



Arbitration CAS 2015/A/4233 World Anti-Doping Agency (WADA) v. Martin Johnsrud Sundby & Fédération Internationale de Ski (FIS), award of 11 July 2016

Panel: Prof. Luigi Fumagalli (Italy), President; The Hon. Michael Beloff QC (United Kingdom); Mrs Jennifer Kirby (United Kingdom)

Skiing (cross-country skiing)

Doping (salbutamol)

Principles of “tempus regit actum” and “lex mitior”

Inhalation of a prohibited substance in excess of the “use threshold” and without a TUE

Definition of “inhaled”

Principle of the individualisation of the sanction

Determination of the category of fault in which a particular case might fall

Automatic disqualification

1. The applicable substantive rules must be identified by reference to the principle *“tempus regit actum”*: in order to determine whether an act constitutes a disciplinary infringement, a CAS panel applies the law in force at the time the act was committed. In other words, new regulations, unless they are more favourable for the athlete in accordance with the *lex mitior* principle, do not apply retroactively to facts that occurred prior to their entry into force, but only for the future.
2. Under the Prohibited Lists, the general rule is that all Beta-2 Agonists are prohibited, unless covered by an exception. As a matter of principle, an exception to a general rule is to be narrowly construed. With regard to salbutamol, only use by inhalation is permitted. The use of inhalation to administer salbutamol (as distinct from administration by ingestion or injection) is a necessary but not a sufficient element to engage the exception. It is also necessary not to exceed the “use threshold” which refers to the maximum dose that can be taken by inhalation, *i.e.* the *“labelled”* or *“nominal”* dose. Considering that the athlete in question used a nebulizer to inhale salbutamol and that the smallest dose available by nebulizer exceeds the “use threshold” for said substance, the athlete’s fault lies in failing to request a Therapeutic Use Exemption (TUE), the grant of which would have enabled him to compete without breach of the rules.
3. The epithet *“inhaled”* is deployed in the context of the exception to the prohibition of all Beta-2 Agonists to identify the mechanics of administration. In other words, it is meant to distinguish “inhalation” from “ingestion” or “injection” (by both of which means salbutamol can be administered), such that only use by inhalation is permitted. The epithet *“inhaled”* does not serve any further or alternative purpose; it cannot bear two meanings simultaneously or describe at one and the same time the stage of administration as well as the mechanics of administration. Such an interpretation

would, in the absence of express indication to that effect, be inconsistent with ordinary rules of construction, including the principle of narrow interpretation of exceptions. It follows that the expression “*therapeutic inhaled dose*” only describes the mechanics of administration.

4. Although consistency of sanctions is a virtue, correctness remains a higher one: otherwise unduly lenient (or, indeed, unduly severe) sanctions may set a wrong benchmark inimical to the interests of sport. Therefore, even if precedents in terms of the approach in principle may provide helpful guidance, each case must be decided on its own facts.
5. According to CAS jurisprudence, in order to determine into which category of fault a particular case might fall, it is helpful to consider both the objective and subjective level of fault. The objective element describes what standard of care could have been expected from a reasonable person in the athlete’s situation. The subjective element describes what could have been expected from that particular athlete, in light of his personal capacities. The objective element should be foremost in determining into which of the three relevant categories of degree of fault (significant, normal, light) a particular case falls. The subjective element can then be used to move a particular athlete up or down within that category.
6. Article 9 of the FIS ADR (corresponding to Article 9 of the WADC) leaves no discretion to the relevant disciplinary body (or to a CAS panel): the results achieved in the given competition shall always be disqualified. This conclusion follows, as an unavoidable consequence, the finding of an anti-doping rule violation, without any possibility for the hearing body to adopt a decision not imposing it, even in those exceptional cases where no sanction is inflicted, because the athlete bears “*No Fault or Negligence*”. In other word, the automatic disqualification operates as a matter of fairness to all other athletes.

1. BACKGROUND

1.1 The Parties

1. The World Anti-Doping Agency (“WADA” or the “Appellant”) is a Swiss private-law foundation. Its seat is in Lausanne, Switzerland, and its headquarters are in Montreal, Canada. WADA was created in 1999 to promote, coordinate and monitor the fight against doping in sport in all its forms.
2. Mr Martin Johnsrud Sundby (the “Athlete” or the “First Respondent”) is a Norwegian cross-country skier, born on 26 September 1984, who competed with considerable success at international level. The Athlete is registered with the Norwegian Ski Federation (*Norges*

Skiforbund: the “NSF”), which is affiliated to the Fédération Internationale de Ski.

3. The Fédération Internationale de Ski (“FIS” or the “Second Respondent”) is the International Federation responsible for the administration and regulation of the sport of skiing. FIS is an association under Swiss law and has its headquarters in Oberhofen am Thunersee, Switzerland.
4. The Athlete and FIS are hereinafter jointly referred to as the Respondents.

1.2 The Dispute between the Parties

5. This case is about an athlete who took, upon medical advice, a medicine in a dosage leading to the adverse analytical findings in the samples he provided. The question to be decided concerns in essence whether such dosage is or is not allowed by the applicable anti-doping rules, adopted by FIS on the basis of the World Anti-Doping Code (the “WADC”) and the consequences of such finding. It was not suggested by WADA (or by FIS) that the Athlete intentionally cheated or intentionally broke the rules and then tried to defend deliberate doping with spurious medical or other justifications. As is well known, however, the anti-doping rules require strict observance: hence the claim brought against the Athlete and the appeal heard by this Panel.
6. The circumstances stated below are a summary of the main relevant facts, as submitted by the parties in their written pleadings or in the evidence given in the course of the proceedings. Additional facts may be set out, where relevant, in connection with the legal discussion which follows.
7. On 13 December 2014, the Athlete underwent an in-competition doping control, performed under the authority of FIS, in Davos, Switzerland. On that occasion sample No 3782813 (the “Davos Sample”) was taken.
8. On 16 December 2014, the WADA-accredited laboratory of Kreischa/Dresden, Germany (the “Laboratory”) received the Davos Sample for analysis.
9. On 8 January 2015, the Athlete underwent another in-competition doping control again performed under the authority of FIS in Toblach, Italy. On this second occasion sample No 3782808 (the “Toblach Sample”; the Davos Sample and the Toblach Sample are hereinafter referred to as the “Samples”) was taken.
10. On 13 January 2015, the Laboratory received the Toblach Sample for analyses.
11. The analyses of the Samples revealed the presence of salbutamol in the following concentrations:
 - Davos Sample: 1.340 µg/mL
 - Toblach Sample: 1.360 µg/mL
12. The presence of salbutamol detected in the Samples was greater than the measure of

1,000ng/mL (corresponding to 1.0 µg/mL)¹ allowed by the lists of prohibited substances and methods published by WADA for 2014 and 2015 (respectively, the “Prohibited List 2014”, the “Prohibited List 2015” and jointly the “Prohibited Lists”) in category “*S.3 Beta-2 Agonists*”, and the decision limit of 1,200 ng/mL (corresponding to 1.2 µg/mL) (the “DL”) according to the WADA Technical Document – TD2014DL on the Decision Limits for the Confirmatory Quantification of Threshold Substances (Version of 1 September 2014)².

13. Therefore, the Laboratory reported to FIS adverse analytical findings (the “AAFs”):
 - on 20 January 2015 for the Davos Sample, and
 - on 23 January 2015 for the Toblach Sample.
14. On 23 January 2015, the FIS notified the NSF of the AAFs, and invited the Athlete to respond within seven days to the following questions regarding the administration of salbutamol, and to provide any additional explanation or any documentation relating thereto:
 - “1. *How many administrations have taken place during the hours before the doping controls?*
 2. *How long were the intervals between each administration?*
 3. *What was the concentration of each dose?*
 4. *How was the substance administered?*
 5. *How was the administration of the substance carried out the days prior to the doping control?”*
15. In the same letter, the FIS informed the NSF and the Athlete that, upon receipt of the Athlete’s answers, the FIS might request him to prove through a “*controlled pharmacokinetic study*” that the AAFs were the consequence of the therapeutic inhaled dose up to the maximum allowed. The FIS, however, indicated that the Athlete could elect, instead of responding to the listed questions, to submit directly to the mentioned “*controlled pharmacokinetic study*”, specified by FIS as follows in accordance with the pertinent guidelines governing it:
 - “1. *The study shall be conducted in a controlled setting allowing a strict and independent supervision of the drug administration (route, dose, frequency, etc) and sample collection (matrix, volume, frequency) protocol.*
 2. *A wash-out period should be established in order to collect baseline urine or blood samples just prior to the administration of the drug, i.e. the athlete should not be taking the medication before the test. Necessity of the drug for health reasons as well as the known pharmacokinetics of the product will need to be taken into account, if necessary.*

¹ The Panel understands in fact that the following ratios apply: 1 g (gram) = 1,000 mg (milligrams); 1 mg = 1,000 µg (micrograms); 1 µg = 1,000 ng (nanograms).

² A decision limit is the level of a prohibited substance to be detected in a sample when the existence of an adverse analytical finding depends on a quantitative determination. The decision limit is set considering the threshold provided for the substance in question increased by a factor intended to reflect the measurement uncertainty.

3. *Collection of urine samples shall occur whenever that athlete wishes to deliver samples but no less than every two hours during the monitoring period. Sampling periods should be adjusted to the known pharmacokinetic of the product (e.g. every 30 min. or night collections might be considered, if justified).*
 4. *The athlete shall take the drug in accordance with the treatment course (dose, frequency, route of administration) declared in the doping control form or, alternatively, following the therapeutic regime indicated on a granted TUE, if any. The administered dose shall never exceed the maximal dose/frequency recommended by the drug manufacturer or a safe level prescribed by the athlete's physician.*
 5. *The samples shall be analyzed in a WADA accredited laboratory with the validated relevant anti-doping method. Correction for specific gravity shall be applied in accordance with the provisions of the ISL and related Technical Documents.*
 6. *The WADA accredited laboratory will issue a comprehensive report indicating the results of the analyses and interpretation, if needed. If deemed necessary, review of the results by an independent expert can be sought by the Testing Authority".*
16. In a letter to FIS of 26 January 2015, the Athlete wrote the following, in order "to comment on the results of the analysis and answer the questions" asked by FIS:
- "From 7/12-2014 I have been in a state of airway obstruction with more intensive anti-asthmatic medication than usual. I was recommended to take Ventoline (salbutamol) inhalation by nebuliser before taking inhaled Pulmicort, which I usually take four times a day during exacerbations. In practice I have used inhaled salbutamol 2 mg/ml single-dose ampoules à 2.5 ml three times daily from this time until end of Tour de Ski due to continuous symptoms. During the Tour de Ski competitions I also developed production of bronchial mucous plugs and was put on Klacid antibiotics on 8th of January. My dosing regimen of asthma drugs during this period was as follows on days of competition (when competition starts at 1330, like in Toblach):*
- Ventoline (salbutamol) 2 mg/ml single dose ampoule, 2.5 ml nebulised before nebulised Pulmicort 8.30 a.m.*
- Ventoline (salbutamol) 2 mg/ml single dose ampoule, 2.5 ml nebulised together with nebulised Atrovent 0.5 mg/ml 1ml (single dose ampoule) at 11.30a.m.*
- Ventoline (salbutamol) 2 mg/ml single dose ampoule, 2.5 ml nebulised together with nebulised Atrovent 0.5 mg/ml 1ml (single dose ampoule) at 13.00 (1.15 p.m.)*
- After the competition Pulmicort nebulising fluid, repeated in the evening.*
- During days of training I also inhaled 3 doses of Ventoline nebulising fluid in the morning, midday and not later than 17 (5 p.m.) as my sleep is disturbed by using Ventoline later in the evening.*
- I would like to add that two years ago I developed atrial fibrillation and was examined electrophysiologically. At the time I was taken off all inhaled beta-2-agonists, stopped using Seretide which was substituted with the inhaled steroid Alvesco. Later I have again started taking Ventoline during periods of increased mucous production and asthma symptoms".*
17. On the same 26 January 2015, Dr Knut Gabrielsen, team doctor of the NSF, sent a separate letter to the FIS as follows:

“Martin has suffered from asthma from early childhood. He has repeatedly been shown to have bronchial responsiveness as demonstrated by metacholine bronchial challenges. As team doctor in Norwegian Ski Federation I have treated him during the later years.

He contacted me by phone the 7th of December because of more severe airway obstruction.

In view of his earlier history of airway obstruction I recommended him to start inhalation of nebulised salbutamol (Ventoline) 2mg/ml ampoules á 2,5ml up to 3 times a day before budesonide (Pulmicort) inhalation.

His symptoms did not improve, and he continued this medication. During the Tour de Ski his respiratory symptoms worsened, developing bronchial plugging with production of small bronchial plugs.

After the competition and examination of Martin on the 8th of January I recommended treatment with clarithromycine (Klacid) 500mg tbl daily.

I have seen the results of the analyses of the urinary doping control on the 13th of December and the 8th of January, and both test were performed shortly after competition. It is not unlikely to think that the athletes were in a status of dehydration at this time point. Also the competitions were performed at medium to high altitude both in Davos and Toblach which may also have an impact on the results. Studies performed by Vibeke Backer and her group has shown that urinary salbutamol concentrations may be varying and high especially after high exercise levels and on repeated dosing of salbutamol”.

18. The FIS submitted the results of the analyses, together with the comments of the team doctor and of the Athlete, to Professor Ken Fitch, School of Sports Science, Exercise and Health at the University of Western Australia.
19. In a letter dated 2 February 2015, the FIS informed the NSF that, in light of the comments received, it had determined that *“the causation of the AAFs has been credibly explained and does not need to be double-checked by a controlled pharmacokinetic study. Hence, the FIS will not request the Athlete to undergo the pharmacokinetic study”*. At the same time, the FIS advised that no provisional suspension would be imposed on the Athlete and indicated to the NSF the actions to be taken in accordance with the applicable FIS Anti-Doping Rules (the “FIS ADR”).
20. The report issued by Professor Fitch, dated 3 February 2015 (the “Fitch Report”), reads, in the pertinent portions, as follows:

“Dosage of Salbutamol: *WADA advise that the maximum dose of inhaled Salbutamol is 1,600mcg in 24 hours. Introduced by the IOC in 1997, this ceiling was considered to equate to not more than 16 inhalations of 100mcg from a hand-held metered dose aerosol (MDI). When WADA assumed responsibility for the Prohibited List, this recommended maximum daily dose was continued and has since. From 2000, the IOC introduced a maximum urinary threshold of 1,000ng/mL [...] which WADA has continued. However, currently, WADA’s Prohibited List states merely that 1,600mcg is the maximum dose by inhalation [...].*

WADA has never addressed the issue of nebulised Salbutamol but it is acknowledged to be an acceptable method of administration as it is ‘by inhalation’. The manufacturer’s recommended dose of Salbutamol for nebulisation by adults is 2.5-5mg three times a day – i.e. a maximum of 15mg per day which is nine times greater than 1,600mcg.

Nebulisers to administer drugs to manage respiratory conditions have been used for many years but mainly in hospitals. Their primary advantage over MDIs is the ability to deliver higher doses of drugs such as Salbutamol faster to the airways to manage acute severe asthma. Nebulisers can also be useful in young children with asthma who cannot manage an MDI and spacer. The delivery of a drug such as Salbutamol via nebulisation does not provide much superior delivery to that achieved by an MDI, used correctly with a spacer. Although the prescribed dosage is within the manufacturer's therapeutic guidelines for 24 hours, when administered within five hours, it must be described as unnecessarily high.

Comments by the athlete's doctor.

The athlete's physician suggested that the result may be due to dehydration. However, the reported SG of the two samples would exclude this explanation. WADA do not allow a correction for SG down to 1020 for exogenous substances with a threshold such as Salbutamol. The SG of the two samples was 1019 and 1014 and even if permitted, such a conversion could not be invoked.

The team doctor mentions that the urinary concentration of salbutamol can vary after strenuous exercise. This is correct but it can vary between persons and within persons even when not exercising [...]. However, this explanation cannot be considered relevant. The athlete had two doping controls 26 days apart, both immediately after strenuous exercise. On each occasion, he administered the same dose (15mg) of Salbutamol, by the same route (nebulisation), and in the same five hour time-frame and the resultant urinary concentrations (1,340ng/ mL and 1,360ng/ mL) were virtually identical.

