SR/408/2024

IN THE MATTER OF PROCEEDINGS BROUGHT UNDER THE ANTI-DOPING RULES OF WORLD ATHLETICS

Before:
Mr. Alan Galbraith KC (Chair)
Dr Tom Murray
Mr. Peter Koh

BETWEEN:

WORLD ATHLETICS ***Anti-Doping Organisation***

and

Koki IKEDA ***Respondent***

DECISION OF THE DISCIPLINARY TRIBUNAL

A. INTRODUCTION

1. World Athletics ("**WA**") is the international federation governing the sport of athletics worldwide. It has its registered seat in Monaco.

2. World Athletics has delegated its authority for Results Management and Hearings to the Athletics Integrity Unit ("**AIU**") as well as the implementation of its Anti-Doping Rules ("**ADR**") pursuant to Rule 1.2 of the World Athletics Anti-Doping Rules 2023, effective 31 March 2023 ("**2023 ADR**").

3. The Respondent, Mr. Koki Ikeda (the "**Athlete**") is a 26-year-old Japanese race walker. He was the silver medallist in the 20 kilometre road walk at the 2020 Summer Olympics in Tokyo and placed second in the 2022 World Athletics Championships in Oregon.

4. The Athlete is an International-Level Athlete for the purposes of the ADR.

5. The Athlete has been charged by the AIU with an Anti-Doping Rule Violation ("**ADRV**") in connection with abnormalities in the haematological module of his Athlete Biological Passport ("**ABP**"). In particular, the matter concerns several abnormalities detected in blood Samples collected from the Athlete between 16 February 2019 and 17 February 2024 that are alleged to indicate blood manipulations.

6. The Athlete denied having used any Prohibited Substances or Prohibited Methods that could have caused the abnormalities detected in his ABP and advanced alternative explanations. The Athlete requested that the matter be determined by way of a hearing before the Disciplinary Tribunal.

7. Hereafter, the Athlete and the WA are referred to collectively as the "**Parties**".

B. JURISDICTION

8. The Disciplinary Tribunal is constituted in accordance with Rule 1.3 2023 ADR to hear the alleged ADRVs and other breaches of these ADR.

9. Pursuant to Rule 8.2(a) 2023 ADR, the Disciplinary Tribunal has jurisdiction to hear and determine all matters in which an ADRV is asserted by the AIU against an International-Level Athlete. The AIU's responsibility for the Results Management for potential violations in connection with any testing conducted by WA or the AIU under the ADR is set out in Rule 7.1.3 2023 ADR.

10. The Athlete has not challenged the application of the ADR, the jurisdiction of the AIU, or that of the Disciplinary Tribunal.

11. World Athletics has, pursuant to Rule 4.1 of the World Athletics Disciplinary and Appeals Tribunal Rules, determined that the Disciplinary Tribunal shall have a Secretariat which is independent of WA. Sport Resolutions acts as Secretariat to the Disciplinary Tribunal.

C. THE CHARGE

12. From 16 February 2019 until 17 February 2024, WA collected 31 ABP blood Samples from the Athlete.

13. Each of the Samples was analysed by a WADA-accredited laboratory and logged in the Anti-Doping Administration and Management System ("**ADAMS**"). Using the Adaptive Model, the Athlete's longitudinal profile of haematological values was constituted and identified anonymously as BPID XYP9E53U (the "**Passport**").

14. The Athlete's ABP was submitted by the Athlete Passport Management Unit ("**APMU**") to a panel comprised of three experts with knowledge in one or more of the fields of clinical and Laboratory haematology, sports medicine or exercise physiology (the "**Expert Panel**").

15. In their quantitative analysis of the Athlete's ABP profile, the Expert Panel noted that "*the most abnormal results, highly indicative of blood doping, were observed in 2023*". The Expert Panel noted several abnormal patterns which are quoted or summarised below:

    a) Sample 25 (collected on 20 June 2023): displays a low HGB (11.0 g/dL) coupled with high RET% (4.38%) and increased immature reticulocyte fraction ("**IRF**") (19.4%), consistent with an acute loss/withdrawal of blood.

    b) Samples 27-29 (collected between 16 August and 13 September 2023): a large increase in HGB (with a peak at 15.7 g/dl) and decreasing RET% (until 0.74%), just prior (and following) the Athlete's participation in the Budapest World Athletics Championships on 19 August 2023, indicative of an artificial augmentation of RBC/HGB (and the consecutive suppression of RET%), most likely resulting from a blood reinfusion.

16. The Expert Panel concluded in their First Expert Panel Joint Opinion dated 8 April 2024 ("**First Joint Expert Opinion**"):

> *"The passport data, therefore, presents a straightforward doping scenario: it is highly likely that the Athlete withdrew a massive amount of whole blood or concentrated RBCs before the collection of sample 25 in June, allowing the stimulated bone marrow erythropoiesis to recover his blood values to the baseline. Finally, blood was likely reinfused before collecting samples 27 and 28.*
>
> *[…]*
>
> *We, therefore, conclude, considering the information within the Passport at this stage and in the absence of an appropriate explanation, that a prohibited substance or prohibited method has highly likely been used and that it is highly unlikely that the Passport is the result of any other cause, such as environmental factors or a medical condition."*

17. Consequently, on 1 November 2024, the AIU issued the Athlete with a Notice of Charge ("**NoC**") for violating Rule 2.2 ADR for the alleged Use of a Prohibited Substance and/or Prohibited Method during 2023.

D. PROCEDURE BEFORE THE DISCIPLINARY TRIBUNAL

18. On 15 November 2024, the matter was referred to the Disciplinary and Appeals Tribunal.

19. On 22 November 2024, the Chair of the Disciplinary and Appeals Tribunal, Mr. Charles Hollander KC KC, appointed Mr. Alan Galbraith KC, as Chair ("**Chair**") to hear this matter.

20. On 3 December 2024, a preliminary meeting was held via video conference between the Chair and the Parties in accordance with Rule 8.10 ADR. The Parties agreed that the matter should be determined by a panel of three (3) members of the Disciplinary Tribunal. The Parties also agreed to a procedural timeline which required the AIU to file its brief by 23:59 (Central European Time) on 20 December 2024, for the Athlete to file his answer brief by 23:59 (Japan Standard Time) on 17 January 2025 and the AIU to file a reply brief by 23:59 (Central European Time) on 29 January 2025. was complied with. The Parties

further agreed that an Operative Award be issued ahead of the fully reasoned decision, given the Athlete's intention to compete at a Race Walk event on 16 February 2025.

21. On 6 December 2024, the Chair issued procedural Directions by consent of the Parties, which included a provision for the arrangement of interpreters at the hearing, to ensure that the Athlete could fully comprehend the proceedings and meaningfully participate.

22. On 17 December 2024, Dr Tom Murray and Mr. Peter Koh were appointed alongside Mr. Alan Galbraith KC, to constitute the Panel ("**Panel**") in these proceedings.

23. No objections were received to those appointments.

24. On 8 January 2024, the Athlete applied to the Panel for the appointment under Rule 8.9.1(b) of an independent expert to assist and advise the Panel. The Panel declined to make that appointment while noting that the power under Rule 8.9.1(b) remained open to the Panel.

25. The geographic dislocation of the Parties required the hearing to be conducted virtually via video-conference with the added complication of differing time zones.

26. The hearing was convened on 5, 6 and 7 February 2025 (European dates) or 6, 7 and 8 February 2025 (Japan dates).

27. The following individuals attended the hearing:

28. <u>On behalf of the AIU:</u>

    a) Mr. Adam Taylor, WA counsel;

    b) Mr. Huw Roberts, AIU General Counsel;

    c) Ms. Laura Gallo, Case Manager;

    d) Prof. Giuseppe d'Onofrio, Professor in Clinical and Laboratory Haematology and in Clinical Pathology, Member of the Expert Panel;

    e) Dr Laura Lewis, Director of Science, United States Anti-Doping Agency, Member of the Expert Panel.

