COMMUNITY GAME FIRST AID STANDARDS

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Disclaimer

This document contains general medical information, but this does not constitute medical advice and should not be relied on. Nor is this guidance a substitute for medical advice from a qualified medical practitioner or healthcare provider. You must not rely on this guidance as an alternative to seeking medical advice from a qualified medical practitioner or healthcare provider. If you have any questions or concerns about a particular medical matter, you should immediately consult a qualified medical practitioner or healthcare provider. If you think you may be suffering from a medical condition you should seek immediate medical attention. You should never delay seeking medical advice, disregard medical advice or discontinue medical treatment because of the information contained in this guidance.

1 RESPONSIBILITY FOR FIRST AID IN COMMUNITY CLUBS

Rugby League is a high-speed collision sport in which injuries to participants may occur. The Club and volunteers in roles of responsibility have a legal duty of care to ensure that appropriate health and safety and first aid standards are met. This includes adequately trained staff who can provide First Aid to players. In addition, clubs have legal obligations to ensure the safety of the public on their premises which also extends to ensuring the safety of volunteers. The Community Game First Aid Standards focus solely on First Aid for playing, training and related matters.

1.1 What is "Duty of Care"?

The duty rests upon an individual or organisation to ensure that all reasonable steps are taken to ensure the safety of any person involved in any activity for which that individual or organisation is responsible.

1.2 What are the Club's Responsibilities?

The Club (or other body) which runs club and team activities including the organisation of matches (which in practice usually means the Management Committee), is responsible for ensuring that it conducts all of the following steps:

Ensure a system is in place for ensuring that First Aiders (FA) have relevant qualifications and a system to record these qualifications, keep track of expiry dates and make sure that refresher training is undertaken.

- Complete a risk assessment to determine the appropriate level of first aid provision before any rugby league activity.
- Establishes a First Aid Emergency Action Plan (EAP) to cover all possible medical emergencies
- Ensure that any FA holds a valid qualification and keep up to date with refresher courses as recommended by the qualification body.
- Ensures that RFL policies relating to first aid provision, protocols and injuries are accessible to all and followed
- Ensures no volunteer acts beyond the scope of their qualification
- Makes sure that recording and reporting of incidents take place
- Ensures that suitable first aid facilities and equipment are available, in date and good working order
- Makes sure that FA, coaches and other volunteers comply with its risk assessment, Emergency Action Plan and RFL policies

1.3 What are the Volunteers' Responsibilities?

Volunteers have a responsibility to:

- Follow their club's risk assessment, EAP and procedures (refer to Appendix 1 & 2)
- Follow the relevant RFL policies
- Be aware of their Duty of Care to players and other volunteers

1.4 Risk Assessment

During any activity rugby-related or otherwise, the number and type of first aid personnel and facilities should be based on a risk assessment. This process is no different from other risk assessments carried out for Health and Safety purposes. Guidance on this is provided in Appendix 1.

In assessing the need, the club/organiser should consider the following:

- Rugby and non-rugby hazards and risks
- The club's and individual team's history (at each level of competition) of injuries and accidents, including any relevant research.

- The number of people involved (players and spectators)
- The needs of players at away matches
- The nature (adult/child/additional needs) and distribution of the players such as the size of the site or more than one site
- The remoteness and accessibility of the site from emergency medical services, including phone signal
- Use of shared facilities and first aid resources
- Facilities in use and any risk mitigations required to avoid increased risk of injury (e.g., corner flags, padding, 3G/4G pitches etc.)
- Holiday and other absences of first aid trained personnel.
- Additional requirements for special groups i.e. children, and disabled players.