Cause of this Adverse Analytical Finding (AAF)

This skier's two AAFs were due to the excessively high dose of Salbutamol as it was administered within five hours rather than the recommended 24 hours. Hence, there is no justification to conduct a pharmacological study as recommended by WADA. In fact, the above mentioned variation in the metabolism and excretion of Salbutamol makes such a study, conducted in a laboratory and not after strenuous exercise questionably useful as its justification is based on just one Swiss track and field subject with a grossly abnormal metabolism of Salbutamol [...]. As the reported concentration was only marginally above the threshold, it seems highly likely that had the three doses of nebulised Salbutamol been administered over 24 hours as is recommended, neither of this athlete's urine samples would have exceeded WADA's threshold of 1,000ng/ mL

Can this dosage be deemed justified because of the athlete's clinical condition?

Having noted the athlete's and his doctor's comments on his respiratory condition and this athlete's competition results from 21 November 2014 to 11 January 2015, I make the following comments.

i) WADA do allow a retroactive TUE for acute asthma necessitating higher than maximum doses of Salbutamol prior to a doping control test for acute severe asthma [...] but this is only for one such episode on one specific day. When this medical situation arises, higher doses of Salbutamol are administered by inhalation and the athlete is selected for a doping control, he/she must apply to a TUEC for a retroactive TUE prior to the Laboratory result being known. In this instance, the athlete's dose of 15mg of nebulised Salbutamol was taken daily for about a month.

ii) Between 7 December and 8 January, this skier competed in eight skiing competitions and completed all, winning one and being placed third in three others. Prior to the 7 December 2014 when he sought medical advice, his competition results were superior to those after that date and this could have been due, at least in part, to his respiratory condition. However, because that he competed with success in many elite, endurance cross country skiing events in this period, it would appear that his condition could not be described as 'acute severe asthma'.

iii) While in certain circumstances there may be medical justification for an asthmatic with acute severe asthma needing three nebulisations of Salbutamol of 15mg administered within five hours, this would only be on one occasion and after appropriate lung function evidence obtained and there is no information that spirometry was performed by this athlete. If this did not effectively manage the condition, alternative treatments should be instituted.

In conclusion, it would appear that the fundamental reason why this athlete exceeded the urinary threshold for Salbutamol of 1,000ng/mL was the quantity of Salbutamol administered in the five hours immediately prior to his two events. A secondary reason could be that this dosage had been delivered daily for a week prior to his first doping control and for a month prior to the second. However, I do not consider that this athlete sought to dope or to unfairly enhance his performance by his high dose of Salbutamol taken daily within five hours prior to these two competitions”.

21. On 3 February 2015, the NSF informed the FIS that the Athlete (i) waived his right to request the opening and analysis of the B-samples, (ii) requested a hearing before the FIS Doping Panel, and (iii) indicated that further comments would be submitted in writing prior to the hearing.
22. On 6 February 2015, the FIS informed the Athlete that a hearing in his case would be held before the Doping Panel on 11 February 2015, in Vail, Colorado (USA).
23. On 8 February 2015, the Athlete submitted a “personal statement to the FIS Hearing Panel ... to explain and describe the most important facts in this case from [his] point of view”, with the “hope and intention is to describe the situation in a sufficiently thorough and understandable manner, and obtain a fair treatment in this hearing”. After an indication of his “perception of the situation”, of his “medical history” and of the “accuracy and alignment to rules and regulations”, the Athlete expressed the following “summary” and “closing remark”:

“Summary

1. *I have never used more than the allowed doses of Ventoline prescribed by medical experts.*
2. *Professor Ken Fitch concluded that there was no indication that the “athlete sought to dope or unfairly enhance his performance by his high dose of Salbutamol taken daily within five hours prior to these two competitions”.*
3. *Over the past week it has been brought to my attention that studies have proven that use of allowed doses can represent a risk of exceeding the FIS regulated amount of Salbutamol in the urine.*
4. *This knowledge [...] is not communicated or stated in any FIS or WADA information or regulations as a warning.*
5. *I have had one of the world’s most recognized lung specialists as my medical advisor for almost 20 years. He has not seen any reason to warn me of any hazard related to my usage of the allowed doses of medicine.*
6. *I have never been advised that allowed doses has to be taken in any special manner.*
7. *I have not been able to find any regulations indicating that time span between intake of the daily doses and a test after the race can represent any risk. I do not have the required medical knowledge to understand this potential risk.*

8. *I have never received any warning related to factors like height training, illness, dehydration, weight-loss or intake of other medicines and the level of Salbutamol in my urine tests.*
9. *As an athlete I have never had any reason to believe, or been warned that I even have been close to exceed the allowed limit when I never have exceeded the allowed doses.*
10. *The excess value is stated in the external report to have no connection with an intention of enhancing performance.*
11. *I have in fact during this period used less than the maximum doses due to my anxiety for heart rhythm disturbances and insomnia.*
12. *I find it hard to understand the consistency of regulations that on one hand states a limit and on the other hand allows usage of doses that can exceed the same limit.*
13. *I perceive this inconsistency as a trap for an athlete when met with the argument that "a limit is a limit". It should be possible to harmonize the allowed doses and the accepted limits of Salbutamol in the urine without sacrificing athletes.*
14. *I believe that I should have been made aware of the positive test in Davos at much earlier point in time in order to find out how this could have happened.*

Closing remark

The potential punishment for the accusations I am faced with has the potential to ruin me, my family and our future. If I should be disqualified from the races I risk being considered as a cheater, regardless of the explanation. A disqualification from Tour de Ski reaches a level of punishment that for me seems totally out of proportion with the facts in this case, especially when Ken Fitch concludes with marginal excess values, not intended to enhance performance. The magnitude of such a punishment will potentially put an end to my career. I kindly ask you to understand that I have followed the rules and been in good faith".

24. On 9 February 2015, the NSF forwarded to the FIS a letter of the same day sent by the Athlete's counsel and requested the FIS to reconsider its decision to convene a hearing in the Athlete's case. The conclusions of the letter from the Athlete's counsel were summarized as follows:

- “ *The athlete has suffered from asthma from early childhood.*
- *The reason for prescribing nebulized Ventoline (Salbutamol) was for therapeutic reasons only.*
- *Nebulizer is a common method for administration of Salbutamol.*
- *Using the nebulizer makes it necessary to add a much higher dose of Salbutamol as with the hand-held metered dose spray, because much of the drugs remains in the nebulizer.*
- *The dosage of Salbutamol (5mg x3) is equivalent to 1500 mcg. inhaled dosage, hence the inhaled dosage (1500 mcg.) did not exceed the limit of 1600 mcg.*
- *WADAs prohibited list 2014/2015 S3 Beta2-agonist bullet point 1 specifies that it is prohibited to inhale more than 1600 mcg. on a daily basis (24 hrs.). WADAs prohibited list does not specify the number of dosages during a day or the frequency, hence the dosage of Salbutamol (5mg x3) within a period of approx. 5 hours was in line with WADAs prohibited list. The dosage of Salbutamol (5 mg x 3) within 5 hours was also in line with the recommendations from both the Medical Authorities and the manufactures, hence the dosage was not unnecessarily high.*

- *There is no Adverse Analytical Finding (AAF) in this case as the inhaled dosage (1500 mcg.) is within the accepted maximum by WADA of 1600 mcg.*
 - *The reports from professor Carlsen and professor Bjermer support this, and the FIS' expert, Professor Fitch, concludes that the test results is due to the frequency of the inhalations (3 within 5 hrs.).*
 - *A TUE was not necessary as the dosage 15 mg is equivalent to 1500 mcg. inhaled dosage, and within the accepted maximum, and was also in accordance with earlier approved for in previously granted TUEs.*
 - *FIS has, with reference to the report from the FIS expert, not requested the athlete to undergo a pharmacokinetic study”.*
25. The letter of the Athlete’s counsel had attached, *inter alia*, expert statements dated 9 February 2015 and signed by Professor Kai-Håkon Carlsen, Professor of Paediatric Respiratory Medicine and Allergology, University of Oslo, Norway, and by Professor Leif Bjermer, Professor at the Department of Respiratory Medicine & Allergy of the University of Lund, Sweden. More specifically:
- i. Professor Carlsen, in his report (the “First Carlsen Report”), concluded that he would *“support the conclusion by Professor Fitch that the athlete did not use the dose of salbutamol to improve his athletic performance, but to resolve or prevent bronchial obstruction that would otherwise have prevented his participation in competitions”;*
 - ii. Professor Bjermer, in his report (the “First Bjermer Report”), confirmed that the Athlete has *“a chronic non-allergic asthma triggered by exercise and cold air. The disease is characterized by moderate sensitivity to inhaled corticosteroids and with need for bronchodilation and mucus secrete mobilization. The prescription of nebulized salbutamol 5 mg three times daily combined with saline should be considered to be in line with common practice, with no other intention than to reduce air trapping and to clear the lungs from excess mucus secretions. 15 mg is bioequivalent to 1500 µg salbutamol delivered by MDI with spacer and under the by WADA recommended maximum daily dose of 1600 µg. The reason for the measured elevated levels was in this case dosing within a relatively short interval, five hours. Moreover, strenuous exercise and dehydration may also have influenced the urinary levels. In addition to the bronchodilation and secrete mobilizing effect, there is no evidence that the prescribed regimen could improve endurance performance, rather the opposite”.* In order to support his statement that *“15 mg”* inhaled by nebulization *“is bioequivalent to 1500 µg salbutamol delivered by MDI with spacer”* Professor Bjermer made reference to a study of S.H. Mazhar, N.E. Ismail, D.A.G. Newton and H. Chrystyn, Relative lung deposition of salbutamol following inhalation from a spacer and Sidestream jet nebulizer following an acute exacerbation, *Br J Clin Pharmacol* 65:3, 334-337 (the “Mazhar Study”).
26. Addendums to the First Bjermer Report were thereafter provided:
- i. on 10 February 2015, Professor Bjermer answered (in the “Second Bjermer Report”) the question whether it is *“possible to, with high degree of confidence, in a laboratory setting, replicate what occurred in real life”* as follows: *“There are many factors in real life that are unique and difficult to reproduce in a laboratory setting. The dynamic of a race balancing your resources over time in order to squeeze maximum effect out of the body is one factor difficult to reproduce. High altitude performance is another factor to consider and there are at least theoretical reasons for to believe that this could have*

influenced the salbutamol excretion. More research is needed in order to explore the influence by strenuous exercise in high altitude”;

- ii. on 11 February 2015, Professor Bjermer answered (in the “Third Bjermer Report”) in the affirmative (“yes”) to a second question (“*whether a dose of 15000 µg salbutamol delivered by a nebulizer can be biological equivalent to 1500 µg delivered by pMDI with a spacer*”).
27. On 11 February 2015, in a procedural order No 1, the Chairman of the FIS Doping Panel decided, *inter alia*, to cancel the hearing scheduled for that day and to order the Athlete to undergo a pharmacokinetic study to prove that the test results of the Samples were the consequence of the use of the therapeutic inhaled dose up to the maximum of 1,600 µg/24h.
28. On 8 April 2015, at the WADA-accredited drug control centre, King’s College London, a “*controlled pharmacokinetic study*” for salbutamol took place under the supervision of Professor David Cowan. A report was provided on 16 April 2015 (the “London Study”), which in the pertinent portions reads as follows:

“The athlete uses Ventoline® nebuliser with 5 mg doses (2.5 mL of 2 mg/mL) of salbutamol.

A zero time urine sample was collected at 9:11 a.m.

Mr Sundby then nebulised 2.5 mL of a 2 mg/mL solution of salbutamol, with no additional saline, between 9:19 and 9:23 a.m.

Approximately thirty minutes after the first administration at 9:56 a.m. Mr Sundby produced a sample of urine. He produced further samples ...

Mr Sundby was observed for the duration of the study by the Doping Control Officer Mr Murray Brook. Professor Cowan observed all nebulisations (all of 5 mg), the second being between 12:28 and 12:32 p.m. and the third between 13:59 and 14:03 p.m.

The sample volumes were estimated by the laboratory, the specific gravity and pH measured and the concentration of non-sulphated salbutamol determined. The measured concentrations were also adjusted to take into account the specific gravity of each urine sample. ...

... these data show that the specific gravity adjusted maximum concentration of approximately 4,800 ng/mL occurred at approximately at 5.75 hours after the start of the study just over one hour after administration of the third dose of salbutamol. The maximum specific gravity adjusted concentrations after the first and second doses were 3,155 ng/mL and 3,760 ng/mL respectively indicating that some drug accumulation was occurring following repeated doses. The largest unadjusted concentration measured was 4,400 ng/mL, which was the peak following the third administration when the urine specific gravity was fairly normal (1.021).

Very little salbutamol was detected (8 ng/mL after specific gravity adjustment) in the urine sample collected pre-administration.

The half-life of elimination appeared to be approximately 1 hour (based on the samples collected from 10:25 until 12:20) with a terminal half-life of elimination of about 2 hours 20 minutes (based on the final four samples).

Inspection of the data leads me to the opinion that the peak concentration will readily meet and may exceed the concentrations found in the athlete’s two samples (1,340 and 1,360 ng/mL). Furthermore, in my opinion, these

data are consistent with the dose of salbutamol administered in this study and are consistent with published data”.

29. On 17 April 2015, Professor Cowan issued another report intended to supplement the London Study and *“comment on the amount of salbutamol inhaled by the athlete”*.
30. In a letter of 4 May 2015, the FIS noted the results of the London Study and the Athlete’s position. It therefore told the Athlete to make himself ready for an opportunity to provide additional factual evidence (e.g., by another medical study) that the test results of the Samples were the consequence of the use of the therapeutic inhaled dose up to the maximum of 1,600 µg/24h of salbutamol, when taking the specificities of the mode of application into account.
31. On 15 May 2015, an additional pharmacokinetic study took place at the WADA-accredited Norwegian Doping Control Laboratory, Oslo University Hospital, under the supervision of Dr Yvette Dehnes and Professor Peter Hemmersbach (the “Oslo Study”). During the Oslo Study, the Athlete inhaled 1,600 µg through a metered dose inhaler (“MDI”). The report summarizing the results of the Oslo Study, dated 20 May 2015, states that the data collected

“... show that the specific gravity adjusted maximum concentration of approximately 1480 ng/ml occurred at about four hours after the start of the study and approximately 3.5 hours after the administration of the last dose. The largest unadjusted concentration measured was approximately 1700 ng/ml, when the specific gravity was 1.023. Most of the samples collected during the study were somewhat diluted (around 1.010), although the athlete only drunk about 0.75 L of salbutamol free water”.