On behalf of the Athlete:

a) Mr. Koki Ikeda, Athlete;

b) Mr. Masaki Sakaida, Athlete's counsel;

c) Mr. Yoichiro Kuriyama, Athlete's counsel;

d) Mr. Tomoki Yanagisawa, Athlete's counsel;

e) Mr. Yuji Nakano, Athlete's counsel;

f) Mr. Kosuke Oji, Athlete's counsel;

g) Mr. Satoshi Arakawa, Athlete's counsel;

h) Prof. Masayuki Yamamoto, Executive Director Tohoku University;

i) Dr Ritsuko Shimizu, Professor and Chairman, Department of Molecular Haematology, Tohoku University.

Other:

a) Ms. Hiroko Kodera, interpreter;

b) Ms. Noriko Iwamoto, interpreter;

c) Ms. Yumiko Saito, interpreter;

d) Ms. Masako Komai, interpreter;

e) Mr. Takashi Shimodaira, observer.

Secretariat:

a) Ms. Freya Pock, Sport Resolutions Case Manger

29. On 13 February 2025 the Operative Award was issued to the Parties and stated as follows:

> 12. The Panel rules as follows:

(i) *That the Disciplinary and Appeals Tribunal has jurisdiction in the present matter.*

(ii) *That the Athlete has committed an ADRV as charged pursuant to Rule 2.2 of the World Athletics Anti-Doping Rules.* [1]

(iii) *That credit is given for the period of Provisional Suspension imposed on the Athlete from 1 November 2024 until the date of the Operative Award against the total period of Ineligibility, provided that the Provisional Suspension has been complied with.*

(iv) *That all competitive results of the Athlete between 20 June 2023 and 1 November 2024 are disqualified with all resulting consequences including the forfeiture of any titles, awards, medals, points and prize and appearance money pursuant to Rule 10.10 of the 2024 ADR.*

(v) *No order is made as to costs.*

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[1] *Pursuant to the 2023 Anti-Doping Rules (ADR in force at the material times) and the 2024 Anti-Doping Rules (with respect to procedural matters).*

E. POSITION OF THE PARTIES

30. The present matter brought before the Panel, posed a beguilingly straightforward question – whether the Panel was comfortably satisfied, as required by Rule 3.1 2023 ADR, that the Athlete had used a Prohibited Substance and/or Prohibited Method in the period encompassed by Sample 25 and Samples 27, 28 and 29. The issues raised by that question produced a hearing bundle of 2,655 pages and the consideration of detailed haematological expert evidence and articles.

I. WA's Position

31. WA's position as set out in the NoC, its brief, its reply brief, and its counsel's oral submissions at the hearing, is in essence as follows:

a) The Passport data presents a straightforward doping scenario: the marker values reflected in Sample 25 (collected in June 2023), interpreted in the context of the Athlete's ABP, evidenced the withdrawal of a large amount of blood (two or three bags of whole blood or concentrated red blood cells ("**RBCs**"), and the marker values in Samples 27, 28 and 29, (collected between 16 August 2023 and 13 September 2023) indicated its reintroduction shortly before the World Athletics Championship in August 2023.

b) The Expert Panel dismissed each of the explanations given by the Athlete and maintained its opinion of "*highly likely*" doping throughout its four (4) Joint Expert Opinions.

c) In view of the foregoing, WA submits that in the absence of an appropriate explanation such as environmental factors or a likely justification for a medical condition that a Prohibited Substance and/or Prohibited Method has highly likely been used.

II. The Athlete's Position

32. The Athlete's position is set out in the Athlete's initial explanation, the Athlete's petition for lifting of the provisional suspension, the Athlete's written challenge to the Charge, and the Athlete's answer brief.

33. The Athlete's core case was that in his individual circumstances there existed a combination of multiple confounding factors, i.e.;

a) The values collected and recorded for Sample 25 (decrease in HGB and increase in RET% and IRF) are due to the following conditions:

(i) The Athlete's underlying characteristics (genetic vulnerability to hemolysis);

(ii) The Athlete's disorder (intermittent anaemia) caused by foot-strike hemolysis through physical exercise (acute and prolonged exercise) as a consequence of intensive training;

(iii) Gastrointestinal bleeding through the side effect of taking a non-steroidal anti-inflammatory drug, which the Athlete was prescribed to treat a knee injury and the stress due to that injury; that should preclude the Tribunal from being comfortably satisfied in respect to the alleged breach.

b) The values collected and recorded for Samples 27–29 (increase in HGB levels and decrease in RET% and IRF) are due to the following conditions:

(i) Recovery from intravascular hemolysis;

(ii) Recovery from gastrointestinal bleeding;

(iii) Physiological recovery from anaemia through increased erythropoiesis.

c) The Athlete presented several additional arguments, including a discrepancy in the temperature control for Sample 25, the impossibility of the Athlete withdrawing the necessary volume of blood, alternatively what was submitted to be the impracticalities of the Athlete contending with the necessary processes for withdrawal, frozen storage and reintroduction of such a large volume of blood.

F. FACTUAL BACKGROUND

34. The relevant facts and allegations based on the Parties' written submissions, pleadings, and evidence presented in these proceedings, as they concern the merits of this case, are summarised below. Additional facts and allegations found in the Parties' written submissions, pleadings, and evidence may be set out, where relevant to the legal discussion that follows. While the Panel has considered all the facts, allegations, legal arguments, and evidence submitted by the Parties in these proceedings, it only refers to the submissions and evidence it deems necessary to explain its reasoning.

I. Blood Doping and the ABP

35. There are three (3) widely known substances or methods used for blood doping, namely: (i) administering recombinant human erythropoietin ("**rEPO**") (administered by injection to trigger erythropoiesis, the stimulation of the production of red blood cells); (ii) synthetic

oxygen carriers (i.e., infusing blood substitutes such as a haemoglobin-based oxygen carrier ("**HBOC**") or perfluorocarbons ("**PFC**") to increase haemoglobin well above normal levels; and (iii) blood transfusions (i.e., infusing a matching donor's or the athlete's own (previously extracted) red blood cells to increase the haemoglobin well above normal).

36. rEPO is a Prohibited Substance and is included in class S2. Peptide Hormones, Growth Factors, Related Substances, and Mimetics of the World Anti-Doping Code Prohibited List. It is a non-Specified Substance, prohibited at all times. Synthetic oxygen carriers and blood transfusions are Prohibited Methods under class M1. Manipulation of Blood and Blood Components on the World-Anti Doping Code Prohibited List. They are non-Specified Methods, prohibited at all times.

37. To combat blood doping, the ABP programme was developed and refined by the World Anti-Doping Agency ("**WADA**") and formally introduced by World Athletics in 2009. It is an electronic record that monitors selected variables (i.e. biomarkers) from an athlete over a period of time that indirectly reveal the effect of doping. Thus, it "*compiles and collates a specific athlete's test results and other data over time and is unique to that particular athlete*[1]*."*

38. The following description is taken from the World Athletics' brief:

> *11. The values collected and recorded include haemoglobin concentration ("**HGB**" or "**HB**") and the percentage of immature red blood cells viz. reticulocytes ("**RET%**"). The ratio of the HGB and the RET% values is also used to calculate a further value, known as the "**OFF-score**", which is sensitive to changes in erythropoiesis.*
>
> *12. The marker values from the blood samples collected in the ABP programme are inputted into a statistical model, known as the "Adaptive Model". The Adaptive Model uses an algorithm that takes into account both (i) the variability of such values within the population generally (i.e. blood values reported in a large population of non-doping athletes) and (ii) factors affecting the variability of the athlete's individual values (including gender, ethnic origin, age, type of sport, and instrument -related technology).*

[1] World Athletics Brief, para 10.