1.5 Risk Management

Once the risk assessment is complete and the level of first aid cover has been decided additional risk management measures should be considered:

- A person (or group of people) with the appropriate qualifications to take day-to-day responsibility for First Aid. We encourage having multiple people in this role to ensure coverage in case of absence.
- Write a First Aid Emergency Action Plan
- Emergency procedures should be developed as part of the First Aid Emergency Action Plan and be readily available and shared with all staff (for further guidance on emergency procedures refer to Appendix 2).
- Emergency services contact details must be readily available.
- Ambulance access to the pitch/training ground must be maintained at all times.
- Establish contacts with the local NHS Ambulance Trust and Hospital Emergency Department. Maintain a good level of communication with them on the club's activities, especially festivals.
- Appropriate first aid facilities and equipment based on their risk assessment and level of training of personnel.
- Annual training of personnel who may be required to assist in emergencies.
- First aid equipment must be appropriately, stored, maintained, and cleaned.
- A First Aider must hold Safeguarding qualifications as set out within the RFL Safeguarding Policy. They must always adhere to the RFL Safeguarding Policy when delivering care to children and vulnerable adults.

2 FIRST AID PROVISION

2.1 Level of First Aid Provision

The level of First Aid provision at each club and event should be determined by the Risk Assessment process as set out above.

Please refer to the HSE link for information on the appropriate qualifications. https://www.hse.gov.uk/pubns/geis3.htm

However, as a minimum, the RFL states that each club should have:

- An Emergency FA qualified to relevant Emergency First Aid Course standard on duty at every game.

- and the RFL recommends that each club should have a Mental Health First Aider (see Section 8.7)

The FA must be appropriately trained persons and a list of all qualified FA should be registered on GameDay. NB It is the responsibility of each Club to check each FA hold valid qualifications and find alternative cover if this cannot be evidenced.

2.2 Qualifications

Clubs must always see confirmation that any person used to cover the First Aid role has the qualifications that they claim to hold and ensure that the qualification is still valid.

Clubs must see their certificate and make sure that they attend refresher courses as recommended by the awarding body. Holders of the Football Association/RFL Emergency First Aid Course should attend another course as a refresher every three years

For Allied Health Professionals and Health Care Professionals clubs should ask for their professional body registration and HCPC registration number which allows the club to check that they are qualified online. Clubs should also check the Health Care Professional is covered by their own medical indemnity insurance.

Please remember that it is known for individuals to masquerade as an FA or Health Care Professional – clubs must always check.

2.3 Relevant Courses

FA Emergency First Aid in Football
RFL Emergency First Aid
HSE EFAW Course
Equivalent Emergency First Aid course to the RFL Emergency First Aid course

First Aiders must have completed the relevant course which is HSE compliant, together with the completion of the concussion module on Our Learning Zone.

The RFL also have a sport-specific Emergency First Aid course which includes a section on managing head injuries. People can book the course by visiting the activfirst website https://www.activfirst.co.uk/product/rfl-firstaid/

2.4 First Aiders - Role Description

A First Aider holds a current First Aid certificate from a recognised awarding body (see above). A First Aider may be the person who writes the club's EAP.

2.5 First Aiders – Duties on Match Day

The FA should introduce themself to the team manager, venue officials (where relevant), match officials, opposing team's FA, coaches and players and make them aware of where the FA will be stationed during the match. They must:

- Take charge when someone is injured or ill, including calling an ambulance if required.
- Provide emergency first aid to the injured or ill person until more expert help arrives.
- Understand, apply, and disseminate education to participants, volunteers and parents on the RFL Concussion Rules.
- Look after the first aid equipment, e.g., restocking the box and removing and replacing expired items.

FA should not attempt to give first aid for which they have not been trained. Every team should have an Aider to help any injured or ill player until more expert help arrives. The FA should be located in an accessible location to the pitch, to allow immediate care during the match.

2.6 Allied Health Professional & Health Care Professional

Clubs may engage an Allied Health Professional (AHP) or Health Care Professional (HCP) in a voluntary or paid capacity to provide First Aid services in rugby league activities. Eligible professionals include Sports Therapists, Sports Rehabilitators, Paramedics, Nurses, Physiotherapists, Doctors, Osteopaths, and Chiropractors. These individuals must be:

1. **Certified** – They should be members of their relevant professional bodies.
2. **Insured** – They must have appropriate indemnity insurance, with confirmation that this coverage extends to providing First Aid in rugby league settings.
3. **Competent and Qualified** – They must hold a current First Aid qualification and only operate within the scope of their professional competencies.