32. Additional expert reports and submissions were thereafter filed, which included:
 - i. an amendment to the previous statements signed by Professor Bjermer on 23 May 2015 (the “Fourth Bjermer Report”), commenting on the Oslo Study as follows: *“1600 µg of Salbutamol was delivered from an MDI with spacer during 28 minutes and Urinary salbutamol excretion levels were repeatedly measured up to 7 hours after dose delivery. At two occasions, salbutamol levels in urine exceeded the levels measured during competition 1703 ng/ml and 1631 ng/ml compared to 1340 ng/ml and 1360 ng/ml. I believe this data strongly support the statement that Sundby did not inhale salbutamol exceeding recommended maximum dose of 1600µg. The systemic bioavailability from inhaled salbutamol is directly related to the amount of drug delivered from the device and to the fraction of respirable particles that deposit in the lungs [...]. This in contrast to the metered dose that relates to the amount of drug entering the dosing chamber but not to the amount actually leaving the device after actuation. As the recommended upper dose limit in one [...] day is limited to 1600µg salbutamol, the laboratory data confirm that MJS has not exceeded that limit. Thus, when setting limit values I believe it is important to consider the existence of outliers like MJS, with excellent ability to adsorb inhaled drug via the lungs to the systemic circulation”*;
 - ii. a declaration of Professor Carlsen dated 27 May 2015 (the “Second Carlsen Report”), noting that: *“the pharmacological study performed by Professor Cowan on nebulised salbutamol in the London doping laboratory, and the one on metered dose inhaler administered through the Optichamber by Professor Hemmersbach of the authorised doping laboratory in Oslo confirm the dose ratio between metered dose inhaler and nebulized salbutamol, as both studies show urinary levels above the decision levels as set by WADA. The last study on metered dose inhaler and inhalation chamber (Optichamber)*

shows that the dose of 1.6 mg (the maximum allowed dose) resulted in urinary salbutamol levels higher than the values from the doping tests in December and January and in urinary samples taken at the same time intervals after administration of salbutamol. ... With the results of the pharmaceutical tests it has been demonstrated that a violation of the doping rules in this case has not been performed as also confirmed by the available scientific evidence”;

- iii. an undated statement of Professor Henry Chrystyn of Inhalation Consultancy Ltd, Leeds, United Kingdom (the “First Chrystyn Report”), concluding as follows: *“1500 mcg inhaled from a MDI attached to a spacer is equivalent to 15mg inhaled from a Sidestream Nebuliser. The Sidestream nebuliser has a similar performance to that used by MJS. There is an approximate 2.5 fold variability in the performance of different nebuliser systems. The WADA pharmacokinetic study reveals that MJS has high lung deposition. Hence MJS's urine samples would contain more salbutamol than those of an individual with lower lung deposition after inhaling the same dose from the same inhalation method. MJS has a fast salbutamol elimination half life which reflects the zero concentrations pre-dosing for the WADA pharmacokinetic study. There will be, therefore, no day to day accumulation of salbutamol in his body when he uses his 3*5mg salbutamol nebulised dosing schedule. Comparing MJS's WADA pharmacokinetic data to that of the doping samples suggests reduce lung deposition during the sporting events due to either an exacerbation (related to the degree of bronchoconstriction), different nebuliser performance or different environmental conditions. The effect of altitude on the performance of the nebuliser is not known”;*
- iv. a report prepared by Dr Audrey Kinahan, member of the WADA Prohibited List Expert Group (the “LEG”), on 14 July 2015 (the “First Kinahan Report”), indicating the reasons why, in her opinion, the Athlete committed an anti-doping rule violation:
 - “- *Inhaled as defined by the LEG covers all methods of inhalation and all devices for inhalation, and if the LEG wanted to make an exception for this we would have included it.*
 - *The List is written such that all beta-2-agonists are prohibited with some exceptions to cover normal therapeutic use of some inhaled beta-2-agonists; all other usage of beta-2-agonists that does meet those exceptions is prohibited.*
 - *It cannot be accepted that 15000 mcg by nebulisation is “bioequivalent” to 1500 mcg by MDI. The subjects in the Mazhar et al study, which is referenced frequently, all had very poor lung function, were much older and over one third of them had Chronic Obstructive Pulmonary Airways Disease (COPD), so their breathing capacity could be regarded as compromised. Their physiology is significantly different to that of an elite, young, male cross-country skier. Due to such fundamental differences the same correlation between the two devices cannot be made for an elite aerobically-fit athlete. This is reflected in the discussion by Professor Chrystyn on the differences in the greater lung deposition and excretion of salbutamol in elite athletes and explains the higher excretion of salbutamol by MJS than the subjects in the Mazhar study.*
 - *The difference is further illustrated by the pharmacokinetic (PK) studies undertaken by the athlete, whereby after inhalation of 15000 mcg over 4.5 hours via nebuliser, urine concentrations over 4000 ng/ml were achieved and after 7 hours post administration of the first dose urine levels were still in excess of 1000 ng/ml, the prohibited list threshold. The maximum urine concentration achieved using an MDI combined with spacer to maximise the amount of the 1600 mcg (administered as a single-dose rather than over 24 hours) inhaled dose was 1703 ng/ml (unadjusted) and 1481 ng/ml (specific gravity adjusted).*

- *GINA guidelines on best practice in asthma management, recommend that high doses of salbutamol, a short-acting beta-2-agonist (SABA), are best reserved for emergency situations. A nebulised dose of 15000 mcg administered over 5 hours would not be regarded as normal therapeutic inhaled use. Indeed it would seem that this occurred on a consecutive number of days. As it was not normal therapeutic inhaled use, it would be expected that there would be TUE application or if it was an emergency situation even a retroactive TUE application to cover a once-off usage. The Norwegian information on `salbutamol indicates that it is prohibited with certain exceptions/restrictions”;*
- v. a second expert statement dated 20 June [July] 2015 of Professor Chrystyn (the “Second Chrystyn Report”), commenting on the report of Dr Kinahan, and more exactly on the point where it was stated that *“the report by AK states that the 10:1 comparison between the Sidestream Nebuliser and the metered dose inhaler (MDI) attached to a spacer is not valid (Mazhar et al, 2008) because it is a comparison carried out in patients”*. In Professor Chrystyn’s opinion, in fact, *“the data reported by Mazhar et al (2008) is a valid comparison. Patients do have a lower lung deposition but the study is a RCT and their lung condition was the same on the study days. MJS has a higher systemic bioavailability than would be expected. This is most likely due to greater oral absorption evidenced by a tmax of 2 hours after an inhalation which is the same as that following an oral dose. MJS has a higher relative bioavailability following an inhaled dose but this has only been found from pharmacokinetic studies. The Nebuliser pharmacokinetic study shows much greater relative lung and systemic bioavailability than all the other data. I am not aware of the nebuliser conditions, the fill volumes and the residual amounts or the compressor used. One reason could be that the nebulised salbutamol doses are higher than the equivalent MDI+spacer dose but this does not explain the higher percentages when normalised for the dose inhaled or the higher relative bioavailability”;*
- vi. a statement of Professor Carlsen dated 23 July 2015 (the “Third Carlsen Report”), also replying to Dr Kinahan, and indicating, *inter alia*, that *“it is correct that this administration [a nebulised dose of 15,000 µg salbutamol administered over 5 hours] would ordinarily not been used in a regular maintenance therapy of well-controlled asthma. However, MS has had a severe asthma from early childhood. ... MS has a reduced lung function as compared to most competitive athletes. Therefore, the statement of dr. Kanaban that athletes have high lung function values and therefore high lung deposition values of inhaled drugs is not relevant to MS. I therefore do not agree in her statement that the data from the Mazhar study is not relevant for MS”;*
- vii. a third expert statement dated 26 July 2015 of Professor Chrystyn (the “Third Chrystyn Report”), as follows: *“The doping samples, of MJS, are similar to the MDI attached to the spacer study completed by MJS and the ratios are similar to those reported by Mazhar et al (2008). Thus on the day of the doping samples his delivered dose would have been similar to the maximum permitted dose according to the WADA regulations. The reason for the elevated concentrations are that the doping samples represent the amount he had excreted in the 3 hours after his last dose and that the amount of urine was 140ml and 120ml ... The reason for the increased urinary excretion, by MJS, following the nebuliser study is not known. One explanation is that on the day of the nebuliser study in London he absorbed much more salbutamol than he did on the day the doping samples were taken and when the MDI+Spacer study took place. It could have been due to altered nebuliser conditions, different fill volumes, a lower residual volume left in the chamber of the nebuliser or a different altitude affecting the nebuliser's performance. Although the Pharmacokinetic study suggests a high dose nebulised the doping samples and the MDI attached to the spacer study supports that the nebulised doses he received were*

within the recommended range. ... Dr Kanahan, in accordance with WADA regulations, frequently refers to urinary salbutamol concentrations but these should not be considered in isolation because the concentration is dependent on the amount and the volume ... This highlights why my defence for MJS does not focus on concentrations. ... The time of maximum absorption (T_{max}) in MJS after the nebuliser and MDI+Spacer pharmacokinetic studies is 2 hours not 5.75 and 4.3 hours, respectively, quoted by Dr Kanahan. The difference is that T_{max} is obtained by analysis of the excretion rate with respect to time not the maximum concentration that was measured. Another reason why analysis should be based on amounts not concentrations. MJS has an elimination half life of 2 hours (measured during the nebuliser pharmacokinetic study). It is normal to eliminate all the dose administered in 5 half lives. Hence MJS would have very little amounts of salbutamol left in his body by the time he goes to bed. Any cardiac stimulation effects during the night would not be due to his salbutamol”.

33. On 9 August 2015, the hearing took place before the FIS Doping Panel.

34. On 4 September 2015, the FIS Doping Panel issued the following decision (the “Decision”):

- “1. *The FIS Hearing Panel finds that the abnormal results of the analyses of the samples provided by the athlete Martin Johnsrud Sundby NOR in Davos SUI on 13 December 2014 (sample number 3782813) and in Toblach ITA on 8 January 2015 (sample number 3782808) do not constitute an Anti-Doping Rule Violation and no further consequences shall apply to the Athlete.*
2. *No costs are to be awarded.*
3. *This decision may be appealed exclusively to the Court of Arbitration for Sports in Lausanne (CAS) in accordance with the provisions applicable before such court. The time to file an appeal to CAS shall be twenty-one days from the date of receipt of this decision by the appealing party.*
4. *This decision shall be communicated to the parties, the Norwegian Ski Association, the Norwegian Anti-Doping Agency (ADN) and the WADA”.*

35. In explanation of the Decision, the FIS Doping Panel noted the following:

“1. *Late notification of the analysis results by the Laboratory*

36. *The Athlete submits that he was only notified of the results of the analysis of the sample taken on 13 December 2014 (Davos) and the sample taken on 8 January 2014 on 23 January 2015. The Athlete argues that late notification constitutes a violation of the WADA International Standards for Laboratories (ISL) and maintains that had he been notified of the analysis of the first sample in a timely fashion he would most likely not have used the nebuliser in Toblach.*

37. *According to Article 5.2.6.5 ISL (2015):*

“5.2.6.5 Reporting of “A” Sample results should occur within ten working days of receipt of the Sample. The reporting time required for specific Competitions may be substantially less than ten days. The reporting time may be altered by agreement between the Laboratory and the Testing Authority”.

38. *The FIS Doping Panel finds that the 10 days reporting time horizon does not constitute a strict deadline which invalidates a finding of the laboratory. Rather, the Panel finds that the timeline expresses the intent of the rule that the laboratories should proceed without undue delay, especially when taking the wording of the rule (“should”) into consideration. While the FIS Doping Panel agrees that a more expedited*

analysis procedure would have been desirable in the interest of the Athlete and his competitors, it still accepts that in the case at hand, there is no evidence of any undue delay, especially when taking the Christmas holidays into account: The FIS Doping Panel therefore accepts that there are two valid laboratory reports concerning the samples taken in Davos and Toblach. The Panel rejects the Athlete's argument that the second alleged rule violation could have been avoided if he had been notified beforehand of the results of the first analysis.

2. The alleged Anti-Doping Rule Violation

a. The Burdens and Standards of Proof

39. *According to Article 3.1 FIS ADR, it is the burden of FIS of establishing that an anti-doping rule violation has occurred. The standard of proof shall be whether FIS has established an Anti-Doping Rule Violation to the comfortable satisfaction of the FIS Doping Panel bearing in mind the seriousness of the allegation which is made. Whereas the FIS Doping Panel (including the Prohibited List) place the burden upon the Athlete to rebut a presumption or establish specified facts or circumstances, the standard of proof shall be a mere balance of probability.*

40. *The FIS has submitted the Laboratory Reports which demonstrate that in two samples the urinary concentrations of salbutamol exceeded the DL of 1,2 ng/ mL, which constitute abnormal results according to Section S.3 of the Prohibited List. The Athlete submits that FIS has not met its burden of proof since it has failed to demonstrate to the comfortable satisfaction of the FIS Doping Panel that he inhaled more than 1,600 µg over 24 hours. In the alternative, the Athlete argues that, in the event that the FIS Doping Panel accepts that FIS established the Anti-Doping Rule Violation, the pharmacokinetic studies prove by a mere balance of probability that the abnormal results were the consequences of the use of the therapeutic inhaled dose up to the maximum of 1,600 µg over 24 hours.*

b. How must the exception of "Inhaled salbutamol (maximum 1600 micrograms over 24 hours)" be understood?

41. *Before the FIS Doping Panel can determine whether the Athlete has violated Section S.3 of the Prohibited List, it must be convinced that the applicable rule is clear and unambiguous.*

42. *The parties have fundamentally different interpretations of the applicable rule. In particular, the Parties disagree on the meaning of the expression "inhaled" combined with the maximum dose of salbutamol of 1600 µg.*

43. *The FIS bears the burden of proof for all aspects of the alleged ADRV, including the meaning of the applicable rules and argues that the Prohibited List refers to inhalation to distinguish the mode of application from other methods of administration, such as injection or oral application of a powder. This position is supported by WADA and by Dr. Kinahan who attended the hearing as an expert and member of the WADA List Committee.*

44. *More particularly, the FIS submits that the phrase "Inhaled salbutamol" refers to the dose of salbutamol which is released per spray, irrespective of where it goes or how good or bad the user's inhalation technique may be, which amount remains in the device or which amount eventually gets deposited on the lungs. If a doctor prescribes a certain dose of medication to a patient, that is the dose which is indicated on the medication package or container.*

45. *FIS maintains that it would be impossible for WADA to draft a rule in the Prohibited List based on the dose which enters the body or reaches the lungs of an individual athlete, especially given the numerous*

inhalation devices available, the inhalation technique and the health condition of each athlete. FIS suggests that the interpretation of the rule that they advance is based essentially upon common sense and the Prohibited List must be clear and easily understood by athletes, coaches, prescribers and users of medicines listed. For this reason, the List Expert Group have drafted the rule in the only way that it would avoid confusion and it therefore must be understood to mean that where reference is made to doses this must be understood as the dose referred to and described on a prescription.

46. *The Athlete argues that the Prohibited List explicitly uses the expression “inhaled salbutamol” which cannot be understood in any way other than the dose which was inhaled and entered his body after the use of any given inhalation device or method. The Prohibited List does not refer to a specific mode of administration and, in particular, does not state whether it refers to inhalation by MDI. There are many other inhalation methods. Thus, the Athlete argues that MDI cannot be used as a reference to determine the maximum allowed dose. What matters is the dose which was actually delivered to the Athlete’s body irrespective of the mode of administration. The dose indicated on the package or leaflet may be the metered dose of salbutamol, however this is irrelevant.*
47. *In support of his position the Athlete submits that the WADA in a document titled “2013 Prohibited List – Summary of Major Modifications and Explanatory Notes” of 10 September 2012 with regard to another Beta-2 agonist, namely formoterol, commented on the difference between inhalation and delivery of a substance. Accordingly, by its own document WADA supports the Athlete’s position that the relevant dose must be understood as the dose actually delivered to the athlete’s body:*

S3. Beta2-agonists:

- *The permitted delivered (inhaled) dose of formoterol has increased to 54 micrograms over 24 hours with a corresponding increase of the urinary threshold to 40 ng/ mL.*
- *For clarity, all optical isomers (d- and l-) where relevant, are prohibited.*
It should be noted that there are differences worldwide in the labelling of the formoterol content in inhalation devices, and that the List refers to the delivered dose of formoterol and not the metered dose. The delivered dose is the dose that leaves the mouthpiece and is available for inhalation. For example, a Symbicort® Turbuhaler®/Turbobaler® labelled as containing 12 micrograms of formoterol delivers to the patient ~9 micrograms per inhalation. If two inhalations twice a day (i.e. 48 micrograms) are administered, the delivered dose is 36 micrograms, which is the maximum approved daily dose in most countries. In some countries the permitted maximum delivered dose for temporary occasional use for treatment of asthma exacerbations is 54 micrograms over 24 hours.

Where formoterol is delivered via an Aerolizer® device, studies have shown that 60-85% of the dose is delivered.

WADA is continuing to evaluate other beta-2-agonists in order to establish appropriate urinary threshold levels for these products. Regardless of the dosage permitted, all athletes are encouraged to seek appropriate medical advice to ensure that they are receiving optimal treatment. For more information regarding beta-2-agonists refer to the Medical Information to Assist TUE Committees document on Asthma.

48. *According to the Athlete, it is accepted that the dose which enters an athlete’s body cannot easily be determined by an athlete or a team doctor themselves but may require a pharmacokinetic study. However, scientific studies show that there is a ratio of approx. 1:10 or more between the dose delivered by an MDI and the dose which is available when using a nebulizer. Also when comparing the recommendations by*

the producer, there are significant differences between the metered doses for use by MDI or by nebulizer. There are no advantages when using a nebulizer instead of an MDI or another device for inhalation. Using a nebulizer is an accepted mode of administration with the sole difference that a higher dose must necessarily be applied in order to have the same amount of salbutamol delivered to the patient's body.