13. *The selected biological markers are monitored over a period of time and a longitudinal profile is created that establishes an athlete's upper and lower limits within which the athlete's values would be expected to be found, assuming normal physiological conditions (i.e. the athlete is healthy and has not been doping).*

14. *The upper and lower limits have been calculated (as per the WADA ABP Operating Guidelines (the "**Guidelines**") with a "specificity" of 99%. The Adaptive Model also calculates the probability of abnormality of the sequence of values in the ABP profile.*

15. *The athlete becomes their own point of reference and each time a blood sample is collected from the athlete and recorded in their ABP, the Adaptive Model calculates where the reported HGB, RET% and OFF-score values fall by reference to the athlete's expected distribution or 'corridor'. After each new test, a new range of expected results for the athlete is determined.*

16. *It is now well settled in CAS jurisprudence that the ABP model is a reliable means of establishing blood doping, i.e. the ABP model is reliable evidence of the athlete's use of a Prohibited Substance or Prohibited Method.*

17. *World Athletics implements the ABP in accordance with the International Standard for Results Management (the "**ISRM**") through a procedure that is designed to afford the athlete due process in establishing whether an ADRV has been committed. The procedural steps, which were followed in this case, are set out in the ISRM section C.1.3:*

    a) *The review begins with the application of the Adaptive Model.*
    b) *In case of an Atypical Passport Finding or when the Athlete Passport Management Unit considers that a review is otherwise justified, an Expert conducts an initial review and returns an evaluation based on the information available at that time.*
    c) *In case of a "Likely doping" initial review, the Passport is then subjected to a review by three (3) Experts including the Expert who conducted the initial review.*
    d) *In case of a "Likely doping" consensus of the three (3) Experts, the process continues with the creation of an Athlete Biological Passport Documentation Package.*

e) *An Adverse Passport Finding is reported by the Athlete Passport Management Unit to the Passport Custodian if the Experts' opinion is maintained after review of all information available at that stage, including the Athlete Biological Passport Documentation Package.*

f) *The Athlete is notified of the Adverse Passport Finding and offered the opportunity to provide explanations.*

g) *If after review of the explanations provided by the Athlete, the Experts maintain their unanimous conclusion that it is highly likely that the Athlete Used a Prohibited Substance or a Prohibited Method, an anti-doping rule violation is asserted against the Athlete by the Passport Custodian."*

39. Rule 3.2 ADR provides that an ADR may be established by "*any reliable means*". It has been well settled in Court of Arbitration for Sport ("**CAS**") jurisprudence that the ABP model is a reliable and accepted means of evidence to assist in establishing an ADRV.[2]

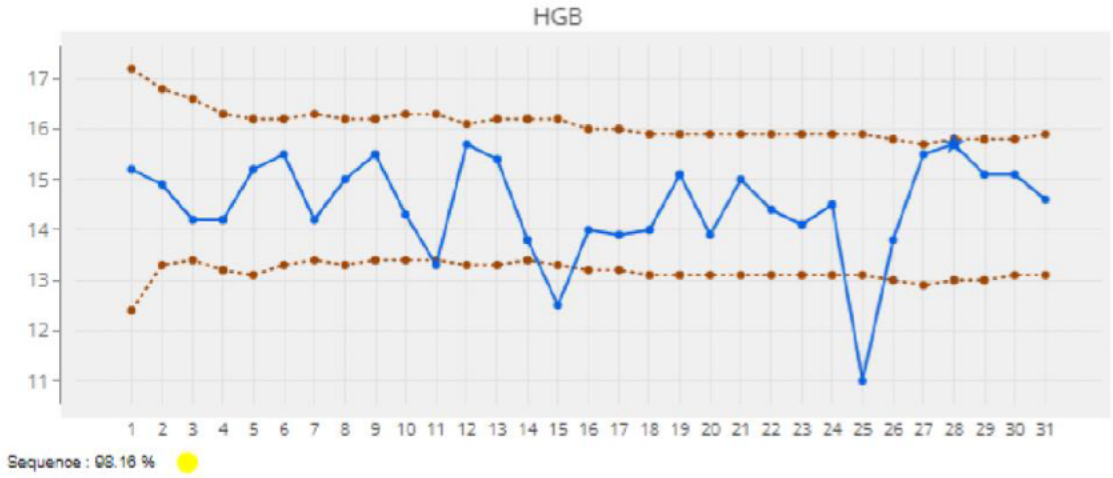
II. The Athlete's ABP

40. As an International-Level Athlete, the Athlete participated in WA competitions throughout the period covered by the ABP profile and was thus subject to the ADR and the Results Management of the AIU.

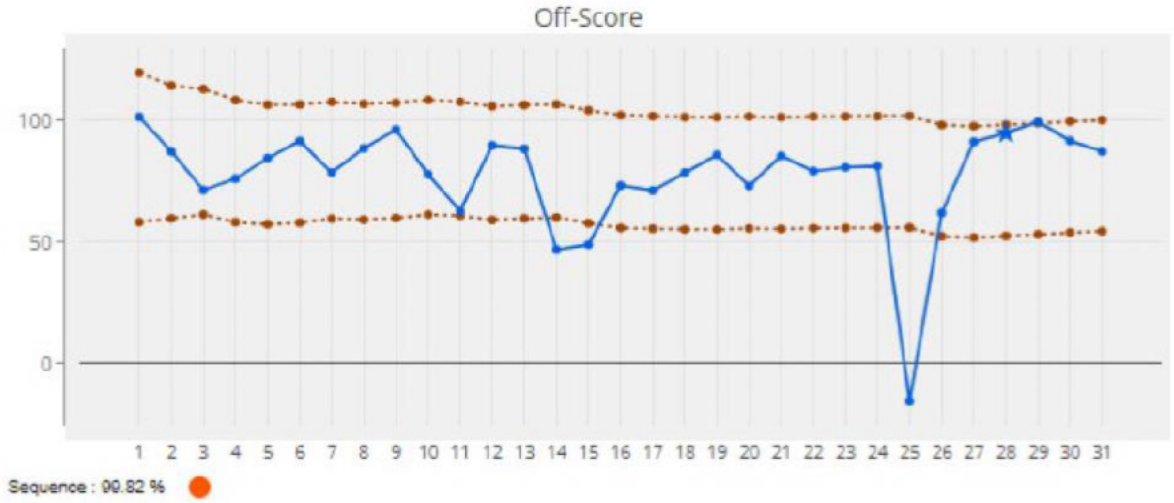
41. Graphs and a summary table of the Athlete's ABP, presented to the Panel, showing inter alia the Athlete's HGB, OFF-score and RET%, from 31 blood Samples taken from 16 February 2019 to 17 February 2024, is set out below:

[2] CAS 2018/0/5822 IAAF v RUSAF; CAS 2020/A/7377 Dazza v World Athletics; CAS 2020/A/7509 Ustyugov v International Biathlon Union; CAS 2020/A/7510 World Athletics v Wanjiru.

