management to derive better outcomes.

Legal recommendations

1. First and foremost, there needs to be preservation of Australian's common law rights and access to justice. Legislative reform over the years has slowly eroded these rights, making it extremely difficult for sports people to pursue access to justice. As a result of these amendments, there is little by way of consequence to motivate defendants to assess their practices, warn, inform and take steps to make the sports safer or to make decisions that take into account long term health consequences; to make the game safer and sustainable. This in turn results in financial support and outcomes from not professionals, but kids accessible grass roots programs. No fault schemes fail to provide consequences which focus on improved safety and forcing players to purchasing their own insurance policies are often unaffordable or lack the correct coverage required at all levels.
2. For professionals, affordability studies need to be undertaken about including sports people as employees under the workers compensation scheme so as to allow them access to appropriate care, treatment and support and to ensure employers obligations are abrogated.

This is a serious injury and a serious problem requiring urgent action. Starting with basic education and awareness around concussion/mTBI and CTE.

Jamie Shine
General Manager of Head Trauma Litigation at Shine Lawyers
February 2023