3. The FIS Doping Panel's finding

49. *It is extremely difficult for the FIS Doping Panel to determine the exact meaning of Section S.3 of the WADA Prohibited List, especially the meaning of "inhaled salbutamol". The Prohibited List is not a document drafted by the FIS but by WADA and which is, to the FIS Doping Panel's knowledge, not supported by any supporting comments or published jurisprudence, when it comes to the interpretation of Section S.3 of the Prohibited List and the meaning of the word "inhaled".*
50. *The Panel's task is even more delicate since the WADA Prohibited List applies worldwide to all athletes whose federations and even states which have adopted that list, and not only to skiers and snowboarders. It is in the best interests of all concerned that there should be a uniform understanding of the Prohibited List and its content.*
51. *When interpreting the rule in question, the Panel resorts to the Swiss law construction principles. The goal of interpretation is to determine the true meaning of a provision as understood in good faith by the addressees of the provision. Any interpretation starts with the wording of the provision but may take additional elements into account, such as the systematic context and the history of the provision.*
52. *The FIS, the Athlete and their expert witnesses have presented valid arguments on how "inhaled salbutamol" and the reference to the maximum allowed does of 1,600 µg must be understood.*
53. *There is merit to the argument promoted by FIS that there must be a clear rule which is easily understood by all athletes and medical advisers what constitutes an Anti-Doping Rule Violation involving salbutamol. Such understanding must be based on the information available to the rule applicers, namely the product information that comes with the medication.*
54. *On the other hand, there is also merit to the argument presented by the Athlete that there are various modes of inhalation of salbutamol which require a different dose to achieve the same effect which would not be covered by FIS' and WADA's interpretation of Section S.3 of the Prohibited List.*
55. *There is indeed a clarification by WADA for another Beta-2-agonist (formoterol) supporting the Athlete's reading but the Panel is also aware of the labelling differences which made such clarification necessary. Hence, the Panel hesitates to simply extend the explanation for formoterol to also apply for salbutamol.*
56. *The history of Section S.3 shows that initially a TUE (and later an abbreviated TUE) was always required for salbutamol until (and including) 2009. At the time, Section S.3 provided that an abnormal result of a sample analysis was considered to be an ADRV despite the granting of a TUE, unless the athlete proved that it "was the consequence of the use of a therapeutic dose of inhaled salbutamol". There was no indication about the dose which was considered to be a "therapeutic dose of inhaled salbutamol". A quantification of the "therapeutic dose" was introduced only in the 2010 Prohibited List, namely 1,600 µg over 24 hours.*

57. *While the history of that provision does not resolve the issue, it may give at least an indication of the intent of the rule maker, namely to quantify what was meant to be a “therapeutic dose” of salbutamol and why a certain maximum dose was introduced.*
58. *The difficulty is that the revised rule does not address the various ways of administration. This question cannot be answered by this Panel but only by scientific experts.*
59. *In particular, the Panel cannot determine whether the various modes of administration of salbutamol are equivalent, which ratio must be applied when comparing the various modes of administration or whether e.g. inhalation by nebulizer has a different effect on the athlete’s system which goes beyond a mere therapeutic use.*
60. *It is also not possible for the Panel to determine whether the changes introduced by WADA in 2010 stipulating that the therapeutic dose did not require a TUE was meant to be a dose “used in a regular maintenance therapy of well-controlled asthma” only (as advocated by FIS and Dr Kinahan) or whether it also included any dose for the therapeutic treatment of severe asthma including exacerbations, i.e. the kind of asthma from which the Athlete had suffered, as proposed by Prof Carlsen.*
61. *It is however clear for the Panel that there is no evidence before it indicating that inhalation of a dose of salbutamol as inhaled by the Athlete may have a systemic effect such as performance enhancement or muscle growth.*
62. *When faced with these scientific questions, the Panel refers to CAS 2014/A/3488, para. 97:*
“The Panel in the present case recognises that it is not its function to step into the shoes of scientific experts, or to seek to repeat the exercises carried out by those experts. It also recognises that any Tribunal faced with a conflict of expert evidence must approach the evidence with care and with an awareness as to its lack of scientific expertise in the area under examination. Bearing in mind the prescribed provisions as to burden and standard of proof, the Panel considers that its role in applying the applicable standards as an appellate body is to determine whether the experts’ evaluations (upon which WADA’s case rests) are soundly based on the facts, and whether the experts’ consequent appreciation of the conclusion be derived from those facts is equally sound (see also CAS 2010/A/2235, para. 79). In carrying out this task the Panel is bound to form a view as to which of possibly competing expert views it considers to be more persuasive”.
63. *When assessing the evidence presented by the Parties, the Panel must also take the seriousness of the allegation into account which includes the seriousness of the consequences of an ADRV in the specific case.*
64. *While there is no allegation that the Athlete may have attempted to gain a competitive advantage by administering salbutamol by nebulizer and no period of ineligibility has been requested, a conviction and a reprimand would automatically lead to his disqualification from the Davos and Toblach competitions and, as a further consequence, the disqualification from the Tour de Ski 2015 of which Toblach was one stage race, and as a final consequence to the loss of the Nordic Ski World Cup which was won by the Athlete.*
65. *Under the circumstances, the Panel finds that Section S.3 of the Prohibited List is not sufficiently clear to support FIS’ allegation that the Athlete has committed an Anti-Doping Rule Violation when he inhaled three times 5 mg within five hours of salbutamol by a nebulizer.*

66. *In particular, the Panel members are not convinced to their comfortable satisfaction that the maximum allowed dose of 1,600 µg of salbutamol refers exclusively to the metered dose (i.e. the dose of salbutamol contained in the spray or solution of Ventoline) and not to the dose delivered to the patient's body, since that would restrict the inhalation methods to the MDI, which is not even mentioned in Section S.3 and practically exclude the use of a nebulizer and other inhalation methods. The FIS and WADA have not provided any evidence that such other inhalation methods which require a higher metered dose would create a higher risk of doping.*
 67. *The Panel is however not in a position to determine what constitutes an accepted dose of "inhaled salbutamol" when administered by nebulizer or any other inhalation method and whether a certain ratio must apply if a nebulizer is used instead of an MDI.*
 68. *The Panel therefore invites WADA to further specify how Section S.3 of the Prohibited List must be interpreted and to clarify how to determine the maximum doses for inhalation by MDI, nebulizer and other methods of inhalation of salbutamol without a TUE.*
 69. *The Panel wishes to emphasize that its decision must not be understood as a carte blanche for the Athlete or others subject to the FIS ADR to inhale salbutamol in higher doses than 1,600 µg over 24 hours by any means or devices without a TUE. As a matter of precaution and in case of doubt, the athletes are well advised to apply for a TUE if inhalation of such higher doses seems to be medically required.*
 70. *As a consequence, it is not necessary for the Panel to address the further issues raised by the parties".*
36. On 21 September 2015, the case file was made available to WADA by FIS.

2. THE ARBITRAL PROCEEDINGS

2.1 The CAS Proceedings

37. On 12 October 2015, the Appellant filed a statement of appeal with the Court of Arbitration for Sport (the "CAS"), pursuant to Article R47 of the Code of Sports-related Arbitration (the "Code"), to challenge the Decision. The statement of appeal had attached 6 exhibits and indicated the appointment of The Hon. Michael J. Beloff M.A., Q.C. as an arbitrator.
38. On 26 October 2015, the Respondents jointly nominated Ms Jennifer Kirby as an arbitrator.
39. On 10 November 2015, the Appellant filed its appeal brief, pursuant to Article R51 of the Code, together 31 exhibits and 3 expert reports, of Dr Olivier Rabin dated November 2015 (the "Rabin Report"), Dr Audrey Kinahan dated 9 November 2015 (the "Second Kinahan Report") and Professor Vibeke Backer dated 7 November 2015 (the "Backer Report"). The appeal brief contained also a request for disclosure in the following terms:

"WADA requests that the Athlete disclose the following elements that are apparently missing from the case file related to the proceedings before the FIS Doping Panel:

1. *A comprehensive list of all the medication (including dose and mode of administration) taken by the Athlete before commencing the course of nebulized salbutamol further to the call with Dr. Knut Gabrielsen on 7 December 2014.*

2. *A comprehensive list of all medication (including dose and mode of administration) taken by the athlete from the commencement of the course of nebulized salbutamol until 8 January 2015.*
3. *The prescription(s)¹ in respect of the salbutamol taken by nebulization in December 2014 and January 2015.*
4. *The name of the pharmacy where the salbutamol was purchased.*
5. *Proof of purchase of the salbutamol (e.g. sale receipt).*
6. *The precise name and model of the nebulisation equipment used.*
7. *The name of the outlet or hospital where the nebulization equipment was purchased or sourced (as the case may be).*
8. *Proof of purchase (or sourcing) of the nebulization equipment.*
9. *Records of delivery of the salbutamol and the nebulization equipment to the Athlete (e.g. courier receipts).*
10. *Contemporaneous evidence that the Athlete and/or his medical team analyzed in advance whether the nebulization of 15,000 micrograms of salbutamol would come within the permitted use of salbutamol on the Prohibited List.*

¹ *WADA understands that a prescription for salbutamol ampoules (for nebulisation) would cover a maximum of 60 ampoules. As the athlete nebulized three per day for over a month, there were presumably two prescriptions and two purchases” [Footnote in the original].*

40. On 11 November 2015, the CAS Court Office forwarded to the Respondents the appeal brief, noting, *inter alia*, the Appellant’s request for disclosure and inviting the First Respondent, within a set deadline, to produce voluntarily the requested documents and/or information or, in the alternative, to state the basis of his refusal.
41. By letter dated 18 November 2015, the CAS Court Office informed the parties that, pursuant to Article R54 of the Code, the Panel to deal with this matter had been constituted as follows: Prof. Luigi Fumagalli, President, The Hon. Michael J. Beloff M.A. Q.C. and Ms Jennifer Kirby, Arbitrators.
42. On 7 December 2015, the Second Respondent confirmed to the CAS Court Office that it would not submit an answer in accordance with Article R55 of the Code, but that it would exercise its right to attend the hearing and, if need be, to make oral submissions.
43. On 22 December 2015, the First Respondent lodged with CAS his answer in accordance with Article R55 of the Code, together with 30 exhibits, which included statements of Professors Carlsen dated 15 December 2015 (the “Fourth Carlsen Report”), Bjermer dated 13 December 2015 (the “Sixth Bjermer Report” and Chrystyn dated 17 November 2015 (the “Fourth Chrystyn Report”). The First Respondent’s answer addressed also the Appellant’s request for disclosure.
44. On 12 February 2016, the CAS Court Office issued on behalf of the President of the Panel an order of procedure (hereinafter referred to as the “Order of Procedure”), which was accepted

and signed by the parties.

45. On 25 and 26 May 2016, pursuant to notice given to the parties in a letter of the CAS Court Office dated 29 January 2016, a hearing was held in Lausanne. The Panel was assisted at the hearing by Mr Brent J. Nowicki, Counsel to CAS. The following persons attended the hearing:
- i. for the Appellant: Mr Ross Wenzel and Mr Nicolas Zbinden, counsel;
 - ii. for the First Respondent: the Athlete in person, assisted by Ms Anne-Lise Rolland, counsel, and by Mr Tord Jordet, Norwegian Sports Federation, observer;
 - iii. for the Second Respondent: Dr Stephan Netzele and Dr Barbara Abegg, counsel.
46. At the opening of the hearing, the parties confirmed that they had no objections to the composition of the Panel. Then, after introductory statements by counsel, the Panel heard the declarations rendered by Mr Tron Nystad and by Dr. Knut Gabrielsen, and, thereafter, by way of “expert conferencing” the opinions expressed by Professor Carlsen, Professor Bjermer, Professor Chrystyn, Dr Rabin, Dr Kinahan and Professor Backer (collectively, the “Experts”). Finally, the Athlete himself made a statement.
47. The declarations heard by the Panel can be summarized as follows³:
- i. Mr Nystad, coach of the Athlete, confirmed the factual circumstances relating to the use on the day of a competition by the Athlete of a nebuliser to administer salbutamol in front of many people, including the fact that some liquid remained in the container disposed of after the administration, and that from time to time the Athlete was speaking while using the nebuliser;
 - ii. Dr Gabrielsen, a doctor for the NSF cross-country ski team, confirmed that he spoke with the Athlete on the telephone before the Davos competition and that he advised the nebulization of 15,000 µg of Salbutamol (3 times 5,000 µg) per day, in light of the Athlete’s physical condition. Dr Gabrielsen confirmed that he was aware, in giving this advice of the ratio between salbutamol delivered to the lungs by nebulization and salbutamol delivered to the lungs when an MDI was used, as described in the Mazhar Study. At the same time, Dr Gabrielsen declared that the Athlete had been using a nebulizer for years, having started at least in 2009, before he himself joined the NSF cross-country ski team as a doctor. With respect to his prescription in November 2015, which enabled the Athlete to obtain from a pharmacy 60 doses of salbutamol for nebulization, Dr Gabrielsen explained that it was made in anticipation of a possible need to use them during the season, chiefly when the Athlete was travelling for competitions and a doctor was not with him;
 - iii. the Experts discussed *inter alia* the following points:

³ The summary which follows is intended to give an indication only of a few key points touched at the hearing. The Panel emphasises that it considered the entirety of the declarations made at the hearing and/or contained in the relevant expert reports.

- the background to the allowed doses of salbutamol mentioned in the Prohibited List. In this respect, Dr Rabin explained the reasons which led to the modification of the rules with respect to “beta-2-agonists” (which include salbutamol), and underlined that the amount of 1,600 µg per day of salbutamol was set taking in mind the maximum measure of administration with an MDI (16 “puffs” of 100 µg each) per day for therapeutic purposes, and was based on toxicology studies and well as on the experience gained by sporting authorities while administering the athletes’ applications for a therapeutic use exemption (“TUE”). A discussion, then, took place with regard to the possibility that the use of 1,600 µg per day might return an analytical finding exceeding the DL. In that respect, the First Respondent’s counsel made reference during the Experts’ examination to a study authored also by Professor Backer (C. Bjerre Haase, V. Backer, A. Kalsen, S. Rzeppa, P. Hemmersbach, M. Hostrup, The influence of exercise and dehydration on the urine concentrations of salbutamol after inhaled administration of 1,600 µg salbutamol as a single dose in relation to doping analysis, *Drug Test. Analysis*, 2015)⁴, showing the risk of adverse analytical findings in samples collected after inhalation of the maximum permitted amount of salbutamol. At the same time, the Experts agreed that in their understanding the rule in the Prohibited List in referring to “inhaled” salbutamol excludes other ways of administration (ingestion or injection) of that substance;
- the nebulization of salbutamol: use and commonality;
- the distinction between “nominal”, “labelled”, “available for inhalation”, “inhaled” and “delivered” doses of salbutamol, with specific reference to its administration by nebulization. Discussions, in that regard, took place as to the percentages of the substance that remained in its original container or in the nebulizer and the related equipment, of the amount dispersed in the air, of the amount ingested or remaining in the mouth and of the amount actually received in the lungs;
- the “10:1 ratio” between nebulized salbutamol and salbutamol inhaled by MDI (or with a dry-powder inhaler: a “DPI”), including the conclusions reached in the Mazhar Study⁵, the calculations contained in the Fourth Chrystyn Report (in the table at its § 5.3) and the London Study / Oslo Study;
- the possible enhancement of performance effect of salbutamol. In that regard, Dr Rabin underlined that use of salbutamol beyond the limits allowed in the Prohibited Lists or its administration by ingestion or injection may have anabolizing effects,

⁴ In addition, the parties and the Experts discussed also the observations contained in J. Dickinson, J. Hu, N. Chester, M. Loosemore, G. Whyte, Impact of Ethnicity, Gender, and Dehydration on the Urinary Excretion of Inhaled Salbutamol with Respect to Doping Controls, *Clin J Sport Med* (2014) 24: 137-149 (the “Dickinson Study”).

⁵ Reference was made in the discussion to the Silkeston Studies (V.L. Silkstone, S.A. Corlett, H. Chrystyn, Relative lung and total systemic bioavailability following inhalation from a metered dose inhaler compared with a metered dose inhaler attached to a large volume plastic spacer and a jet nebuliser, *Eur J Clin Pharmacol* (2002) 57: 781–786; and V.L. Silkstone, S.A. Corlett, H. Chrystyn, Determination of the relative bioavailability of salbutamol to the lungs and systemic circulation following nebulization, *Br J Clin Pharmacol*, (2002) 54: 115–119) and to the Rodrigo Study (C. Rodrigo, G. Rodrigo, Salbutamol Treatment of Acute Severe Asthma in the ED: MDI Versus Hand-Held Nebulizer, *Am J Emerg Med* (1998) 16: 637-642).