2.7 Insurance and Liability

In a medical emergency, it is recommended to avoid any delay in lifesaving interventions that may arise on the grounds of concerns of 'being sued'. The Resuscitation Council UK said in August 2010 that *'Although there have been a few cases in the United Kingdom where a claim has been brought against a 'rescuer', there have been no reported cases where a victim has successfully sued someone who came to their aid in an emergency.'*

The RFL Public Liability policies extend to indemnify volunteers (except medical doctors where their medical indemnity must cover any care provided). As such volunteer FA will have protection under the policies.

2.8 Position on Match Days

An FA should be situated on or near the team benches. Other than to treat a casualty the FA should remain in situ until the match is complete.

2.9 DBS Disclosures

FA (or Health Care Professionals) who will work with Junior or Youth teams must always be subject to an enhanced Disclosure & Barring Service check through the RFL.

3.0 FIRST AID EMERGENCY ACTION PLAN AND RESPONSIBILITIES

3.1 Emergency Action Plan (EAP)

All Rugby League clubs should have a clear that outlines the actions and processes that need to be fulfilled in all medical emergency situations, this includes home and away matches and training sessions for each team within the club. It should consider all those involved, including players, coaches, officials, first aiders, volunteers, parents and spectators. It should provide a simple, safe and systematic approach to ensure that any emergencies can be dealt with quickly and efficiently. Clear plans can make a significant difference to the outcome of an emergency. Once an EAP has been created it must be communicated to all staff, volunteers and players within the organisation. It is best practice to share the EAP with your opponent on or ahead of the matchday.

The club must nominate who is responsible for developing, reviewing and sharing the EAP. A First Aider would be the usual choice to develop the EAP due to their training in medical emergencies. EAPs should be under annual review as a minimum review, and more frequently if there are any operational or venue changes. The responsible person must ensure they are familiar with the club's risk assessments to develop on this; the playing and training venues and other areas used at the club; and RFL policy and First Aid Standards.

The EAP must include:

People
- Who will be part of the emergency team for matches and training for each team
- Roles and responsibilities should be allocated within their competencies.
- Who and how will emergency services be contacted
- Who will meet and guide emergency services on arrival
- Who will contact players next of kin
- Who will travel with a player if they need to attend hospital
- How will a player attend hospital if an ambulance is not needed
- The contact details of all FA in the club.
- Who is the club safeguarding lead

Facility
- Address and postcode of call club facilities that may be used. It is best practice to include what3words for accurate locations.
- Ambulance access points.
- Plan for opening of gates and doors for all routes where access may be needed.
- Location of first aid room.

Local Services
- Nearest trauma A&E centre, minor injuries unit.

Equipment
- Location of first aid equipment and defibrillator (if available)
- How will equipment be checked for presence, working order, restocking and valid dates?
- Where are the nearest accessible phones
- Where is the medical information and next of kin details for players stores
- Easily accessible information cards for CPR step-by-step guidance for children and adults, choking, and other emergency treatments as an aide memoir

  https://www.resus.org.uk/sites/default/files/2021-04/Adult%20Basic%20Life%20Support%20Algorithm%202021.pdf

  https://www.resus.org.uk/sites/default/files/2021-04/Adult%20Choking%20Algorithm%202021.pdf

https://www.resus.org.uk/sites/default/files/2024-01/Paediatric%20Out%20of%20Hospital%20Basic%20Life%20Support%20Algorithm%202021%20Jan%202024%20V1.1.pdf

https://www.resus.org.uk/sites/default/files/2021-04/Paediatric%20Choking%20Algorithm%202021.pdf

- Location and distribution of EAPs
- Useful patient information leaflets for common medical problems such as concussion.

It is also recommended to develop notices referencing key information from the EAP that can be displayed in public places such as entrances, changing rooms and notice boards for ease of reference. It should also be provided to volunteers, visiting teams and FA and stored in first aid kits.