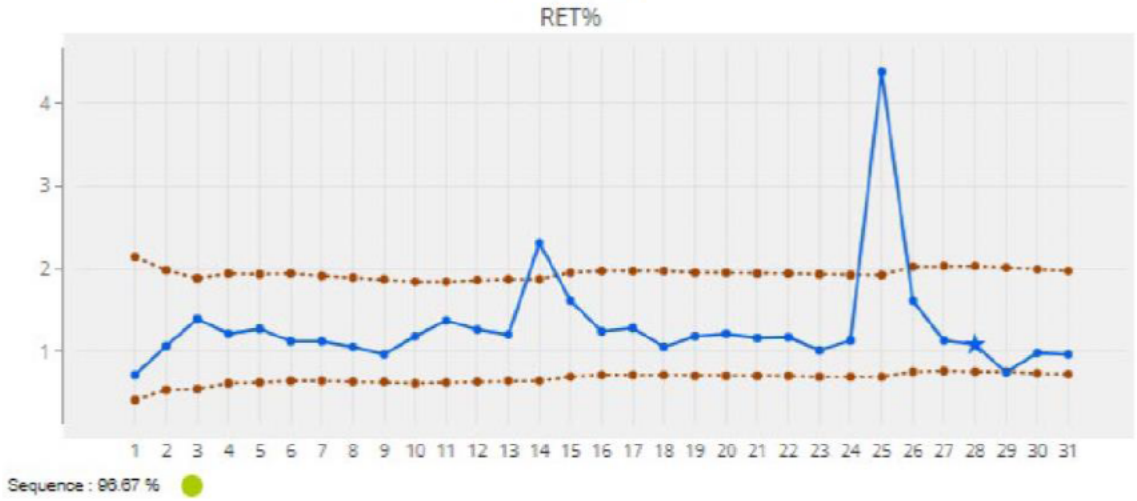
3.1.1 Full profile for haemoglobin (HGB)



3.1.2 Full profile for OFF-score



3.1.3 Full profile for reticulocytes (RET%)



3.2.3 Haematological results

#	Sample code	Collection date	HGB	RET%	OFF-score	HCT	RET#	IRF
1	353960	16.02.2019	15.2	0.71	101.44	45.5	0.0357	5.6
2	688710	29.09.2019	14.9	1.06	87.23	44.7	0.0509	7.3
3	664247	21.01.2020	14.2	1.39	71.26	42.1	0.0635	10.5
4	689884	15.02.2020	14.2	1.21	76	43.3	0.0558	8.2
5	681624	25.10.2020	15.2	1.27	84.38	46.2	0.0624	11.0
6	698852	27.01.2021	15.5	1.12	91.5	47.8	0.0577	8.2
7	735870	20.02.2021	14.2	1.12	78.5	44	0.0520	7.1
8	739952	19.03.2021	15.0	1.05	88.5	44.7	0.0501	12.2
9	903727	25.04.2021	15.5	0.96	96.2	46.2	0.0480	7.0
10	739958	09.06.2021	14.3	1.18	77.8	42.8	0.0540	6.6
11	712535	04.08.2021	13.3	1.37	62.8	39.9	0.0585	10.4
12	739919	19.08.2021	15.7	1.26	89.7	45.6	0.0629	11.1
13	905885	13.12.2021	15.4	1.20	88.3	44.1	0.0593	7.6
14	919531	16.01.2022	13.8	2.31	46.8	41.4	0.1035	20.7
15	919526	22.01.2022	12.5	1.61	48.9	37.7	0.0658	12.5
16	905203	13.02.2022	14.0	1.24	73.2	42.6	0.0572	9.5
17	10000275568	02.03.2022	13.9	1.28	71.12	43.1	0.0584	9.2
18	903365	16.04.2022	14.0	1.05	78.5	42.2	0.0476	9.6
19	0042770	16.06.2022	15.1	1.18	85.8	46	0.0578	12.2
20	193839V	11.07.2022	13.9	1.21	73	41.9	0.0537	10.3
21	0042771	10.11.2022	15.0	1.16	85.4	44.6	0.0572	10.3
22	970632	14.01.2023	14.4	1.17	79.1	44.1	0.0559	9.1
23	962316	18.02.2023	14.1	1.01	80.7	42.4	0.0473	8.4
24	1087823	02.04.2023	14.5	1.13	81.2	42.5	0.0537	11.9
25	1149925	20.06.2023	11.0	4.38	-15.6	33.4	0.1542	19.4
26	978360	04.07.2023	13.8	1.61	61.9	41.3	0.0707	9.6
27	1210375	16.08.2023	15.5	1.13	91.22	46.5	0.0570	4.1
28	1209658	19.08.2023	15.7	1.08	94.65	46.1	0.0539	6.1
29	507400	13.09.2023	15.1	0.74	99.4	43.3	0.0364	5.5
30	5740425	13.01.2024	15.1	0.98	91.6	44.0	0.0477	5.2
31	307447	17.02.2024	14.6	0.96	87.2	42.6	0.0444	5.0

Units for the results are those presented in ADAMS. All the results are based on ADAMS information.

42. In accordance with the procedural steps stipulated in the International Standards for Result Management ("**ISRM**") the Athlete's ABP was submitted to the Expert Panel.

43. In respect to Sample 25 the First Joint Expert Opinion explained:

> *"After samples 22-24 showing values perfectly in line with the Athlete's baseline, sample 25, collected out of competition on 20.06.2023, unexpectedly showed a fall in the HGB from 14.5 to 11.0 g/dL, combined with a marked rise in reticulocytes to 4.38%. The Immature Reticulocyte Fraction (IRF) was also markedly increased (19.4%). The OFF score showed an unusual and highly abnormal negative value (-15.6), which is extremely rare in athletes' ABP profiles. The OFF score is calculated from HGB and reticulocyte percentage using the formula: [OFF score = HGB(g/l)-60✓reticulocytes (%)] Its negativity reflects the marked increase in the reticulocyte percentage combined with decreased HGB.*
>
> *Such a hematological constellation is typical of acute blood loss, responsible for the low HGB, with reactive stimulation of the erythropoiesis in response to the decreased oxygen availability in tissues, causing the accelerated release of very young and immature reticulocytes from the bone marrow into the circulating blood. Without a medical reason, these anomalies indicate the withdrawal of a large amount of blood (two or three bags of whole blood or concentrated red blood cells (RBCs)). According to the ABP Supplementary form information, the Athlete did not donate or lose blood due to medical or emergency conditions during the previous three months."*

44. In respect to Samples 27, 28 and 29, the Expert Panel said:

> *"Sample 27 was collected on 16.08.2023, four days before the 20 km Race Walk at the 2023 World Championship. Sample 28 was collected in competition on the eve of the same Race. Their results showed increased HGB concentration (15.7 g/dL), at the equal highest level in this Passport, with decreasing reticulocytes (1.08). IRF was below the Athlete's average in both cases (4.1 and 6.1%). These changes indicate artificially augmented circulating RBC and HGB mass, suppressing the production of new reticulocytes. Reticulocyte suppression, with a high OFF score outlier, persisted in sample 29."*

The Joint Opinion conclusion was that the passport data presented a straightforward doping scenario and which was highly unlikely to be the result of any other cause, such as environmental or a medical condition.

45. The First Joint Expert Opinion, dated 8 April 2024 was followed by:

a) An interview with the Athlete on 28 June 2024;

b) A detailed written Explanation (the "**Explanation**") by the Athlete on 24 July 2024 accompanied by the Athlete's experts' opinions by Prof. Yamamoto, Dr Shimizu, Dr Manabe and Dr Kamahara;

c) A Second Expert Panel Joint Opinion ("**Second Joint Expert Opinion**") dated 10 October 2024 responding to the Athlete's Explanation;

d) The NoC issued on 1 November 2024 which also confirmed the imposition of a Provisional Suspension on the Athlete;

e) A denial by the Athlete and request that the Provisional Suspension be lifted, dated 15 November 2024;

f) A written Challenge by the Athlete submitted on 30 November 2024 which raised the issue of his genotype contributing to a significant hemolytic predisposition;

g) A Third Expert Panel Joint Opinion ("**Third Joint Expert Opinion**") dated 13 December 2023 responding to the Athlete's arguments;

h) The AIU brief dated 20 December 2024;

i) The Athlete's Answer brief dated 17 January 2025, inclusive of the Athlete's expert's opinion ("**Athlete's Expert Opinion**").

j) And a Fourth Expert Panel Joint Opinion ("**Fourth Joint Expert Opinion**") dated 27 January 2025.

46. A significant number of expert articles accompanied a number of the filings, together with documents evidencing factual matters such as medical treatment or consultations.

47. The AIU has the burden to prove the ADRV charged. The standard of proof is to the "comfortable satisfaction" of the hearing Panel. That is a standard higher than "reasonable possibility" and "balance of probabilities".

