

RFL HEAD INJURIES & CONCUSSION POLICY

There are two types of head injury both of which are serious and potentially life threatening, they are **concussion** and **structural brain injuries**. Everyone in the game has a responsibility to understand head injuries and what action they should take.

CONCUSSION

What is Concussion?

Concussion may be caused either by a direct or indirect blow to the head, face, neck or elsewhere on the body which causes the brain to be shaken inside the skull.

Concussion usually leads to a temporary impairment of the brain's function. If concussion is not treated properly this can lead to permanent damage and in some cases can be fatal.

Concussion is more serious in children (under the age of 18) where the brain is still developing.

How is concussion identified?

It is difficult to recognise concussion and only trained medical staff should attempt to do so. Coaches and first aiders must assume that where a player has had a bang to the head that the player is concussed. In addition if the player shows any of the signs below concussion should be suspected (even if a head impact has not been seen) and the player removed from play for his own protection. Coaches and/or first aiders may also use the **Pocket CONCUSSION RECOGNITION TOOL** (attached or available from the RFL).

It is important to realise that a player does not need to be knocked out (lose consciousness) to have a concussion. Less than 15% of concussion cases involve a player being knocked out.

Any of the following may be signs of concussion:

The player:

- Doesn't know the venue, last scorer, opposing team or the score
- Shows signs of confusion, disorientation or is easily distracted
- Cannot remember things that happened before and/or after the injury
- Has a delayed response to verbal commands
- Is not playing as well as expected
- Has been (or may have been) knocked out
- Headache/localised pain
- A fit or convulsion (arms and legs jerking uncontrollably)
- Dizziness/light-headedness/dazed expression
- Unsteady on feet/loss of balance/uncoordinated movement
- A blank stare/glassy eyed
- Loss of vision, seeing double or blurred vision, seeing stars or flashing lights
- Ringing in the ears
- Nausea and/or vomiting
- Slurring of speech
- Poor concentration
- Strange or inappropriate emotions (laughing, crying, getting angry easily)
- Generally feeling unwell

Why is it important to diagnose Concussion?

Players who continue to play or return to play before they are recovered from concussion face significant risks:

- A second concussion including Second Impact Syndrome which is a rapid swelling of the brain usually resulting in death or at least severe brain damage
- An increased risk of other injuries (to self, teammates & opposition players) due to poor decision making or reduced reaction time
- Serious injury or death due to an unidentified structural brain injury such as bleeding on the brain or a fracture
- Potential increased risk of developing long term brain damage such as chronic traumatic encephalopathy (punch drunk)

What to do when Concussion is suspected?

If it is suspected that a player has a Concussion they must be removed from play straightaway. Continuing to play increases their risk of more severe, longer lasting concussion symptoms as well as increasing their risk of other injury:

- **Remove the player from play immediately**
- **Do not let them return to play that day**
- Don't leave them on their own
- Make sure they see a doctor or go to an A&E department
- Don't let them drive

It is also important that parents, friends and/or family are informed so that they can ensure that the player gets rest and that they aren't left on their own.

How is concussion treated?

The most important thing is for the player to get plenty of rest. This includes not just physical rest but also mental rest which includes avoiding computers, game consoles, reading etc. Once the player is completely symptom free and cleared to do so by a medical practitioner they can begin to take part in physical exercise again in a Graduated Return to Play (GRTP).

How soon can a player return to play after a concussion?

The majority of concussions resolve in a short (7-10 day) period although this may be longer in children and adolescents.

What is a Graduated Return to Play (GRTP)?

GRTP is a system of gradually increasing physical exercise when returning from concussion, checking that the player doesn't have any concussion symptoms after each stage.

The table sets out the timescales which are in force in Rugby League and shows the activity level appropriate at each stage of the GRTP.

Stage	Minimum Time post-concussion – Adult (child U19) {child U15}	Activity Level	Exercise at each stage of GRTP	Objective
1	+1 (+7) {+14} day(s)	No activity for 24 hours (adult) or 7 days (up to 19 year olds)	Symptom limited physical & mental rest	Recovery
2	+2 (+8) {+15} days	Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum predicted heart rate.	Increase heart rate
3	+3 (+9) {+16} days	Sport specific exercise	Running drills – no impact.	Add movement
4	+4 (+10) {+17} days	Non-contact training drills	More complex training drills eg passing drills. May start progressive resistance training.	Exercise, co-ordination and cognitive load.
5	+5 (+11) {+18} days	Full contact practice	Normal training activity	Restore confidence and coaching staff to assess functional skills
6	+6 (+12) {+19} days	Return to play	Normal training and/or match activity	Recovery complete

What can be done to prevent players getting concussed?

Concussion can't be prevented completely as it is often caused by a complete accident, however, coaches should ensure that their players are encouraged to play within the rules and that high tackles, dangerous throws, shoulder charges and spear tackles are not allowed within their team. Tackling technique is also important as players can be concussed by their head coming into contact with the ball carrier. It is important that the playing surface is not too hard (frost or drought) and that there are no dangerous structures such as unpadded posts or fences close to the pitch.

Should all players wear head guards?

The overwhelming view of international experts in sport-related head injury is that soft helmets do not prevent brain injury (as opposed to superficial head injury) and because of the phenomenon of 'risk compensation' there is a risk that encouraging helmet use in players may paradoxically increase the head injury rates. Because of this medical consensus, the RFL does not support the mandatory wearing of protective head guards in Rugby League.

STRUCTURAL BRAIN INJURIES

A player who has had a bang to the head may have structural brain injuries such as bleeding or swelling inside the brain, again these injuries may well be invisible but can be fatal.

If a player has any of the following symptoms they should be referred to a hospital immediately and must be accompanied by a responsible adult. If in doubt call an ambulance.

- A headache that is getting worse
- Vomiting or prolonged nausea
- Drowsiness or can't be woken or develops slow or noisy breathing
- Slurred speech or difficulty in speaking or understanding
- Abnormal behaviour/restlessness/irritability/aggression
- Weakness, numbness
- Decreases in coordination and/or balance
- Increased confusion
- Loss of consciousness
- A fit or convulsions (arms & legs jerking uncontrollably)
- Acutely painful/stiff neck which increases in severity
- Sensitivity to light and/or noise
- Blurred or double vision or pupils which vary in size
- Clear fluid coming out of ears or nose
- Deafness in one or both ears

Return to play in these cases must follow the medical advice given by the hospital.

THE RFL HEAD INJURY CARD

First aiders should complete the RFL Head Injury Card (attached and available to download on the RFL website) and make sure that a parent/guardian/relative/carer is given a copy.

RFL
February 2014