- though this has yet to be the subject of specific study;
- the interpretation of the rule regarding the allowed dose of salbutamol according to the Prohibited Lists;
- iv. the Athlete gave evidence as to his use of the nebulizer, demonstrating also how such use took place, and indicated that a portion of the medicine always remained in its original container, that he never nebulized the medicine to its end (and therefore that a portion of it remained in the nebulizer) and that during the nebulization he, from time to time, was distracted and had to remove the wand in order to talk. In other words, the way in which the actual administration of salbutamol took place was very different from the way in which salbutamol was administered for the purposes of the London Study. The Athlete then explained that he needed salbutamol in order to “open his lungs” and allow them to receive the medicines he needed to treat his asthma: and that the use of salbutamol was not intended to enhance his performance, but had a medical justification, which was the reason for a previous requests for a TUE at a time when salbutamol could never be used compatibly with the WADC without one. At the same time, the Athlete explained that in the period between 7 December 2014 and 11 January 2015 he did not take the full dose of 15,000 µg of salbutamol per day, since the prescription he had received was for administration “up to” such dose. In the season 2015-2016, on the other hand, he did not need to use the nebulizer, since there was no medical necessity. Finally, the Athlete emphasised that he never used performance-enhancing drugs and never cheated or intended to cheat, and underlined the seriously adverse effects for his reputation and career in the event the Panel were to find that he committed an anti-doping rule violation.
48. The parties next, by their counsel, made submissions in support of their respective cases and answered the questions asked by the Panel. At the conclusion of the hearing, finally, the parties, while adhering to their respective positions on the merits, expressly stated that their right to be heard and to be treated equally in the CAS arbitration proceedings had been fully respected, save that the First Respondent objected that the rules of the Code did not make express provision for a second exchange of written submissions, so as to allow a respondent to prepare its own rebuttal of the appellant’s reply, presented only orally at the hearing, to the respondent’s answer.

2.2 The Position of the Parties

49. The following outline of the parties’ positions is illustrative only and does not necessarily comprise every submission advanced by the Appellant and the Respondents. The Panel has nonetheless carefully considered all the submissions made by the parties, whether or not there is specific reference to them in the following summary.
- a. *The Position of the Appellant*
50. In its statement of appeal, the Appellant requested the CAS to rule that:
- “1. *The appeal of WADA is admissible.*

2. *The decision rendered by the FIS Doping Panel on 4 September 2015 in the matter of Mr. Martin Johnsrud Sundby is set aside.*
 3. *Mr. Martin Johnsrud Sundby is sanctioned with a reprimand (and no period of ineligibility) or a period of ineligibility up to a maximum of two years. In the event that a period of ineligibility is imposed, it shall commence on the date on which the CAS award enters into force. Any period of provisional suspension imposed on, or voluntarily accepted by, Mr. Sundby before the entry into force of the CAS award, shall be credited against the total period of ineligibility to be served.*
 4. *All competitive results obtained by Mr. Martin Johnsrud Sundby from and including 13 December 2014 are disqualified, with all resulting consequences (including forfeiture of any medals, points and prizes).*
 5. *WADA is granted an award for costs”.*
51. Such request for relief was confirmed in the appeal brief.
52. In essence, the Appellant criticizes the Decision for a number of reasons, and requests it to be set aside. In support of such conclusion, WADA submits that both Samples evidence clear anti-doping rule violations and that the FIS Doping Panel erred in ruling otherwise. The basic (and unchallenged) fact, in the Appellant’s opinion, is that the Athlete, who was not in possession of a valid TUE, took 15,000 µg of salbutamol per day by inhalation, while the Prohibited List only entitled him to take 1,600 µg over 24 hours. The argument based on “*bioavailability*” advanced by the First Respondent, who contends that he did not “*inhale*” more than the maximum (daily) dose and that, in any event, a dose of 15,000 µg by nebulization is bioequivalent to the inhalation of only 1,500 µg by MDI, to deny the anti-doping rule violation, is based on a wrong interpretation of the rules, is flawed on its merits and fails for legal and scientific reasons.
53. According to the Appellant, the central issue in this dispute concerns the interpretation of the expression “*maximum 1600 micrograms over 24 hours*” contained in the Prohibited Lists. Such interpretation is to be based on the language of the rule, against the background of “(i) *the historical background* (ii) *and the regulatory context ... and (iii) the purpose of the rule and intention (objectively construed) of the association*”.
54. As a preliminary point, WADA describes, however, two of the delivery systems used for the administration of salbutamol (MDI and nebulization) and underlines that nebulization is not a standard treatment for “normal” asthma, that it is used mainly in hospitals and that most asthma sufferers will not own or regularly use nebulization equipment. The Athlete, by using a nebulizer, “took a risk” in that the nebulization of 15,000 µg over 5 hours leads to analytical findings exceeding the DL, as shown by the London Study. As a result, in the WADA’s opinion, a TUE would be necessary for the use of salbutamol with a nebulizer, in the same way as a TUE is necessary for the administration of an amount larger than 1,600 µg per day.
55. In light of this, the Appellant submits, in respect to the expression “*maximum 1600 micrograms over 24 hours*”:
- i. with regard to its literal meaning, that the wording is clear and therefore there is no need to consider other elements. In fact, in the opinion of WADA, in the absence of further specification, a reference to a maximum dose can only sensibly be construed as being to

the labelled dose. It is in fact common medical practice that prescriptions for pills, tablets and other formulations refer to the labelled dose. Indeed, when the Prohibited List sought to refer to a quantity other than the labelled dose, it made this explicit in the text, as it did with formoterol, which specifically refers to the “*delivered*” dose. As a result, the nebulization of a labelled dose of 15,000 µg clearly exceeds the maximum labelled dose of 1,500 µg;

- ii. with regard to its meaning in light of further principles of interpretation, that the exception to the prohibition of use of salbutamol was introduced to avoid the need to apply for a TUE in the event of its normal therapeutic use to treat asthma: the rule was not intended to apply to the treatment of exacerbations of severe asthma by nebulization – a mode administration not used for the day-to-day treatment of asthma in the ordinary course of events. At the same time, WADA explains that the dose was determined based on the recommended, labelled dose of salbutamol for normal/routine therapeutic treatment of asthma (corresponding to 16 “puffs” per day of 100 µg each with an MDI) and at a level where the resulting urinary concentrations enable systemic administration methods to be distinguished. More specifically, WADA explains that, *“if the reference to 1600 micrograms was to delivered dose, it would result in higher number of concentrations of salbutamol in excess of 1000 ng/mL. This in turn would make it significantly more difficult to distinguish permitted inhaled use from other prohibited, systemic forms of salbutamol administration. The very purpose of the rule would thus be undermined ... Moreover, the regulatory context and legislative background demonstrate that the maximum dose for salbutamol is a labelled dose: where WADA wished to apply a delivered dose (i.e. for formoterol), it made a specific decision to that effect ... Finally, it is worth highlighting that none of the dozen or so independent experts that form part of the List Committee has ever seen fit to make a proposal (or even initiate a discussion) to switch to a delivered dose for salbutamol ...”*.

56. In WADA’s opinion, however, the Athlete exceeded the maximum dose allowed even if it were a “*delivered dose*”, i.e. the “*dose that leaves the mouthpiece and is available for inhalation*”, as it was provided for and explained with respect to formoterol when the Prohibited List was modified in respect of that substance. Therefore, considering that the labelled dose of salbutamol taken by the Athlete was 15,000 µg, the Athlete would need to demonstrate that 13,400 µg of nebulized salbutamol did not leave the equipment in order to show that only 1,600 µg were available for inhalation. However, scientific studies make it clear that at least 40% of salbutamol is available for inhalation; this leads to a dose clearly in excess of the allowed one.
57. WADA, at the same time, takes issue with respect to the Athlete’s “*bioequivalence argument*” (i.e., that “*a nebulization of 15,000 micrograms is bioequivalent to 1,500 micrograms by MDI based on an estimation of the quantity of salbutamol that is effectively delivered to the lungs*”) and submits that:
 - i. its premise is flawed, because the delivery of a drug to the body depends on a number of factors that are subject to “*significant inter-individual and even intra-individual variables*”, making it “*entirely nonsensical*” that a universally applicable maximum threshold would be based on a quantity that is difficult to measure and subject to significant variation;
 - ii. the “*bioequivalence argument*” is contradicted by the London Study and the Oslo Study, which show that, with respect to the Athlete, the nebulization of 15,000 µg of salbutamol

- over five hours results in a greater dose than 1,600 µg by MDI;
- iii. the studies “*cherry-picked*” and produced by the Athlete (chiefly the Mazhar Study) do not support his thesis;
 - iv. the calculations made in the Fourth Chrystyn Report (in the table at its § 5.3) are wrong, as they are based on the amounts of salbutamol excreted but do not take into account the possibility that the Athlete may have urinated in the period between the first administration of salbutamol and the collection of the Davos Sample on 13 December 2014 and the first administration of salbutamol and the collection of the Toblach Sample on 8 January 2015.
58. In conclusion, in WADA’s opinion, the Athlete committed an anti-doping rule violation: he may have erred by taking a dose of salbutamol close to 10 times higher than the one allowed, and then tried to rationalize this error “*ex post facto*”. However, WADA accepts that, even though the Athlete committed an anti-doping rule violation, he is not a “cheater”, since the use of the prohibited substance took place in a therapeutic context.
59. Finally, with respect to the applicable sanction, WADA accepts that it “*would be prepared to make the favourable assumptions that the Athlete (i) did not intend to cheat or enhance his sport performance and (ii) has established No Significant Fault or Negligence within the meaning of the FIS ADR. ... In these circumstances, the Athlete would be able to benefit from the application of art. 10.4 of the 2014 FIS ADR (with respect to the First Positive Sample) and art. 10.5.1.1 of the 2015 FIS ADR (with respect to the Second Positive Sample). Both these provisions set the sanction at between a reprimand (at a minimum) and a two year period of ineligibility (at a maximum). In both instances, the level of sanction within the abovementioned parameters depends on the Athlete’s degree of fault. The appreciation of the Athlete’s fault and, by extension, the fixing of the appropriate sanction within the abovementioned parameters, are within the Panel’s discretion*”. In that regard, the guidelines set by CAS (in CAS 2014/A/3327 & 3335) should be applied. As a result, in the case of the Athlete, in the event it is found that he did not personally exercise appropriate due diligence, it would be difficult to conclude that he bore only a light degree of fault. In addition, considering the subjective factors, the Athlete should be “*toward the upper bound of the relevant category of fault*”.
60. At the same time, however, WADA confirmed at the hearing that it is not seeking the disqualification of the results obtained by the Athlete after the collection of the Davos Sample and of the Toblach Sample, through to the commencement of any period of ineligibility period but only of the results obtained in Davos and Toblach.
- b. The Position of the Respondents*
- b.1 The Position of the Athlete
61. In his answer, the First Respondent sought from the CAS the following relief:
- “1. *The appeal of WADA is dismissed in its entirety.*
 - 2. *The decision rendered by the FIS Doping Panel on 4 September 2015 in the matter of Mr. Martin Johnsrud Sundby is upheld.*

3. *Mr. Martin Johnsrud Sundby is granted an award for costs.*

If the CAS rules that the decision by the FIS Doping Panel is set aside and that Martin Johnsrud Sundby has violated the rule in section S.3 of the list concerning the specified substance Salbutamol, he respectfully requests the CAS to rule that he is sanctioned with the lowest possible sanction”.

62. In summary, in the First Respondent’s opinion, the Decision challenged by WADA should be confirmed, as the Appellant’s arguments in support of a finding of an anti-doping rule violation are not well founded. According to the First Respondent in response to those arguments:

- “ *The medical condition of the Athlete is well documented. He has suffered from asthma for many years. Lung function test of the Athlete indicate a severe bronchial obstruction of a level very rarely seen in top athletes, due to his chronic asthma. His medical condition clearly demonstrates the need of efficient anti-asthma medication, both controlling and relieving in times of exacerbations.*
- *His medication use is also well documented. The prescribed doses were clearly in line with good medical practice, ref the statements of professor Bjermer.*
- *The London study is not a replication of how the Athlete used the nebulizer in Davos and Toblach and can therefore not be used as valid proof of what he inhaled in Davos and Toblach.*
- *The expert opinion of Professor Chrystyn shows that the calculation of the ratios in Davos and Toblach prove that he did not inhale more than what is permitted by the Prohibited List.*
- *The Oslo study shows that when the Athlete inhales guaranteed no more than a maximum of 1600 micrograms of Salbutamol, there is evidence of urinary Salbutamol levels above the levels measured in Davos and Toblach. This confirms his explanation of how he used the nebulizer. It also confirms the plausibility of the calculations by Professor Chrystyn. It furthermore confirms the results of the Mazhar-Study.*
- *The Dickinson-study proves that 20 out of 32 persons inhaling 1600 micrograms of Salbutamol have urinary Salbutamol levels above the Decision Limit of the WADA. It is perfectly in line with the conclusion of this study that the Athlete also had urinary Salbutamol levels above the Decision Limit when inhaling.*
- *The urinary Salbutamol levels in Davos and Toblach were just slightly above the Decision Limit, ref the WADA’s email of 28 May 2015 stating that the Athlete’s urinary concentration was only slightly above the authorized level after study in Oslo. More important is the fact that the measured concentrations in Davos and Toblach were below what the WADA specifies as being ‘only slightly above the authorized level’”.*

63. In support of his own position, the Athlete, after setting out the principles concerning burden and standard of proof, invokes a number of reasons, relating to the interpretation of the relevant rules, his medical conditions, the studies he underwent and the expert opinions expressed about his case. The Athlete submits *inter alia* that:

- i. he used to file TUE applications when the use of salbutamol without a TUE was prohibited. In addition, due to his chronic asthma and the presence of chronic airways obstruction, the Athlete was granted in 2009 the use of a nebulizer (CR60) during exacerbations, even though he did not always use the nebulizer when inhaling salbutamol, but did so only periodically. In point of fact, nebulization is a standard treatment for

asthma; however, it is cheaper to use an MDI, which is more practical in many situations and at least as effective therapeutically as the nebulizer. In short, the main reasons why it is generally advised to use an MDI, or an MDI with spacer, instead of a nebulizer are not medical, but based on cost-effectiveness. The Athlete, however, has used a nebulizer for many years, it is the inhaling device with which he is very familiar, and in Norway it is very common to use nebulizers which can be provided free of cost when treating asthma;

- ii. he proved that the AAFs were the result of a therapeutic inhaled dose lower than the maximum allowed. In fact, the London Study confirms that he used a nebulizer in Davos and Toblach, while the Oslo Study makes it possible to calculate the ratio between inhalation through MDI + spacer and inhalation through nebulizer (Davos = 1:11.30; Toblach = 1:13.00) and *“this means that the maximum calculated amount for Davos is 1450 micrograms and for Toblach 1230 micrograms”*. Such result corresponds broadly to the findings of the Mazhar Study, which found a ratio 1:10 between MDI and nebulizer;
- iii. the London Study cannot establish the quantity of salbutamol inhaled (on the Athlete’s interpretation of that word by him in Davos or Toblach, as the conditions of the study were very different from those outside the laboratory;
- iv. the Oslo Study, carried out with an inhalation of a guaranteed amount of 1,600 µg of salbutamol, showed urinary salbutamol levels (1,703 and 1,631) exceeding the levels measured in Davos and Toblach (1,340 and 1,360) making it very plausible that the Athlete had indeed not inhaled more than 1,600 µg in Davos and Toblach;
- v. *“the permitted amount of 1600 micrograms by inhalation refers to the delivered dose, which is the dose that athletes are allowed to inhale without requesting a Therapeutic Use Exemption”*. In any case, *“the rule is not clear and unambiguous. Therefore, the WADA has not fulfilled the burden of proof of the violation”*;
- vi. in the interpretation of the rule defining the permitted amount of *“inhaled salbutamol”*, the Panel should look in the first instance to its literal wording, taking into account syntax, grammar and all other relevant factors: as a result, the historical background, the regulatory context, the purpose of the rule and the intention of the association can serve as elements of interpretation, if the wording is not clear. In addition, how a reasonable person would have understood the rule is the applicable principle of interpretation. Furthermore, the principles of legality and predictability of sanctions call for a narrow interpretation of the provision, and inconsistencies in the rule must be construed against the WADA. In that regard, it is to be noted that:
 - the wording of the rule is clear: *“inhale”* means *“inhale”*. A reference to *“inhaled salbutamol”* can only sensibly be construed as being a reference to the inhaled, *i.e.* the delivered dose of salbutamol. The interpretation that the Appellant argues is contrary to the wording and in any case highly misleading. In accordance with the Oxford dictionary, *“inhale”* means *“breathe in”*, and in medical terms to *“breathe in”* means the inhalation of air or gaseous mixtures. In other words, inhaled means what gets into the lungs through breathing in. For a substance to be inhaled, the minimum requirement would be that it enters the body through the mouth or the nose. The wording suggests therefore explicitly that the maximum amount of 1,600 µg refers the amount that it is actually breathed in;