48. Given the issues in dispute in this case it is helpful to note what a CAS panel said recently about the role of a tribunal:

> *[…] neither scientific nor legal certainty is required. Its members must reach a conclusion on a principled basis in accordance with an assessment of the likelihood of a violation. That assessment requires higher proof than a mere balance of probabilities, i.e. that the violation is more likely than not. But it does not require such higher proof as would satisfy the familiar test for culpability for crimes: beyond a reasonable doubt. In doping matters, the standard is an intermediate one, namely the "comfortable satisfaction" of the Panel, which is another way of saying that an innocent explanation of a positive result is sufficiently remote to be excluded in the interest of fair competition for the entire sports community.*[3]

49. The Panel does not determine scientific issues, it has to assess likelihood on the basis of the evidence before it, of which the ABP is accepted as a reliable means of establishing a quantitative profile which, although not definitive, will carry weight when supported by Joint Expert Opinions.

50. The Charge in the present case is the Use of a Prohibited Substance and/or Prohibited Method which, specific to this case, is Use by the reintroduction of the Athlete's own blood into his circulatory system.

51. Under the Rules, withdrawal of blood is not an ADRV. In the manner in which the AIU's case was presented, the foundation for the Charge was that Samples 25, 27, 28 and 29 evidenced a doping scenario in which the Athlete withdrew a massive amount of whole blood or concentrated RBCs before the collection of Sample 25 in June which was reinfused before the collection of Samples 27 and 28 in August. The primary abnormality of the ABP profile was said by the Expert Panel to lie in the erythropoietic suppression

[3] CAS 2020/A/7510 Wanjiru v World Athletics.

observed in Samples 27 to 29. The Expert Panel opined that the elevated HGB and suppressed reticulocytes reflected increased RBC mass on the eve of the World Championship races.

52. The Panel must consider all the evidence for the purpose of a determination on whether or not it is comfortably satisfied that there has been Use of a Prohibited Substance and/or Prohibited Method. While it may be convenient to separately identify and consider individual elements relevant to that overall determination it is that determination, not the determination in respect of individual elements, to which the requirement of comfortable satisfaction or not applies.

53. The Panel makes that comment because much of the submissions and evidence on behalf of the Athlete focused on the issue of withdrawal or not. That is not the Charge but given the manner in which the AIU case was presented an assessment of the factual and opinion evidence relating to that question must ultimately be critical to the overall consideration of comfortable satisfaction or not as to the Use of a Prohibited Substance and/or Prohibited Method.

54. The Joint Experts' positive position, adopted by the AIU, can be simply described. It was that the ABP established a pattern of normalcy for Mr. Ikeda for the markers that WADA had determined were most appropriate for assessment of compliance with anti-doping standards. The evidence was that the longitudinal perspective for the Passport was adjusted at each time of sampling to reflect the identified range of haematological reactions which Mr. Ikeda had to his training and racing regime over time. That would embrace the fluctuations in training, whether light, sustaining or intensive, tapering and rest.

55. The Joint Experts' initial opinion, which was maintained in the face of the Athlete's Explanation, was that the marker values derived from Samples 25, 27, 28 and 29 were an abnormal departure from normalcy and highly indicative of blood doping.

56. The disparity relied upon by the Joint Experts is identified in the two charts below. The first is of the Samples in the Charge:

	HGB	RET%	Off-score	HCT	RET #	IRF
Sample 25	11.0	4.38	-15.6	33.4	0.1542	19.4
Sample 27	15.7	1.13	91.22	46.5	0.0570	4.1
Sample 28	15.7	1.08	94.65	46.1	0.0539	6.1
Sample 29	15.1	0.74	99.4	43.3	0.0364	5.5

(Underlined values are those contended to be beyond or at the limit of normalcy)

57. The disparity contended for can be illustrated by comparison with the equivalent sample values obtained from Samples 22, 23 and 24 – also in 2023 – but themselves reflective of the range of values obtained from sampling in 2019 through 2022 (with the exception of Samples 14/15 about which the joint experts expressed caution).

	HGB	RET%	Off-score	HCT	RET #	IRF
Sample 22	14.4	1.17	79.1	44.1	0.0559	9.1
Sample 23	14.1	1.01	80.7	42.4	0.0473	8.4
Sample 24	14.5	1.13	81.2	42.5	0.0537	11.9

It was fundamental to the AIU's case that the full range of values[4] between 2019, excluding Samples 14/15, represented normalcy for the Athlete.

58. It was the AIU case that the disparity in values, particularly reticulocytic values in Samples 27, 28 and 29, which the joint experts interpreted as evidencing reintroduction was not substantively met by the Athlete's Explanation. We will return to that issue, which is important in the Panel's ultimate assessment.

59. The Athlete and his experts rejected the Joint Experts' interpretation of normalcy and pressed the combination of multiple confounding factors set out in paras 27 and 28 above

[4] Sample 1 was identified as the product of measurement by different equipment and therefore not comparable.

as a sufficiently credible scenario to deny the Tribunal from being comfortably satisfied with the Joint Experts' doping scenario.

60. It is within that context that the Panel has considered the multiple factors relied upon by the Athlete and his witnesses. Those factors all have to be weighed in the ultimate determination of whether or not the Panel is comfortably satisfied that the AIU has discharged its onus.

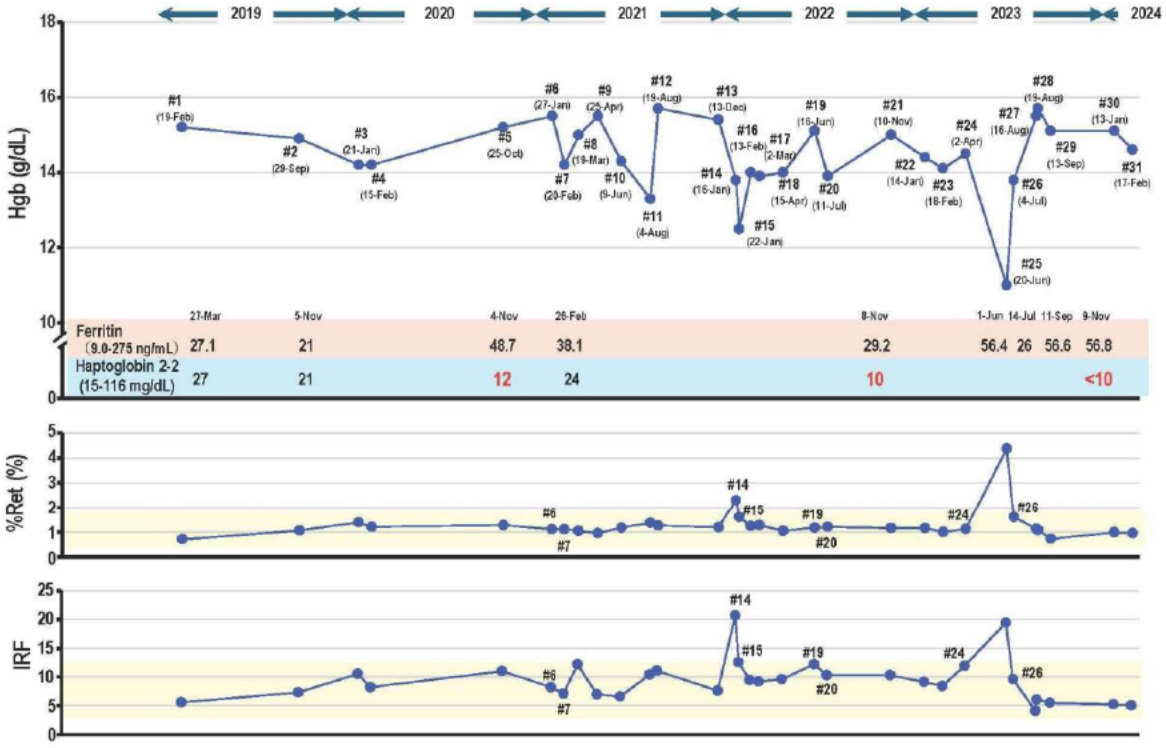
III. Discussion on the Merits

1. Intensive Training and Chronic Hemolysis

61. The Athlete's submission was that, influenced by the Athlete's rare genetic predisposition, the Athlete experienced severe intravascular hemolysis due to high intensity training which was the main cause of the decrease in HGB levels in Sample 25.