An example of an Emergency Action Plan is shown in Appendix 2.

3.2 **Medical Responsibilities Checklist**

The following is a list of the club and FA responsibilities which must be covered by the EAP or other procedures:

- Ensure all FA understand their responsibilities and are aware of how the club wishes them to behave on match days
- Maintaining the accident book and looking after completed accident reports
- Ensuring Club signage in relation to First Aid at the Club is visible to those unfamiliar with the site
- Distributing the Emergency Action Plan document to visiting teams
- Requesting the same information from visiting teams before playing away matches allocating a room for first aid treatment on match days
- Distribution of relevant processes and protocols from the RFL to the wider FA team from time to time
- Assess who will cover the FA role in the event of treatment being given to another player, with consideration to monitoring play
- Understanding that team FA will work together with opposition FA's and volunteers to assist in the treatment of a player, including listening to observations.
- Ensuring FA are aware not to act beyond their level of qualification and competence.
- Ensuring enough qualified FA role is always allocated for training days, home matches and away matches
- Defining the roles and responsibilities of the FA and make sure that they have the full support of the club for decisions that they choose to make.
- Ensuring that that all FA:

    - have attended a relevant first aid training course
    - are familiar with the RFL First Aid Standards including Concussion Rules and Protocols
    - are familiar with the contents of the first aid kits
    - always have their first aid kit with them that they are acting as a FA and have checked that it is fully stocked
    - can administer appropriate treatments to ill or injured casualties both on-pitch and off-pitch
    - understand that they have the authority to stop play if they deem it necessary
    - understand what actions need to be completed after an incident has taken place
    - wear a tabard to clearly identify themselves as the FA
    - introduce themselves to visiting teams (including Match Officials) as the duty FA and make sure that their contact number is entered into the necessary person's phone
    - will hold the contact details of next of kin, provided and stored in a GDPR compliant manner

4 FIRST AID EQUIPMENT & FACILITIES

4.1 First Aid Kit

A fully equipped first aid kit should be available for each FA. Kits should be clearly labelled and easily accessible. There should be at least one first aid kit for each team training and/or playing at any one time. Please note FA should only use those parts of a first aid kit for which they have received training.

Example content for first aid box:

- Minimum of 4 pairs of latex-free (nitrile) disposable gloves
- Hand sanitiser/alcohol gel
- Sterile, saline cleansing wipes
- Pocket mask (disposable resuscitation aid)
- Scissors
- Minimum of 5 sterile water sachets/pods
- Gauze pads/swabs
- Assorted adhesive sterile dressings and plasters
- Assorted non-adhesive sterile dressings
- Minimum of 2 sterile eye pads
- Adhesive dressing tape (to hold dressings in place or to hold the loose end of bandages)
- Minimum of 6 crêpe bandages in assorted sizes
- Minimum of 4 triangular bandages
- Yellow disposable clinical waste bags
- Material and foil blankets
- Umbrella
- Pen/notebook
- Torch / Flashlight
- EAP

Under no circumstances should over the counter or prescription drugs be administered by FA or kept in the first aid box.

4.2 Automated External Defibrillator (AED)

An Automated External Defibrillator (AED) can save lives. Clubs are strongly recommended to have one on site, ideally pitch side during matches and training. It should be checked regularly as part of the EAP to ensure it is in good working order and all elements including the battery and pads are in date. Where a club has access to an AED we recommend key personnel including FA know where it is stored and feel comfortable on how to use it. However, the UK Resuscitation Council state that an AED can be used safely and effectively without previous training and its use should not be restricted to trained rescuers. Training should however be encouraged to help improve the effectiveness of their use such as to minimise the time to shock and correct pad placement.

Clubs can get help in purchasing an AED through the Danny Jones Defib Fund https://www.dannyjonesdefibfund.co.uk/

4.3 First Aid Room

It is best practice for clubs to have a designated first aid room. This should be well signed. A first aid room should have a treatment bed for assessing injured or unwell persons, good lighting, hand washing facilities, washable surfaces and adequate heating and ventilation. The first aid room must be cleaned after use.