- the wording for salbutamol and formoterol was exactly the same in the Prohibited List until 2012. In the WADA Summary of Major Modifications and Clarifications concerning Prohibited List of 2012 a reference to the allowed amount of formoterol was expressed as a reference to the “*inhaled/ delivered*” dose: if the allowed amount is the delivered dose for formoterol (as expressly indicated), then 1,600 µg is also the delivered dose for salbutamol, since it is not possible to have two completely different definitions of the word “*inhaled*”: *i.e.*, if “*inhaled dose*” means “*delivered dose*” for one substance, it cannot mean “*labelled dose*” for another substance unless this is clearly expressed. WADA had itself also specified, in the Summary of Major Modifications and Clarifications concerning Prohibited List of 2013 what “*delivered dose*” meant: “*the dose that leaves the mouthpiece and is available for inhalation*”;
 - if the rule is interpreted as WADA argues, the consequence is that all adult athletes with asthma that used a nebulizer to inhale salbutamol committed a breach of the rule, as the lowest dose for adults contains 2,500 µg of salbutamol. In other words, an athlete with asthma cannot use a nebulizer to inhale salbutamol without a TUE, as even the lowest dose recommended for adults is above the WADA limit. The rules says nothing about the device to be used, but the interpretation of WADA in practice excludes the use of a nebulizer;
 - the interpretation that WADA argues is highly unreasonable as it leads to a situation where low delivered doses through a nebulizer are violations of the rule, while higher delivered doses through an MDI are not violations;
- vii. the problem with the current rule is that, as indicated *inter alia* in the Dickinson Study, it allows an athlete to inhale 1,600 µg of salbutamol, even though the use of salbutamol up to the upper limit may well produce an excretion of salbutamol at urinary concentration levels that exceed the DL for an anti-doping rule violation. If the delivered dose should be much less than 1,600 µg, then MDIs or DPIs should not be used either;
- viii. it is impossible to read the rule itself as inapplicable to the treatment of exacerbations of asthma, as long as that treatment does not exceed a maximum dose of inhaled salbutamol of 1,600 µg per 24 hours. Accordingly, if an asthma exacerbation can be treated with doses within the maximum allowed amounts, it should not be necessary to apply for a TUE.
64. Finally, the First Respondent contends that if the Panel concludes that the Athlete failed to demonstrate, on the balance of probability, that he inhaled a therapeutic dose of salbutamol less than the maximum of 1,600 µg, there is nothing to suggest that he intended to cheat or enhance his sport performance. He inhaled the substance as recommended by his team doctor and the dose taken is compatible with the manufacturer’s recommendations. In addition, according to the Athlete, the Toblach Sample cannot constitute a second anti-doping rule violation, since the Athlete was not given timely notice of the first anti-doping rule violation. It took more than a month before the Laboratory notified the FIS. In the meantime the second doping test was carried out. It is obvious that, had the results of the Davos Sample been notified to the Athlete prior to the competition in Toblach, he could at least have applied for a TUE to be on the safe side. WADA is of the opinion that that Athlete’s only fault was not to have applied for a TUE: if that be so the Athlete result at Toblach on 8 January 2015 should not in any case be cancelled,

as there was a major deviation from Article 5.2.6.5 of the International Standard for Laboratories (the “ISL”) under the WADC (*“Reporting of ‘A’ Sample results should occur within ten (10) working days of receipt of the Sample. The reporting time required for specific Competitions may be substantially less than ten days. The reporting time may be altered by agreement between the Laboratory and the Testing Authority”*).

b.2 The Position of FIS

- 65. As mentioned, the Second Respondent did not file any written answer to the WADA’s appeal.
- 66. At the hearing, the FIS underlined that its only role in this case was of “rule applier” and “enforcer”: its anti-doping rules, in fact, are based on the WADC. Therefore, FIS is not responsible for any obscurity, if any, of the provisions in the WADC.
- 67. At the same time, FIS made it clear that it did not agree with the conclusions reached by its independent Doping Panel. In FIS’s opinion, in fact, the permitted dose of salbutamol is to be defined by reference to the amount of substance indicated on the label of its container before its administration. This is the only amount that can be easily verified by the user and is conducive to the predictability of the rules. As a result, a TUE would be necessary for the administration of salbutamol (be it by nebulization or MDI) of doses exceeding 1,600 µg per day. The Athlete, having nebulized 15,000 µg in 24 hours committed an anti-doping rule violation.
- 68. In light of his medical justification, and the fact that a TUE could be obtained, in the FIS opinion, a reprimand, with no ineligibility period, would be the proper sanction for the Athlete.

3. LEGAL ANALYSIS

3.1 Jurisdiction

- 69. CAS has jurisdiction to decide the present dispute between the parties.
- 70. In fact, the jurisdiction of CAS is not disputed by the parties, has been confirmed by the Order of Procedure, and is contemplated by Article 13.2.1 [*“Appeals Involving International-Level Athletes or International Events”*] of the FIS ADR, as follows:

“In cases arising from participation in an International Event or in cases involving International-Level Athletes, the decision may be appealed exclusively to CAS”.
- 71. A right of appeal to CAS is then granted to WADA by Article 13.2.3(f) [*“Persons Entitled to Appeal”*] of the FIS ADR. It is also undisputed that the First Respondent is an *“International-Level Athlete”* for the purposes of the FIS ADR and the CAS jurisdiction.

3.2 Appeal Proceedings

72. As these proceedings involve an appeal against a decision rendered by an international federation, brought on the basis of rules providing for an appeal to the CAS, they are considered and treated as appeal arbitration proceedings in a disciplinary case of international nature, within the meaning, and for the purposes, of the Code.

3.3 Admissibility

73. The statement of appeal was filed within the deadline set in Article 13.7.1 of the FIS ADR. Accordingly, the appeal is admissible.

3.4 Scope of the Panel's Review

74. According to Article R57 of the Code,
"the Panel shall have full power to review the facts and the law. It may issue a new decision which replaces the decision challenged or annul the decision and refer the case back to the previous instance. [...]".

3.5 Applicable Law

75. The question of what law is applicable in the present arbitration is to be decided by the Panel in accordance with the provisions of Chapter 12 of the PIL, the arbitration bodies appointed on the basis of the Code being international arbitral tribunals having their seat in Switzerland within the meaning of Article 176 of the PIL.
76. Pursuant to Article 187.1 of the PIL,
"The arbitral tribunal shall decide the dispute according to the rules of law chosen by the parties or, in the absence of such a choice, according to the law with which the case is most closely connected".
77. Article 187.1 of the PIL constitutes the entire conflict-of-law system applicable to arbitral tribunals, which have their seat in Switzerland: the other specific conflict-of-laws rules contained in Swiss private international law are not applicable to the determination of the applicable substantive law in Swiss international arbitration proceedings (KAUFMANN-KOHLER/STUCKI, *International Arbitration in Switzerland*, Zurich 2004, p. 116; RIGOZZI A., *L'arbitrage international en matière de sport*, Basle 2005, § 1166 et seq).
78. With respect to Article 187.1 of the PIL, it is to be underlined (i) that it recognizes the traditional principle of the freedom of the parties to choose the law that the arbitral tribunal has to apply to the merits of the dispute, and (ii) that the choice of law it allows can be made also indirectly, through the reference to the rules governing the procedure set in regulation of an arbitral institution, where they contain a "choice-of-law" provision (KAUFMANN-KOHLER/RIGOZZI, *Arbitrage International. Droit et pratique à la lumière de la LDIP*, 2^a ed., Berne 2010, p. 400).

79. As a result, the law applicable in the present arbitration is identified by the Panel in accordance with Article R58 of the Code.
80. Pursuant to Article R58 of the Code, this Panel is required to decide the dispute
“... according to the applicable regulations and the rules of law chosen by the parties or, in the absence of such a choice, according to the law of the country in which the federation, association or sports-related body which has issued the challenged decision is domiciled or according to the rules of law, the application of which the Panel deems appropriate. In the latter case, the Panel shall give reasons for its decision”.
81. In the present case the “*applicable regulations*” for the purposes of Article R58 of the Code are, indisputably, the regulations of FIS, because the appeal is directed against decisions issued by FIS, which were passed applying FIS rules and regulations. More specifically, the Panel agrees with the parties that the particular regulations concerned are the FIS ADR, including the relevant version in force at the material time of the Prohibited List to which they refer.
82. The Panel identifies, in fact, the applicable substantive rules by reference to the principle “*tempus regit actum*”: in order to determine whether an act constitutes a disciplinary infringement, the Panel applies the law in force at the time the act was committed. In other words, new regulations, unless they are more favourable for the athlete in accordance with the *lex mitior* principle referenced in advisory opinion CAS 94/128, rendered on 5 January 1995, do not apply retroactively to facts that occurred prior to their entry into force, but only for the future (CAS 2000/A/274, award of 19 October 2000).
83. As a result, the FIS ADR 2014 apply to the evaluation of the Davos Sample, while the FIS ADR 2015 apply to the evaluation of the Toblach Sample. The Panel however notes that, so far as relevant in these arbitration proceedings, no difference can be identified in the two sets of FIS ADR. As a result, any reference to the FIS ADR is intended to cover both editions (2014 and 2015) of such regulations. The same is true with respect to the Prohibited List: the Prohibited List 2014 applies to the evaluation of the Davos Sample, while the Prohibited List 2015 applies to the evaluation of the Toblach Sample; and any reference to the Prohibited Lists is intended to cover both editions (2014 and 2015) of such list. Any distinction between the 2014 and the 2015 editions of the FIS ADR and/or of the Prohibited List will be drawn only when relevant to the Panel’s discussion.
84. The Panel notes, at the same time, that the FIS ADR are based on the rules contained in the WADC, and more specifically the FIS ADR 2014 on the WADC edition of 2009, and the FIS ADR 2015 on the WADC edition of 2015. As a result, the Panel finds it appropriate to consider also the text and the interpretation of the WADC for the interpretation of the corresponding provisions of the FIS ADR (Article 18.5 FIS ADR 2014, and Article 20.5 FIS ADR).
85. In addition to the FIS regulations (including the Prohibited Lists), the laws of Switzerland apply subsidiarily, pursuant to Article R58 of the Code, since FIS, which rendered the Decision, has its seat in Switzerland.
86. The provisions within the FIS regulations that are relevant in this arbitration include the following:

- i. from the FIS ADR:
 - 2014 and 2015 versions

ARTICLE 2 ANTI-DOPING RULE VIOLATIONS

[...] The following constitute anti-doping rule violations:

2.1 *Presence of a Prohibited Substance or its Metabolites or Markers in an Athlete's Sample*

2.1.1 *It is each Athlete's personal duty to ensure that no Prohibited Substance enters his or her body. Athletes are responsible for any Prohibited Substance or its Metabolites or Markers found to be present in their Samples. Accordingly, it is not necessary that intent, Fault, negligence or knowing Use on the Athlete's part be demonstrated in order to establish an anti-doping rule violation under Article 2.1.*

2.1.2 *Sufficient proof of an anti-doping rule violation under Article 2.1 is established by any of the following: presence of a Prohibited Substance or its Metabolites or Markers in the Athlete's A Sample where the Athlete waives analysis of the B Sample and the B Sample is not analysed; or, where the Athlete's B Sample is analysed and the analysis of the Athlete's B Sample confirms the presence of the Prohibited Substance or its Metabolites or Markers found in the Athlete's A Sample [...]*

2.1.3 *Excepting those substances for which a quantitative threshold is specifically identified in the Prohibited List, the presence of any quantity of a Prohibited Substance or its Metabolites or Markers in an Athlete's Sample shall constitute an anti-doping rule violation.*

ARTICLE 3 PROOF OF DOPING

3.1 *Burdens and Standards of Proof*

FIS and its National Ski Associations shall have the burden of establishing that an anti-doping rule violation has occurred. The standard of proof shall be whether FIS or its National Ski Association has established an anti-doping rule violation to the comfortable satisfaction of the hearing panel bearing in mind the seriousness of the allegation which is made. This standard of proof in all cases is greater than a mere balance of probability but less than proof beyond a reasonable doubt. Where these Anti-Doping Rules place the burden of proof upon the Athlete or other Person alleged to have committed an anti-doping rule violation to rebut a presumption or establish specified facts or circumstances, the standard of proof shall be by a balance of probability.

3.2 *Methods of Establishing Facts and Presumptions*

Facts related to anti-doping rule violations may be established by any reliable means, including admissions. [...]

ARTICLE 9 AUTOMATIC DISQUALIFICATION OF INDIVIDUAL RESULTS

An anti-doping rule violation in Individual Sports in connection with an In-Competition test automatically leads to Disqualification of the result obtained in that Competition with all resulting Consequences, including forfeiture of any medals, points and prizes.

- 2014 version

ARTICLE 10 SANCTIONS ON INDIVIDUALS

10.2 *Ineligibility for Presence, Use or Attempted Use, or Possession of Prohibited Substances and Prohibited Methods*

The period of Ineligibility imposed for a violation of Article 2.1 (Presence of Prohibited Substance or its Metabolites or Markers), Article 2.2 (Use or Attempted Use of Prohibited Substance or Prohibited Method) or Article 2.6 (Possession of Prohibited Substances and Methods) shall be as follows, unless the conditions for eliminating or reducing the period of Ineligibility, as provided in Articles 10.4 and 10.5, or the conditions for increasing the period of Ineligibility, as provided in Article 10.6, are met:

First violation: Two (2) years' Ineligibility.

10.4 *Elimination or Reduction of the Period of Ineligibility for Specified Substances under Specific Circumstances*

Where an Athlete or other Person can establish how a Specified Substance entered his or her body or came into his or her possession and that such Specified Substance was not intended to enhance the Athlete's sport performance or mask the use of a performance-enhancing substance, the period of Ineligibility found in Article 10.2 shall be replaced with the following:

First violation: At a minimum, a reprimand and no period of Ineligibility from future Events, and at a maximum, two (2) years of Ineligibility. To justify any elimination or reduction, the Athlete or other Person must produce corroborating evidence in addition to his or her word which establishes to the comfortable satisfaction of the hearing panel the absence of an intent to enhance sport performance or mask the use of a performance enhancing substance. The Athlete or other Person's degree of fault shall be the criterion considered in assessing any reduction of the period of Ineligibility.

10.5 *Elimination or Reduction of Period of Ineligibility Based on Exceptional Circumstances*

10.5.1 *No Fault or Negligence*

If an Athlete establishes in an individual case that he or she bears No Fault or Negligence, the otherwise applicable period of Ineligibility shall be eliminated. When a Prohibited Substance or its Markers or Metabolites is detected in an Athlete's Sample in violation of Article 2.1 (presence of Prohibited Substance), the Athlete must also establish how the Prohibited Substance entered his or her system in order to have the period of Ineligibility eliminated. In the event this Article is applied and the period of Ineligibility otherwise applicable is eliminated, the anti-doping rule violation shall not be considered a violation for the limited purpose of determining the period of Ineligibility for multiple violations under Article 10.7.