62. The Athlete's submission referenced multiple sources beyond the ABP, as illustrated in the following chart presented by Prof. Yamamoto and included in the Athlete's answer brief.

A chart of hematological data for Mr. Koki Ikeda



Serum ferritin and haptoglobin values on the indicated date, which were examined in JISS, are depicted. Normal ranges of the values are shown in parenthesis.

63. The Athlete first placed reliance on the fluctuations in the HGB values of his Passport, as showing that he had a persistent tendency or predisposition towards hemolysis.

64. This was in contrast to the Expert Panel who identified such variations as likely reflecting physiological variability, with variation of HGB concentration mainly depending on plasma volume shifts, with periods of mild haemoconcentration and haemodilution related to the alteration of different training loads and tapering. The Second Joint Expert Opinion confirmed that this variation was around a baseline seen in all runners and cyclists and was taken into account by the Adaptive Model. Reference was made in the Second Joint Expert Opinion to decades of studies demonstrating variation of the liquid part of the blood (plasma) and, consequently, of HGB (a concentration dependent parameter).[5]

65. At the hearing Dr Lewis was cross-examined as to this issue and explained that it was well established that plasma volume will vary in response to exercise and external conditions such as heat. Because HGB is a concentration measure the increase in plasma volume will result in a decrease in HGB with no or minimal change in blood mass. There will therefore be no or little increase in the reticulocyte response because that limited change does not stimulate the need to replace lost RBCs and is essentially self-correcting. The values in the Athlete's ABP prior to Sample 25, excluding Samples 14 and 15, for which the Expert Panel expressed caution, are consistent with Dr Lewis's and the Expert Panel's explanation of why there was little to no reticulocyte response.

66. In their Second Joint Expert Opinion, the Expert Panel did contemplate the possibility of exercise inducing mild hemolysis by noting that: "*[m]ild IH is observed in athletes but is never described as an acute hemolytic episode with marked HGB fall and reactive reticulocytosis as in Sample 25 of this Athlete's ABP passport*."

67. In that context, reference was made to a paper authored by Lippi and Sanchis-Gomar[6] (available to the Panel) which identified exercise-induced hemolysis (a preferred term to "*march hemoglobinuria*") as common place, paraphysiological because typically mild, and almost self-limiting. As Prof. d'Onofrio accepted the paper did identify influences that could

[5] Convertino et al., 1980; Sawka et al., 2000; Garvican et al., 2010; Garvican-Lewis et al., 2014; Voss et al., 2014; Bejder et al., 2017.
[6] Lippi G, Sanchis-Gomar F,'Epidemiological, biological and clinical update on exercise-induced hemolysis'.

amplify such consequences but, in his opinion, none of those influences were reflected in the Athlete's ABP's longitudinal values for HGB and reticulocytes which were otherwise stable, except for Samples 14,15 and 25. Prof. d'Onofrio also referenced a case report by Fazal. et al. (2017) (also available to the Panel) to similar effect. Both scientific papers are consistent with Dr Lewis's evidence that identified plasma volume increases resulting from endurance exercise. As Dr Lewis said at the hearing, the Athlete's proposition that plasma volume shifts are limited to prolonged exercise imposing a load 2.5 times baseline is incorrect as the discussions in the above scientific papers illustrate.

68. There is nothing in these scientific papers as evidencing a predisposition in a healthy Athlete to acute reticulocytosis as in Sample 25 but rather they identify the consequence of plasma volume changes as common place from exercise, as described by Dr Lewis, which, even if crossing the boundary to hemolysis, would result in mild hemolysis.

69. The Athlete's witnesses, in particular Prof. Yamamoto, sought to avoid that conclusion by preferring the IRF values, which he said were high. However, the evidence of Prof. d'Onofrio was that those levels were well within the normal range of 3-13.8% for healthy subjects except again for Samples 14 and 25 where the values significantly exceeded normal (20.7 and 19.4) and the ABP profile. In the Expert Panel's view those high values as compared to the norm do not support predisposition but rather indicate erythropoiesis stimulated in reaction to blood loss or withdrawal.

70. The Athlete's experts sought support for their predisposition thesis beyond the ABP in results obtained from blood samples privately obtained by the Athlete. Reliance on private samples has been an issue of contention in a number of cases. For the protection of athletes WADA sets stringent guidelines to ensure the quality and consistency of sample results for ABP administration and enforcement management generally. While Mr. Taylor, for the AIU, accepted that private sampling may be relevant and is therefore admissible – as recognised in *Ustyugov v. International Biathlon Union* - he emphasised that there are significant issues as to what weight, if any, should be placed on the result of such samples. This concern was emphasised by Dr Lewis and discussed in *Ustyugov v. International Biathlon Union* at para124:

"*The Panel finds that, irrespective of whether an athlete is retired or competing, private samples are, in principle, admissible evidence. Admissibility, however, only refers to whether the evidence is allowed to be presented by a party in an arbitration and introduced into the file. It is a separate question altogether whether the evidence is reliable, what probative value it may carry and whether private samples may be considered on an equal footing with the official anti-doping samples and inserted into the ABP. The Panel finds that private samples – while generally admissible into the file as legitimate evidence – are hardly reliable and lack any meaningful probative value, given that: (i) collection and analysis of the samples are not carried out using established anti-doping protocols to ensure their trustworthiness and comparability with official anti-doping samples tests in WADA-accredited laboratories; (ii) the laboratories picked by an athlete and the instruments, tests and personnel used by such laboratories, inevitably, would not be certified and validated by WADA as fit for anti-doping purposes and compliant with WADA standards; (iii) unlike official samples (which are specifically taken for anti-doping uses), such samples are taken voluntarily at an athlete's discretion, which means that their collection could be timed to ensure that the recorded values could support the athlete's case; (iv) due to a lack of supervision by an independent authority and lack of anonymity, samples could be altered or manipulated in a deceptive or fraudulent manner; and (v) an athlete could simply pick and choose which private samples to disclose, selecting only those that are beneficial to his case."*

71. The Panel accepts those concerns as justifiably held. That is not to doubt the integrity of the Japan Institute of Sport Science ("**JISS**") system or LSI Medience, a WADA accredited laboratory, but the rigorous standards imposed by WADA are there for a reason. The Expert Panel noted that no information regarding the Athlete's private samples was given as to temperature of storage, sample identification or thawing method. Nor did the tests measure free HGB in serum, which is the primary marker of intravascular hemolysis ("**IH**"). The Panel does have a concern that the equivalent reliability of those samples has not been established by any direct evidence. In addition, the Expert Panel noted that the Athlete's propositions focused on haptoglobin, Lactate Dehydrogenase ("**LDH**") and indirect bilirubin values, which are not values identified by WADA as most appropriate for determination of doping issues.

72. Having expressed those concerns, the Expert Panel did, however, respond to the Athlete's experts' propositions founded on those samples. The Panel notes that the general profile of those tests, while the measure of some elements is different, appears consistent with that recorded in the Athlete's Passport.

73. In the Expert Panel's opinion, the results for LDH and indirect bilirubin were normal, and thus reliably excluding hemolysis. The haptoglobin was generally normal, except two which were not measurable. The Expert Panel doubted the reliability of one of those because of a uniquely low LDH value. The Expert Panel's conclusion, therefore, was that the results were contradictory and lacked diagnostic validity but nonetheless generally represented values within or near normal range. The Panel is satisfied that, for the reasons expressed in the Third Joint Expert Opinion and the Fourth Joint Expert Opinion and, as explained by Prof. d'Onofrio, the private samples do not have the same status as the Athlete's Samples but, in any event, either support the joint experts' interpretation of the ABP values or are not substantially contradictory.