4.4 Ambulance Access

Wherever possible training and matches should take place on areas which have vehicular access so that an ambulance can drive onto the playing area. Where this is not possible it is important to work out how emergency services will be able to reach seriously injured players on the pitch and to make sure that everyone is aware of the route. Access plans should be incorporated into the EAP and included in notices at the Club.

4.5 Communication

It is important that the FA can call for an ambulance or other assistance immediately so a FA should have a fully charged mobile phone and check that there is a signal prior to matches and training. If the venue does not have mobile phone reception an alternative means of emergency communication must be accounted for such as landline in the club buildings.

4.6 Directions

It is vital that FA have details of the location of all used venues for club activity- including buildings and pitches. This should include as a minimum postcode and directions to the exact facility. It is best practice to use what3words for accurate location (https://what3words.com/). This information must be readily available to be provided to the ambulance service.

Where grounds have more than one access point it is essential that the correct information is given to the emergency services, and it is recommended to have a volunteer at the entrance to the ground to direct any emergency service vehicles on arrival.

5 RECORDS

5.1 Recording Injuries

It is Best Practice for the Club's FA to record all injuries they deal with and medical attention they provide. As a minimum should record:

- Date, time and place of incident
- Name (and age if under 18) of the injured or ill person
- Details of the injury – what happened, and the first aid given
- What happened to the person immediately after the incident e.g. continued playing, went to hospital, if they went home who with
- If under 18 names of parent or guardian responsible for the young person
- Name & signature

Please note the reporting of concussion is contained within RFL Head Injury Form in Appendix 8.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) requires individuals who control or manage premises to report and record certain injuries. Further information can he be found HERE on the HSE website. Use of the accident book required under the Health & Safety at Work Regulations is recommended. Alternatively, find a template provided by the RFL in Appendix 3 for recording incidents. This information should be provided to the Club Management Committee regularly to inform its risk assessment and risk management processes.

5.2 Information about Players

All players should complete a medical and consent to participation form. For those under 18 this should be signed by their parent or legal guardian and include the right to act *in loco parentis* in the event of an incident where parents of those players who are under 18 are not present or cannot be contacted in time. This should seek to gain confirmation that there are no known reasons the player would be unsafe to participate in rugby related activity, emergency contact details. Where a player has a medical condition that may impact rugby related activity it is good practice to ask for any further information. This may include names and location of medications e.g., inhalers and when they might be needed, or a letter from a medical practitioner confirming it is safe to participate where relevant.

Medical and Content Form - An example template can be found HERE

5.3 Reporting Death or Serious Injury

When a player has died or has been admitted to hospital for a serious medical condition or injury sustained during - rugby-related activity the RFL should be notified immediately using the emergency number provided below so adequate support can be provided. This does not apply if a person is simply attending A&E and they are subsequently discharged.

Head of Delivery Community Game Competitions - Kelly Barrett 07739 819750

Please provide the following information:

Name of the player
Contact details for player / next of kin.
Injury/condition and prognosis.

The RFL will:

- Inform the Benevolent Fund who will provide moral and financial support to the player and their family
- Handle any enquiries from the media
- Inform the RFL's insurance brokers where relevant

5.4 Witness statements.

Following incidents where a compliance issue or potential insurance or personal injury claim may arise, clubs are advised to retain on file witness statements for 7 years and in line with the UK General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA). These statements must confine themselves to the facts and not include opinion or hearsay or apportion or infer blame. They must be signed and dated by the person making them, or the responsible parent/guardian for those under 18s.

6 MANAGING HEAD INJURIES & CONCUSSION IN RUGBY LEAGUE

All head injuries are serious and potentially life-threatening. If a head injury is not treated properly this may lead to persistent symptoms, time from work or school, and in some cases can be fatal. All head injuries are not concussion and traumatic injuries to the brain can be divided crudely into the following categories:

- Structural brain injuries- for example brain tissue damage and bleeding within the skull.
- Concussion -impairment in the way the brain acts and functions on a chemical level, but no identifiable structural damage on hospital brain scans

Everyone in the game has a responsibility to understand what can cause head injuries and how they should be managed safely.