10.5.2 *No Significant Fault or Negligence*

If an Athlete or other Person establishes in an individual case that he or she bears No Significant Fault or Negligence, then the period of Ineligibility may be reduced, but the reduced period of Ineligibility may not be less than one-half of the period of Ineligibility otherwise applicable. If the otherwise applicable period of Ineligibility is a lifetime, the reduced period under this section may be no less than 8 years. When

a Prohibited Substance or its Markers or Metabolites is detected in an Athlete's Sample in violation of Article 2.1 (Presence of Prohibited Substance or its Metabolites or Markers), the Athlete must also establish how the Prohibited Substance entered his or her system in order to have the period of Ineligibility reduced.

10.7 Multiple Violations

10.7.4 Additional Rules for Certain Potential Multiple Violations

For purposes of imposing sanctions under Article 10.7, an anti-doping rule violation will only be considered a second violation if the FIS (or its National Ski Association) can establish that the Athlete or other Person committed the second anti-doping rule violation after the Athlete or other Person received notice pursuant to Article 7 (Results Management), or after FIS (or its National Ski Association) made reasonable efforts to give notice, of the first anti-doping rule violation; if the FIS (or its National Ski Association) cannot establish this, the violations shall be considered together as one single first violation, and the sanction imposed shall be based on the violation that carries the more severe sanction; however, the occurrence of multiple violations may be considered as a factor in determining Aggravating Circumstances (Article 10.6).

- 2015 versions

ARTICLE 10 SANCTIONS ON INDIVIDUALS

10.2 Ineligibility for Presence, Use or Attempted Use, or Possession of a Prohibited Substance or Prohibited Method

The period of Ineligibility for a violation of Articles 2.1 ... shall be as follows, subject to potential reduction or suspension pursuant to Articles 10.4, 10.5 or 10.6:

10.2.1 The period of Ineligibility shall be four (4) years where:

10.2.1.1 The anti-doping rule violation does not involve a Specified Substance, unless the Athlete or other Person can establish that the anti-doping rule violation was not intentional.

10.2.1.2 The anti-doping rule violation involves a Specified Substance and FIS can establish that the anti-doping rule violation was intentional.

10.2.2 If Article 10.2.1 does not apply, the period of Ineligibility shall be two (2) years.

10.2.3 As used in Articles 10.2 and 10.3, the term "intentional" is meant to identify those Athletes who cheat. The term therefore requires that the Athlete or other Person engaged in conduct which he or she knew constituted an anti-doping rule violation or knew that there was a significant risk that the conduct might constitute or result in an anti-doping rule violation and manifestly disregarded that risk. An anti-doping rule violation resulting from an Adverse Analytical Finding for a substance which is only prohibited In-Competition shall be rebuttably presumed to be not intentional if the substance is a Specified Substance and the Athlete can establish that the Prohibited Substance was Used Out-of-Competition. An anti-doping rule violation resulting from an Adverse Analytical Finding for a substance which is only prohibited In-Competition shall not be considered intentional if the

substance is not a Specified Substance and the Athlete can establish that the Prohibited Substance was Used Out-of-Competition in a context unrelated to sport performance. [...]

10.4 Elimination of the Period of Ineligibility where there is No Fault or Negligence

If an Athlete or other Person establishes in an individual case that he or she bears No Fault or Negligence, then the otherwise applicable period of Ineligibility shall be eliminated.

10.5 Reduction of the Period of Ineligibility based on No Significant Fault or Negligence

10.5.1 Reduction of Sanctions for Specified Substances or Contaminated Products for Violations of Article 2.1, 2.2 or 2.6.

10.5.1.1 Specified Substances

Where the anti-doping rule violation involves a Specified Substance, and the Athlete or other Person can establish No Significant Fault or Negligence, then the period of Ineligibility shall be, at a minimum, a reprimand and no period of Ineligibility, and at a maximum, two (2) years of Ineligibility, depending on the Athlete's or other Person's degree of Fault.

10.7 Multiple Violations

10.7.4 Additional Rules for Certain Potential Multiple Violations

10.7.4.1 For purposes of imposing sanctions under Article 10.7, an anti-doping rule violation will only be considered a second violation if FIS can establish that the Athlete or other Person committed the second anti-doping rule violation after the Athlete or other Person received notice pursuant to Article 7, or after FIS made reasonable efforts to give notice of the first anti-doping rule violation. If FIS cannot establish this, the violations shall be considered together as one single first violation, and the sanction imposed shall be based on the violation that carries the more severe sanction.

10.8 Disqualification of Results in Competitions Subsequent to Sample Collection or Commission of an Anti-Doping Rule Violation

In addition to the automatic Disqualification of the results in the Competition which produced the positive Sample under Article 9, all other competitive results of the Athlete obtained from the date a positive Sample was collected (whether In- Competition or Out-of-Competition), or other anti-doping rule violation occurred, through the commencement of any Provisional Suspension or Ineligibility period, shall, unless fairness requires otherwise, be Disqualified with all of the resulting Consequences including forfeiture of any medals, points and prizes.

- ii. from the Prohibited Lists⁶:

S3. BETA-2 AGONISTS

All beta-2 agonists, including all optical isomers, e.g. d- and l- where relevant, are prohibited.

⁶ The text which follows corresponds to the text of the Prohibited List 2015. The Prohibited List 2014 has an identical content in all material respects.

Except:

- *Inhaled salbutamol (maximum 1600 micrograms over 24 hours);*
- *Inhaled formoterol (maximum delivered dose 54 micrograms over 24 hours); and*
- *Inhaled salmeterol in accordance with the manufacturers' recommended therapeutic regimen.*

The presence in urine of salbutamol in excess of 1000 ng/mL or formoterol in excess of 40 ng/mL is presumed not to be an intended therapeutic use of the substance and will be considered as an Adverse Analytical Finding (AAF) unless the Athlete proves, through a controlled pharmacokinetic study, that the abnormal result was the consequence of the use of the therapeutic inhaled dose up to the maximum indicated above”.

3.6 The Dispute

87. These proceedings concern the Decision rendered by the FIS Doping Panel, which held that the AAFs did not constitute anti-doping rule violations and therefore did not apply any sanction to the Athlete. The Decision, in fact, is challenged by the Appellant and defended by the First Respondent: the former seeks to have it set aside; the latter requests the Panel to confirm it. FIS, on the other hand, while not formally challenging the Decision, rendered by one of its disciplinary bodies, criticizes its reasoning and conclusion.
88. In relation to such dispute, a number of issues have been raised by the parties. In essence, two main issues are before this Panel:
 - i. whether the Athlete committed an anti-doping rule violation; and
 - ii. what are the consequences of the Panel's findings in this respect.
89. The Panel shall examine those issues separately.

i. Did the Athlete commit an anti-doping rule violation?

90. The first question to be addressed by the Panel concerns the issue whether the AAFs show the anti-doping rule violation contemplated by Article 2.1 of the FIS ADR. It is in fact undisputed that the Samples contained salbutamol, a specified prohibited substance falling in category S3 of the Prohibited List, in a measure exceeding the amount of 1,200 ng/mL. However, the First Respondent contends that this finding was the result of the use of a therapeutic inhaled dose of salbutamol lower than the maximum allowed of 1,600 µg per day.
91. In this regard, the debate between the parties was as to whether the reference to “*inhaled salbutamol*” and to “*therapeutic inhaled dose*” (the “Two Phrases”) contained in Section S.3 Beta-2 Agonists of the Prohibited Lists (the “β2A Provision”) (i) describes salbutamol as “delivered”, *i.e.* which was, with the use of the inhaler, “*available for inhalation*” after all dispersions in the container, in the equipment or in the air (the Athlete's position), or (ii) points to the “*labelled*” dose, *i.e.* the “nominal” dose described by the manufacturers as contained in the original vessel (the WADA and FIS position).

92. The β 2A Provision *vis-à-vis* salbutamol has undergone various changes over the years. In broad terms, between 2004 (the first year to which reference was made before the Panel) and 2009 its use was permitted only with a TUE. In 2010, for salbutamol a maximum use of 1,600 μ g in 24 hours (the “Use Threshold”) was set and a TUE was no longer required, but only a declaration of use was requested. In 2011, the need for a declaration of use was abandoned. Between 2011-2015, the Use Threshold was maintained. Throughout the entire period, if a concentration of more than 1,000 ng/mL, as adjusted to the DL of 1,200 ng/mL (the “Test Threshold”), was detected, an adverse analytical finding would be presumed, unless the athlete could show, in ways variously described, that the abnormal result was the consequence of normal therapeutic use (the “Gateway”).
93. The Panel considers that, given the various changes in language and indeed effect of the salbutamol-specific provisions, it must (i) focus on the Prohibited Lists (2014 and 2015), which set the regime in place at the time the Athlete’s samples exceeded the Test Threshold, and (ii) refer to superseded provisions (and associated material) only where such is admissible for and relevant to interpretation of the Prohibited Lists. It does note, however, that from (at least) 2004 onwards only **inhaled** use of salbutamol could ever, subject always to the various conditions, not constitute a doping offence.
94. Under the Prohibited Lists, the general rule is that all Beta-2 Agonists are prohibited, unless covered by an exception. As a matter of principle, an exception to a general rule is to be narrowly construed.
95. The relevant exception for the purposes of this appeal is to “*inhaled salbutamol*” (maximum 1,600 μ g over 24 hours).
96. In the Panel’s opinion, the epithet “*inhaled*” is deployed in the context of such exception to identify the mechanics of administration. In other words, it is meant to distinguish “inhalation” from “ingestion” or “injection” (by both of which means salbutamol can be administered), such that only use by inhalation is permitted. The preceding versions to the Prohibited List point ineluctably to the same conclusion; the phrase used in 2004 is “*by inhalation*”, in 2005-2009 “*administered by inhalation*”, in 2010 “*by inhalation*” and again in 2011-2012 “*taken by inhalation*”. “*Inhaled salbutamol*”, the formula used from 2013 onwards, is, in the Panel’s view, a more succinct way of saying the same thing. This conclusion is expressly confirmed by the TUE Physician Guidelines for Asthma of WADA for 2015, which indicate, at Section IV (“Route”), that “*a) only certain inhaled beta 2 agonists are permitted and only when b) used by inhalation at therapeutic dosages*”. As was convincingly explained to the Panel at the hearing, by the “singling out” for the purposes of the exception “inhalation”, in its revision of the Prohibited List, WADA intended to exclude the possibility for an athlete to ingest or inject salbutamol, since its “systemic administration” produces anabolizing effects, and therefore should therefore not be allowed without a TUE.
97. The epithet “*inhaled*” does not serve any further or alternative purpose. The Panel, in fact, does not accept that it can bear two meanings simultaneously or describe at one and the same time the stage of administration – the Athlete’s position – as well as the mechanics of administration – WADA’s and FIS’s position. Such an interpretation would, in the absence of express indication to that effect, be inconsistent with ordinary rules of construction, including the

principle of narrow interpretation of exceptions. It follows that the expression “*therapeutic inhaled dose*” only describes the mechanics of administration.

98. The use of inhalation to administer salbutamol is, of course, a necessary, but not a sufficient element to engage the exception. It is also necessary not to exceed the Use Threshold. However, once it is accepted that “*inhaled*” refers to the mechanics of administration, it follows that the Use Threshold (*i.e.* 1,600 µg over 24 hours) refers to the maximum dose that can be taken by inhalation (as distinct from ingestion or injection), *i.e.* the “*labelled*” or “*nominal*” dose.
99. This interpretation of the second of the Two Phrases (the expression: “*therapeutic inhaled dose*”) is fortified by the ordinary meaning of the word “dose” (*e.g.*, “*a quantity of medicine prescribed to be taken at any one time*”: Random House Dictionary; “*a definite quantity of a medicine or drug given or prescribed to be given at one time*”: Oxford English Dictionary). This is *a fortiori* when the epithet “*therapeutic*” qualifies the noun “*dose*”; it identifies that the dose is what is prescribed by the doctor or pharmacist. The point has been expressly confirmed in the Second Kinahan Report (§ 14) by a qualified pharmacist, *i.e.* by a person used in her professional capacity to interpret such words in a manner consistent with common medical practice.
100. The reference to “*inhaled salmeterol*” in the same β₂A Provision of the Prohibited Lists “*in accordance with the manufacturers’ recommended therapeutic regime*” points in the same direction (*i.e.*, what is taken by means of inhalation as per the manufacturers’ recommendation). The Panel notes, indeed, that the phrase “*taken by inhalation*” actually appeared in the Prohibited List 2014, but does not consider that the change of vocabulary in Prohibited List 2015 altered its meaning. In the Panel’s view, the Prohibited List 2015 simply says the same thing in a different way.
101. There is yet further support for the above interpretation in the reference to “*inhaled formoterol*”. Once again, “*inhaled*” necessarily refers to the mechanics of administration. However, for reasons explained in the Explanatory Note summarizing the Major Modifications and Clarification introduced in the Prohibited List from 2013 onwards, it was stipulated that what needed to be quantified was the delivered dose, meaning “*the dose that leaves the mouthpiece and is available for inhalation*”). Rather than assimilating the words inhaled and delivered, as the Athlete contends, the summary differentiates between them. The two adjectives are playing distinct roles – inhaled refers to the mechanics of administration, delivered to the stage of administration. The Panel notes that the Summary of Major Modifications and Clarifications regarding the Prohibited List of 2012 confusingly used the phrase “*inhaled/delivered dose*” in relation to the use threshold for formoterol, but this was not replicated in the Prohibited Lists.
102. The Athlete misunderstood “*inhaled*” to refer to the stage of administration, and the debate, therefore, according to him became only whether “*inhaled*” refers to what is in the device (be it MDI, DPI or nebulizer), what comes out of the device, what is in the mouth or what reaches the lungs. For the reasons set out above, it does not; it only describes the way in which the substance can be lawfully (subject always to the other conditions) administered. The debate that he envisages starts from the wrong premise and is therefore misconceived.
103. The Panel accepts that the words “*labelled*” or “*nominal*” nowhere appears in the Prohibited Lists to qualify a dose or to describe what is inhaled. However, the absence of such an adjective does

not undermine the Panel's preferred construction, as other factors suggest that that is what must have been intended.

104. All parties contended that β 2A Provision was clear on its face when advocating for their respective interpretations. At other times, however, the Athlete appeared to contend that, at a minimum, the Panel should consider the β 2A Provision ambiguous and, on that basis, construe it in the Athlete's favour. While the Panel considers that the Athlete genuinely misunderstood the meaning of the β 2A Provision, and also itself considers that the β 2A Provision could have been drafted more clearly in certain respects (an issue the Panel will return to when discussing the appropriate sanction), the Panel does not consider it sufficiently ambiguous to admit the Athlete's reading. This is, *inter alia*, because the Athlete's reading – whereby the Use Threshold refers to the amount actually inhaled (*i.e.*, available for inhalation after dispersion, or received in the lungs) by the Athlete – depends on a wide variety of situational factors that would render the provision difficult (if not impossible) to apply in practice. By contrast, the Panel's interpretation is consistent with the stated intention of the rule maker as appears from the Rabin Report (§§ 7-10), neither contradicted nor challenged, and is easy to administer.

105. It is common ground that, although the β 2A Provision was not drafted with nebulizers in mind, as stated in the Rabin Report (§ 11), on its face it covers them, because it applies without restriction to any type of device for inhalation. The Athlete says that if, as WADA and FIS contend, the Use Threshold refers to “labelled” dose, then in practice the β 2A Provision would not apply to nebulizers, because the smallest dose available by nebulizer contains 2,500 μ g of salbutamol, an amount exceeding the Use Threshold. The Panel accepts that his point is indeed correct in the sense that the β 2A Provision only obviates the need for a TUE where the athlete inhales salbutamol from an MDI or a DPI and that any athlete wishing to nebulize salbutamol needs to request a TUE. It does not, however, follow that the Panel's interpretation of the β 2A provision must be discarded. The need for a TUE for use of a nebulizer is itself a consequence of the provision on its proper interpretation. The Athlete's fault lies indeed in failing to request a TUE, the grant of which would have enabled him to compete without breach of the rules. The Panel acknowledges nonetheless that it would have been better if the provision had more clearly stated its consequence for use of nebulizers.