74. The Panel is not satisfied that there is anything derived from the ABP values or those of the Athlete's private samples that establishes a pre-disposition of sufficient magnitude and causatively linked to the aberration of Sample 25 with its significant drop in HGB and the very significant increase in RET% and IRF. However, the possibility of a genetic predisposition requires consideration.

2. Genetic Predisposition

75. The Athlete submitted that he possesses a rare genetic predisposition which in combination with the intense training at his elite level of competition, contributed to the abnormal results in Sample 25.

76. As a result of a Whole Genome Sequencing Analysis ("**WGS**") of Mr. Ikeda's genome in November 2024, prompted by a draft scientific paper by D'Alessandro et al., focus was placed on the relevance of [redacted] Single Nucleotide Polymorphisms ("**SNPs**"). The scientific paper which was directed to the stability of blood stored for transfusion purposes identified [redacted] SNPs linked to hemolytic tendencies derived from analyses of preserved red blood cells. [redacted]

[redacted]. [redacted]

[redacted].

77. Unfortunately, the original draft of the paper was ambiguous as to these conclusions. Much effort and time was spent in obtaining clarification from Mr. D'Alessandro with final clarification only being obtained on the last day of the hearing.

78. For the Athlete it was said by his experts and contended for by counsel that the identification in his genome that he carries [redacted] SNPs [redacted] must be taken to have [redacted] and its expression in Sample 25.

79. The Fourth Joint Opinion repeated the Expert Panel's view already expressed in the Third Joint Opinion that these propositions were solely based on the study by D'Alessandro, which focused on [redacted], and not [redacted]. In the Expert Panel's opinion, the link of those SNPs with intravascular hemolysis, for which there had been no functional or athlete-wide studies, represented speculation without any proof of causative link to the genesis of the values of the ABP markers in Sample 25.

80. The discussion between experts at the hearing did not advance to any resolution. Prof. Yamamoto emphasised that knowledge in this area was developing but, in the absence of testing and analysis, was unable to draw any specific conclusions as to the actual influence, if any, of these SNPs. In the absence of testing, it was submitted that the Athlete should not be penalised because a causative link had not yet been scientifically established.

81. The difficulty is not just the absence of a proven link but also that, even if there were such a link, whether it could cause the aberrant levels recorded for Sample 25. The Athlete has carried these variants throughout his lifetime and in particular during the time of the ABP. Given his considerable achievements during this period, which must have reflected a commitment over time to intensive training, there is a question as to why this genetic variant, if significant, had only manifested in Sample 25, or possibly in Samples 14 and 15.

82. The issue cannot be definitively resolved given the paucity of information and remains to be considered in the ultimate determination of comfortable satisfaction or not.

3. Gastrointestinal Bleeding

83. The Athlete submitted that gastrointestinal bleeding resulted from a reaction to the medication Loxonin, which had been prescribed after a tooth extraction and used in April and May 2023. Additionally, the Athlete used Loqoa Tape in May and June 2023, to treat inflammation of the fat pad in his right knee. The Athlete's explanation which introduced this proposition was couched in the term "*it is conceivable*". The possibility was derived from the list of side effects which accompanies these medications. Stress arising from a knee injury in May and significant mental anxiety was said to be additional contributing factors.

84. The Expert Panel's response was to identify, with reference to authority, that drug induced immune haemolytic anaemia ("**DIIHA**") is an extremely rare event. It was noted that no report of DIIHA in association with Loxonin or NSAIDs–containing tapes, such as Loqoa Tape - had been published.

85. The only reference to gastrointestinal bleeding is in a note by Dr Kamahara after he had reviewed a blood test obtained for Mr. Ikeda. The results of the blood test were to be sent to Mr. Ikeda with comments added. A comment by Dr Kamahara to the blood test noted Mr. Ikeda's HGB level as indicating mild anaemia and the possibility that the anaemia was caused either by "*insufficient protein intake*" or "*gastrointestinal bleeding due to the use of painkillers*". There is no evidence of a follow-up clinical examination directed at the issue of gastrointestinal bleeding but instead an attendance on Dr Dohi on 6 June 2023 which again noted that total protein was low and recorded a comment to the Athlete that "*currently there is no iron deficiency, so try to take in protein from meals*".

86. Although there were further medical consultations there was no further reference to gastrointestinal bleeding. If gastrointestinal bleeding had occurred to any significant extent, then it would be expected to show up in the Athlete's urine test. However, this was not noted in any medical report. It would also be expected to have been visible to the Athlete. There is no reference in the medical reports around this time to such a symptom. In his Explanation, dated 24 July 2024, the Athlete did say that he recalled black stools

during the periods when he was taking iron supplements and thought that was a consequence of those supplements. Prof. d'Onofrio agreed that this was likely correct. In his Explanation the Athlete further stated that it was very likely that the black stools were actually caused by gastrointestinal bleeding. There are, however, no contemporaneous medical records to support that statement other than the one reference by Dr Kamahara.

87. Again, because of the lack of compelling evidence, this proposition falls into the category of issues raised by the Athlete which have to be considered in the context of the Panel determining comfortable satisfaction or not.

4. Validity of Sample 25

88. Based on the Laboratory Documentation Packages the Athlete raised an issue in respect of the refrigeration of Sample 25, claiming a lack of temperature record from 6.44 GMT until the time of analysis at 7.08 GMT on the 21 June 2023. Additionally, he claims a rise in temperature during an earlier 1 hour 30-minute period and the possibility that these deviations affected the test result.

89. The AIU noted that, where a challenge relates to the integrity of the sampling, Rule 3.2 provides that the onus falls on the Athlete to establish a consequence from the claimed default. The Athlete did not do so. Notwithstanding, the evidence from the joint panel was that the minimal temperature variation would not have had any consequence because HGB is highly resistant to extreme storage conditions and reticulocytes tend to decrease and not increase during prolonged storage at high temperature. Moreover, observing the scattergrams in the duplicate Sysmex reports for Sample 25, with perfect identification and separation of the leukocyte clusters in the WDF scattergram, ensures the absence of any cell injury during storage. The stability analysis for Sample 25 registered a Blood Stability Score ("**BSS**") of 39.03 which is well within the parameter of 85.00.

90. As with all matters raised by the Athlete this falls to be considered within the overall assessment.

5. Impossibility

91. Evidence presented by Prof. Yamamoto and Dr Shimizu in the Athlete's Expert Opinion submitted with the Athlete's answer brief, identified that the decrease in the Athlete's HGB

level from 14.5 g/dL (Sample 24, 2 April 2023) to 11.0 g/dL (Sample 25, 16 June 2023) would represent a loss or removal of at least 1 litre of blood. Given the Athlete's body weight, they calculated that this would result in withdrawal of between 20% - 24% of his blood. In their opinion that could pose a life-threatening risk and therefore it was highly unlikely that the decrease in the Athlete's HGB level observed in Sample 25 was caused by recent phlebotomy.

92. This proposition was put to Dr Lewis in cross examination. Dr Lewis agreed that any withdrawal of such a large amount of blood would require to be controlled, with care being taken to replace the associated fluid loss. However, as she said, Mr. Ikeda's size was no different from many women athletes, cycling professionals or athlete marathon runners and, subject to care, she was satisfied by her experience and knowledge of events of blood doping that such withdrawal could be effected without the consequence postulated by Prof. Yamamoto and Dr Shimizu. No evidence to the contrary was led for the Athlete by a witness having the same experience and expertise in sports physiology and blood doping as Dr Lewis.

93. Again, this is an issue to be considered in respect to the ultimate conclusion.

6. Impracticality

94. The Athlete submitted that blood withdrawal while engaged at the National Training Camp ("**NTC**"), frozen storage of withdrawn blood and possible transport abroad represented the logistical infeasibility of the AIU's proposed doping scenario. Practicality is not an ingredient of the Charge which needs to be proved by the AIU. However, if raised by an athlete with positive and probative evidence it may, depending on the facts, fall into the general category of a factor mitigating against comfortable satisfaction. There was no such substantive evidence introduced. But the Panel would observe, that provided opportunity exists for withdrawal and reintroduction that, unless the claim to impracticality is akin to impossibility, it will likely carry little weight.

G. Burden and Standard of Proof

95. As the Panel has explained, its responsibility is to assess all of the evidence before it and in that context to assess whether or not the AIU has discharged its burden of persuading the Panel to a position of comfortable satisfaction that the Charge has been established.

96. If the Panel's view of the evidence was that the AIU's case did not at least prima facie satisfy the Panel that the ingredients of the violation were established then the Athlete's confounding propositions would not need to be considered. However, in real life, that should be an unlikely position given the rigour of the process which leads to the laying of a Charge.

97. There was an element of that suggestion in the Athlete's case which at times descended into an attack on the integrity of the Expert Panel. The Panel accepts Dr Lewis' evidence that the Expert Panel conscientiously considered the Athlete's Explanation and subsequent submissions and evidence but objectively remained of their view of the existence of a doping scenario. The Panel, without in any way deferring to the view of the Expert Panel, does note that the qualifications required by WADA for such experts goes beyond pure science to the understanding and experience of the athletic environment and physiology. The Expert Panel in this case had depth of expertise in both the science and its practical application.

98. The Panel in considering the ultimate issue has been conscious, as the Athlete's submission and his own evidence emphasised, of the adverse effects on him of a finding that the Charge was proved.

99. The Panel in its Operative Decision has come to that conclusion. The reasons can be relatively shortly stated:

    (a) The Panel accepts the Expert Panel's opinion, as orally explained by Prof. d'Onofrio and Dr Lewis at the hearing, in respect to Samples 27, 28 and 29 that the values represented reflect a further significant departure from normalcy in respect to the reticulocytes suppression. The RET% was in a low range for Samples 27 and 28, and fell to the lowest ABP value of 0.74% for Sample 29 with low IRF values and the lowest IRF value of 4.1 in Sample 27.

(b) The Expert Panel's opinion was that in the present instance the progressive suppression of reticulocytes demonstrated that the increase in erythrocyte mass, after the low value of Sample 25, was obtained not with a physiological recovery, which would have required a more sustained reticulocyte response in Samples after Sample 25, but through an external, exogenous manipulation. That massively increased the availability of oxygen in the tissues, in particular in the renal sensors that lead to the synthesis of endogenous erythropoietin in response to tissue hypoxia, which blocks, with a recognised molecular mechanism, the production of endogenous erythropoietin, causing a decrease in the percentage of immature red blood cells just released into circulation.

(c) The Athlete's submission and the Athlete's experts' responses was to emphasise the lower intensity of his training after his sojourn at the NTC, the improvements to his environment and nutrition, and recovery from gastrointestinal bleeding as contributing positively to his hemotological status in July through August. The Panel notes a difficulty in reconciling this with the Athlete's claim to a predisposition to chronic hemolysis including during what he described as his very favourable environment from 2019 to at least September 2022.

(d) In the Panel's view, the Joint Expert Opinions including their oral explanation was not persuasively countered either in cross-examination or in the Athlete's evidence. The Panel is satisfied that the Expert Panel's opinion, as further explained at the hearing, was consistent with the pattern of values in Samples 25, 27, 28 and 29 and that the values of Samples 27, 28 and 29 likely represented reintroduction within the parameters of a doping scenario.

(e) Consistently with other authority[7] the Panel recognises that this unusual conjunction, in terms of the Athlete's ABP, has occurred immediately before a very significant competition where the Athlete was representing his country and seeking to maintain his stature in his event. The Panel noted that the Athlete in his statement suggested that the competition was not of significant importance to him but has difficulty accepting that given the two factors referred to above.

[7] CAS 2020/A/7377 *Dazza v World Athletics* at [71]

100. While the Panel has accepted the Expert Panel's opinion as to likely reintroduction, the Panel has not applied that view as solely determining the issue of withdrawal or not. What is important, although not decisive, to that question, are the matters previously identified that the Panel is satisfied with:

(a) The reduction in HGB between Sample 24 at 14.5 g/dL and Sample 25 at 11.0 g/dL would represent a loss, however caused, of blood or concentrated RBCs at least in the range of 900mls to one litre; and

(b) That the RET% measure of 4.38 and IRF of 19.4 in Sample 25 reflects such a reactive increase in reticulocytes and immature reticulocytes that it evidences that all or most of that loss likely occurred shortly before Sample 25 was taken; and

(c) That such an event can properly be described as acute.

101. What does follow from those conclusions is that either there was a withdrawal or there would have been a discharge within a relatively short period of much of the 1 litre or so of blood represented by the fall in HGB. Prof. Yamamoto suggested a gradual loss but the Panel is unable to reconcile that with the greatly elevated RET% and IRF values identified in Sample 25. Prof. Yamamoto referred to withdrawal of that volume of blood as potentially life threatening. The Panel is of the view that a discharge of that same volume by natural vacating through urine or bowel would itself be unlikely to escape notice. Given that the Athlete appears to have had ready access to the JISS it is, in the Panel's view, surprising that such an acute event passed without a medical report or notice.

102. The difficulty with the Athlete's confounding issues of predisposition and genetic influence is that they are postulations that cannot be scientifically carried forward to the extent of demonstrating causative effect on the extreme values reflected in Sample 25, or being of any effect in relation to the interpretation of Samples 27, 28 and 29. The scientific evidence in relation to plasma volume and to extensive endurance exercise identifies the possibility of mild intravascular hemolysis, but without systematic evidence supporting the Athlete's proposition of pre-disposition to the massive outcome reflected in the Sample 25 values, the claim remains unsupported.

103. Nor, in the Panel's view, can the postulate of gastrointestinal bleeding bridge that gap. If it was so minor as to pass unnoticed by the Athlete and his medical advisors, then it would have no meaningful effect on the loss/withdrawal dynamic. If it was substantial, it would be virtually impossible to pass without notice. The Panel is not persuaded that gastrointestinal bleeding was a likely scenario and certainly not a scenario contributing substantially to the reduction in blood equating to the Sample 25 value.

104. Nor for the reasons expressed above is the Panel persuaded that any weight should be placed on the challenge to the validity of Sample 25, or the asserted impossibility or impracticability of a withdrawal and reintroduction of the quantity of blood implied by Sample 25.

105. For those reasons the Panel is comfortably satisfied that there was a reintroduction of the Athlete's blood into his circulatory system in the days shortly before Sample 27 was taken which is the substance of the Charge.

H. OPERATIVE AWARD

106. The Operative Award, as set out in paragraph 29 above, determined the penalties set by the Panel arising on the determination that the Charge had been established:

a) In respect to the principal penalty of Ineligibility for four (4) years, under Rule 10.2.1 the Panel had no discretion because the nature of the violation precluded a finding that the violation was not intentional.

b) As required by Rule 10.2 credit was provided for the period from the date of provisional suspension.

c) Rule 10.10 provides for disqualification from the date of a positive sample unless fairness requires otherwise. Given that the violation cannot be characterised as unintentional the Panel determined that disqualification should apply from 20 June 2023 being the date of the earliest Sample constituting evidence of the ADRV.

d) No order in terms of Rule 8.12.4 was made as to costs.

I. RIGHT OF APPEAL

107. This decision may be appealed to the CAS, located at Palais de Beaulieu Av. Des Bergières 10, CH-1004 Lausanne, Switzerland (procedures@tas-cas.org), in accordance with Rule 13 ADR.

108. In accordance with Rule 13.6.1(a) ADR, the deadline for filing an appeal with the CAS is 30 days from the date of receipt of this decision.

Alan Galbraith KC

Dr Tom Murray

Peter Koh

London, UK
28 February 2025