106. The Athlete also argues that the position of WADA and FIS is at odds with the underlying purpose of the β 2A Provision, *i.e.* to prevent sportsmen or women from gaining an unfair competitive advantage by drug use. According to the Athlete, in fact, there is no evidence of such advantage being gained by persons who exceed the Use Threshold by inhalation. The Panel notes that nonetheless in WADA's Summary of Major Modification and Clarifications of the Prohibited List for 2012 it is stated that “Concerns continue to exist about the performance-enhancing effects of beta-2 agonists when taken systematically and/or in large quantities”. In addition, the Panel accepts Dr Rabin's evidence that the Use Threshold was actually chosen to reflect wide and long experience of what is a normal therapeutic use, but recognizes also that it serves this collateral purpose too of avoiding the possible risk of unfair competitive advantage by those who exceed it.

107. The principle of legal certainty has an important role to play in exercise of interpretation. There

is no doubt that the WADA/FIS position has the merit of certainty; those to whom the β 2A Provision is addressed need do no more than look at a label. The Athlete's position requires, as this appeal showed, the introduction of and reliance on detailed scientific evidence (an exercise which may be beyond the resources available to most sportsmen or sportswomen).

108. In light of the Panel's interpretation of the 1,600 μ g Use Threshold as referring to the "labelled" dose, there is no need to consider further any of the subjects of learned scientific debate between the Experts, as developed in the numerous reports filed in the proceedings and explored at the hearing. The Athlete acknowledges that he nebulized 15,000 μ g of salbutamol within a 24-hour period on the days he delivered the Samples. The Athlete has accordingly by virtue of that fact alone admitted the violation at issue here. As a consequence, there is no scope for the Athlete to persuade the Panel through a pharmacokinetic study that his AAFs were produced from taking a labelled dose of only 1,600 μ g in 24 hours. How the guiding principles for the pharmacokinetic study can be implemented in other circumstances is an issue the Panel does not need to address. The London Study and the Oslo Study are irrelevant to the issue of liability.

109. The Panel accordingly finds that the Athlete, who did not have a valid TUE to cover his use of salbutamol at Davos and Tobach, committed an anti-doping rule violation under Article 2.1 of the FIS ADR.

ii. What are the consequences of the Panel's finding that the Athlete committed an anti-doping rule violation?

110. The consequences of the above finding that the Athlete committed an anti-doping rule violation are described by the FIS ADR, in their relevant versions, as follows:

i. as to ineligibility:

a. in the FIS ADR 2015:

- a period of four years, if the FIS can establish that the anti-doping rule violation was intentional (*i.e.*, committed by an athlete engaged in a conduct that he knew constituted an anti-doping rule violation) (Article 10.2.12); or
- a period of two years, if the FIS cannot establish that the anti-doping rule violation was intentional (Article 10.2.2); or
- a reprimand and no period of ineligibility or a period of ineligibility up to two years, if the Athlete proves how the prohibited substance entered his system and can establish "*No Significant Fault or Negligence*" (*i.e.*, that his breach of duty or lack of care, when viewed in the totality of the circumstances, was not significant) (Article 10.5.1.1); or
- no period of ineligibility (and no reprimand), if the Athlete proves how the prohibited substance entered his system and can establish that he bears "*No Fault or Negligence*" (*i.e.*, that he did not know or suspect, or could not reasonably have known or suspected, even with exercise of utmost care, that he had used or had been administered a prohibited substance) (Article 10.4);

- b. in the FIS ADR 2014:
 - a period of two years (Article 10.2); or
 - a reprimand and no period of ineligibility or a period of ineligibility up to two years, if the Athlete can establish how the prohibited substance entered his body and that it was not intended to enhance the Athlete's sport performance (Article 10.4), or
 - no period of ineligibility (and no reprimand) if the Athlete can establish how the prohibited substance entered his body and that he bears No Fault or Negligence (Article 10.5.1);
 - ii. as to disqualification of results:
 - a. in both the FIS ADR 2014 and the FIS ADR 2015:
 - the automatic disqualification of the results obtained in the competition at which the sample returning an AAF was collected (Article 9); and
 - the disqualification of all other competitive results obtained from the date a positive sample was collected through the commencement of any ineligibility period, unless fairness requires otherwise (Article 10.8).
111. As indicated above (§§ 82-83), the two different sets of rules (the FIS ADR 2014 and the FIS ADR 2015) are individually relevant in respect of the two Samples: the consequences of the anti-doping rule violation relating to the Davos Sample are defined by the FIS ADR 2014, while the consequences of the anti-doping rule violation relating to the Toblach Sample are defined by the FIS ADR 2015.
112. The Panel, however, must underline two preliminary points in this context:
 - i. the Athlete is considered to have committed a single anti-doping rule violation: more specifically, the adverse analytical finding regarding the Toblach Sample does not produce the consequences established for a second anti-doping rule violation by Article 10.7 of the FIS ADR 2015. FIS in fact did not establish (and actually did not even claim) that the anti-doping rule violation evidenced by the Toblach Sample was committed after notice had been given to the Athlete regarding the adverse analytical finding in respect of the Davos Sample: both AAFs were in fact jointly notified on 23 January 2015, well after the competition in Toblach;
 - ii. the two editions of the FIS ADR, however much they may differ in other respects, have an identical content as far as the individual case of the Athlete is concerned, given that:
 - WADA is not claiming that the anti-doping rule violation was intentional;
 - the Athlete (i) has established how the prohibited substance entered his body, and (ii) does not submit that he bears "*No Fault or Negligence*" (a circumstance that in any case the Panel would exclude, since as explained in § 119(ii) below, it is unrealistic to conclude that there were no further steps that the Athlete could have taken to ensure that he was rule compliant); and therefore
 - the consequences to be imposed range, under both editions, from a minimum of a reprimand and no ineligibility to a maximum of two years' ineligibility, depending on the Athlete's degree of fault, given that the Athlete indisputably established how

salbutamol entered his body, *i.e.* by his use of the nebulizer, and WADA accepts that he did not intend to enhance his sporting performance;

- the rules governing the disqualification of results are identical.

113. As a result, whatever edition of the FIS ADR applies, the Panel has to exercise its discretion in setting the appropriate sanction, and more specifically in defining the proper measure of the ineligibility period (if any) to be imposed. As mentioned, in fact, under the FIS ADR, the violation committed by the Athlete is sanctioned “*at a minimum*” with “*a reprimand and no period of ineligibility from future competitions*” and “*at a maximum*” with “*two years’ of ineligibility*”. The closing sentences of Article 10.4 of the FIS ADR 2014 and of Article 10.5.1.1 of the FIS ADR 2015 make clear that the measure of the sanction depends on the assessment of the Athlete’s fault. In that respect, the Panel notes that it is a principle under the WADC, on which the FIS ADR are modelled, that the circumstances to be considered in the assessment of the Athlete’s fault “*must be specific and relevant to explain the athlete’s ... departure from the expected standard of behavior*” (footnote to Article 10.4 of the WADC, edition 2009).
114. The Panel notes that an impressive body of jurisprudence has defined the circumstances relevant to the measurement of an athlete’s fault, and translated them into the determination of a proper sanction, chiefly in the context of disputes relating to the use of “contaminated products” (such as food supplements), but also in cases where medicines were taken in a therapeutic context (broadly defined) without a TUE. Also in this arbitration, the Parties have drawn the Panel’s attention to specific decisions. The Panel agrees that precedents in terms of the approach in principle provide helpful guidance. However, the Panel underlines that each case must be decided on its own facts and that “*although consistency of sanctions is a virtue, correctness remains a higher one: otherwise unduly lenient (or, indeed, unduly severe) sanctions may set a wrong benchmark inimical to the interests of sport*” (CAS 2011/A/2518 § 10.23 of the award).
115. At the same time, the Panel notes that in CAS 2013/A/3327 & 3335 the Panel summarized, based on a review of CAS precedents, some principles applicable to the determination of the length of the sanction when Article 10.4 WADC (or provisions corresponding thereto) applies. More specifically, the Panel recognised the following degrees of fault:
 - i. significant degree of or considerable fault
 - ii. normal degree of fault
 - iii. light degree of fault.
116. In CAS 2013/A/3327 & 3335, then, applying these three categories to the possible sanction range of 0-24 months contemplated by Article 10.4 WADC, the Panel arrived at the following sanction ranges:
 - i. significant degree of or considerable fault: 16-24 months, with a “standard” significant fault leading to a suspension of 20 months;
 - ii. normal degree of fault: 8-16 months, with a “standard” normal degree of fault leading to a suspension of 12 months;
 - iii. light degree of fault: 0-8 months, with a “standard” light degree of fault leading to a

suspension of 4 months.

117. The holding in CAS 2013/A/3327 & 3335 was then applied in other CAS decisions, and was recently adopted in CAS 2016/A/4371, in the context of the 2015 edition of the WADC.
118. This Panel agrees with CAS 2013/A/3327 & 3335: in order to determine into which category of fault a particular case might fall, it is helpful to consider both the objective and the subjective level of fault. The objective element describes what standard of care could have been expected from a reasonable person in the athlete's situation. The subjective element describes what could have been expected from that particular athlete, in light of his personal capacities. The objective element should be foremost in determining into which of the three relevant categories a particular case falls. The subjective element can then be used to move a particular athlete up or down within that category.
119. In the present case the Panel notes the following elements:
 - i. in favour of the Athlete:
 - the use of salbutamol was indicated by the Athlete in the doping control form while providing the Samples;
 - the Athlete used salbutamol upon prescription of a doctor;
 - the Athlete has a medical condition requiring the administration of salbutamol;
 - the Athlete used salbutamol within the limits of the doctor's prescription;
 - the β 2A Provision does not expressly rule out the use of nebulizers and could sensibly have done so as to avoid any possible misunderstanding by athletes (or their advisers);
 - questions as to the possibility to use nebulizers and the amount of salbutamol they could nebulize while remaining below the Use Threshold were (apparently) asked by American athletes. When asked, USADA did not respond simply that any athlete wishing to nebulize salbutamol must request a TUE. Instead, it advised athletes who wanted to nebulize to contact the manufacturer to "*ask what percentage of the drug you are using is administered with each dose*". This approach, focussing on what amount of the substance actually reached the Athlete's body by use of the nebulizer, is that adopted by Dr Gabrielsen and, in consequence the Athlete before he used it, and was also the approach sought to be defended by his experts before the Panel;
 - the Athlete openly used a nebulizer before the competitions in Davos and Tolbach;
 - the Athlete had also used a nebulizer in the past without any problems;
 - ii. against the Athlete:
 - the Athlete was an experienced international-level athlete whose career has spanned over many years. He was further subject to regular anti-doping controls. The Athlete was fully aware of his anti-doping obligations;
 - the prescription of the doctor as to the use of a nebulizer to administer salbutamol outside a hospital was arguably questionable from a medical point of view;

- a TUE had in the recent past always been necessary for the use of salbutamol. The Athlete should have shown accordingly, particular caution in ascertaining the degree to which an exception had been made under the relevant revised provisions of the WADC;
 - the Athlete himself appears to have relied exclusively upon his medical advisers and made no enquiry of WADA, FIS or the manufacturer before use of the nebulizer. Such enquiry was not made either by Dr Gabrielsen, who declared that he relied only on the Mazhar Study;
120. Having regard to all of the circumstances of the case, that is in light of its objective and subjective elements, and especially the fact that there was medical justification for the Athlete's use of salbutamol, the Panel comes to the conclusion that the Athlete's degree of fault was light and accordingly warrants the imposition of a sanction shorter than the standard measure for such cases, in this instance of two months ineligibility.
121. The Decision is therefore to be set aside and replaced by a decision imposing a two-month ineligibility period.
122. In accordance with Article 10.11 of the FIS ADR, such ineligibility period shall commence on the date of this award.
123. The next issue, concerns the disqualification of results.
124. With respect to the results obtained in the competitions at which the Samples returning the AAFs were collected, Article 9 of the FIS ADR (2014 and 2015 editions) require their "automatic" disqualification. In other words, the Panel has no discretion to impose or not to impose that consequence: the results achieved by the Athlete in Davos and in Toblach must be disqualified, with all ensuing consequences.
125. In order to avoid such consequence, the Athlete maintains that at least the result which he obtained on 8 January 2015 should not be cancelled in any case, as there was a major deviation from Article 5.2.6.5 of the ISL. Under that provision, "*reporting of 'A' Sample results should occur within ten (10) working days of receipt of the Sample*"; however, it took more than a month before the Laboratory notified the FIS of the test result of the Davos Sample. According to the Athlete, had the results of the Davos Sample been notified to the Athlete prior to the competition in Toblach, he could at least have applied for a TUE: this would have allowed him to compete without risking the disqualification of the results obtained in Toblach.
126. On the one hand the Panel finds that non-compliance with the 10-day reporting deadline could not allow a departure from the rule that the result obtained by the Athlete in Toblach should be disqualified. In this regard, the Panel notes the following:
- i. Article 9 of the FIS ADR (corresponding to Article 9 of the WADC) leaves no discretion to the relevant disciplinary body (or to a CAS Panel): the results achieved in the given competition shall always be disqualified. This conclusion follows, as an unavoidable consequence, the finding of an anti-doping rule violation, without any possibility for the

hearing body to adopt a decision not imposing it, even in those exceptional cases where no sanction is inflicted, because the athlete bears “*No Fault or Negligence*”: as explained in the footnote to Article 9 of the WADC, “*when an athlete wins a gold medal with a prohibited substance in his or her system, that is held to be unfair to the other athletes in that competition, regardless of whether the gold medalist was at fault in any way; only a “clean” athlete is allowed to benefit from his or her competitive results*”. In other word, the automatic disqualification operates “*as a matter of fairness to all other athletes*”⁷;

- ii. in any case, as also noted by the FIS Doping Panel, the timeline set by Article 5.2.6.5 of the ISL expresses the intent of the rule that the laboratories should proceed without undue delay, especially when taking in consideration the wording of the provision (“*should*”) rather than, for example, “*must*”. In the case at hand, there is no evidence of any undue delay notwithstanding that the 10-day target had not been met and the delay did not render the laboratory analysis in any way suspect.
127. On the other hand, no issue arises with respect to the disqualification of all other competitive results, obtained by the Athlete from the date the Samples were collected through the commencement of any ineligibility period. The imposition of such consequence, pursuant to Article 10.8 of the both the FIS ADR 2014 and the FIS ADR 2015, was not requested by the Appellant. Therefore, all other competitive results, obtained by the Athlete from the date the Samples were collected through the commencement of any ineligibility period stand unaffected.

3.7 Conclusion

128. In light of the foregoing, the Panel holds that the appeal brought by WADA is to be upheld. The Decision is to be set aside and replaced by a decision (i) finding the Athlete responsible for an anti-doping rule violation and (ii) suspending the Athlete for a period of two months, starting on the date on which this CAS award is issued. The results obtained in Davos on 13 December 2014 and in Toblach on 8 January 2015 shall be disqualified. All other competitive results, obtained by the Athlete from the date the Samples were collected through the commencement of any ineligibility period shall not be disqualified.

⁷ See the award of 28 September 2000, CAS OG 00/011, § 27. Such conclusion was confirmed two years later by another CAS Panel in the award of 15 October 2002, CAS 2002/A/376, § 3.29, as follows: “*in order to ensure the integrity of results the mere presence of a prohibited substance requires disqualification*”. In the same way, in the award of 9 July 2001, CAS 2001/A/317, p. 17, it was underlined that “*it is ... perfectly proper for the rules of a sporting federation to establish that the results achieved by a ‘doped athlete’ at a competition during which he was under the influence of a prohibited substance must be cancelled irrespective of any guilt on the part of the athlete. This conclusion is the natural consequence of sporting fairness against the other competitors. The interests of the athlete concerned in not being punished without being guilty must give way to the fundamental principle of sport that all competitors must have equal chances*”.

ON THESE GROUNDS

The Court of Arbitration for Sport rules that:

1. The appeal filed on 12 October 2015 by the World Anti-Doping Agency (WADA) against the decision taken on 4 September 2015 by the Doping Panel of the Fédération Internationale de Ski (FIS) is upheld.
2. The decision taken on 4 September 2015 by the Doping Panel of the Fédération Internationale de Ski (FIS) is set aside.
3. Martin Johnsrud Sundby has violated Article 2.1 of the applicable FIS anti-doping rules and is sanctioned with a period of ineligibility of two months starting from the date of this award. The results obtained by Mr Martin Johnsrud Sundby on 13 December 2014 in Davos (SUI) and on 8 January 2015 in Toblach (ITA) are disqualified.
4. (...).
5. (...).
6. All other motions or prayers for relief are dismissed.