It is mandated for every FA working in rugby league to undertake the Concussion in Sport Module alongside their First Aid HSE qualification.

The FA must be aware of the signs and symptoms of and effective management of potential concussion and structural brain injuries. At all levels in all sports, if an individual is suspected of having a concussion, they must be immediately removed from play. Caution must be applied where any sign or symptom may be present, and players must be removed and remain off the field of play.

IF IN DOUBT SIT THEM OUT!

It is not the role or responsibility of any volunteer, coach, or FA to diagnose concussion/. There is no 'Head Injury Assessment' process in the community game. It is the roles of club associated staff to recognise possible signs and symptoms of concussion and brain injuries and to act in an appropriate and safe manner by prioritising removal from the field and appropriate medical assessment by a trained professional.

6.1 Red Flags of Structural Brain Injuries

Any player who suffers head injury may develop a structural traumatic injury to the brain, this includes bleeding, swelling and damage to brain tissue. These injuries can be life altering or fatal.

It can be challenging to tell the difference between concussion and structural brain injury as many of the signs and symptoms overlap, which is another reason it is very important that all players with signs of injury to the brain seek medical attention as outlined below.

If a player has one or more of the following **red flag** signs or symptoms after a head injury or they should have an urgent medical assessment in a hospital Accident and Emergency (A&E) Department using emergency ambulance (999) transfer if necessary:

They must be accompanied by a responsible adult, and they should not personally drive under any circumstances.

- Previous history of brain surgery or bleeding disorder
- Current 'blood-thinning' therapy
- Current drug or alcohol intoxication
-

Symptoms may include the following.

- Any loss of consciousness because of the injury
- Deteriorating consciousness- becoming more drowsy
- Develops slow or noisy breathing
- Problems with memory, before or after the event.
- Confusion following the injury
- Unusual behaviour such as restlessness, irritability, aggression
- Any changes in neurological function
    - Difficulty with understanding speaking, writing, reading

- Decreased sensation in part of the body
- Weakness in part of the body
- Poor balance or coordination
- Double or blurry vision

- Seizure/convulsion or limb twitching or lying rigid/ motionless due to muscle spasm
- Severe or increasing headache
- Repeated vomiting
- Severe neck pain
- Suspicion of a skull fracture: cut, bruise, swelling, depression, severe pain
- Clear runny fluid coming out of ears or nose after injury
- Deafness in one or both ears after injury
- Symmetrical bleeding around both eyes, or behind the ear

Anyone with any of the above symptoms must only return to exercise and sporting activity under the direction of a medical doctor.

6.2 Concussion

6.2.1 What is Concussion?

Concussion is an injury to the brain resulting in a temporary disturbance to brain function- it affects the way a person thinks, feels and remembers. It may be caused either by an impact to the head, which maybe a direct (e.g., head clash, high tackle or head to ground) or indirect transfer of force to the head (such as to the neck or elsewhere on the body e.g., late hit on the passers body which they weren't expecting causing a whiplash like effect). This causes the brain to be shaken inside the skull.

Signs and symptoms of a concussion can be apparent immediately, or they can take some time to develop over the next few days- called an evolving injury. Not all concussions are the same for each person, or each concussion for the same person. Being knocked out (loss of consciousness) happens in less than 1 in 10 concussions. FA and coaches must be aware of the potential for a delayed onset of concussion this and continue to consider this during training and/or matches even if an obvious mechanism isn't present.

A history of previous concussion may make someone more like to have another concussion that takes longer to recover. Repetitive head injuries may result in changes to a player's mental health and longer-term functional impairment of the brain. Players experiencing a second concussion within a short time frame of a first could cause rapid swelling of the brain 'Second Impact Syndrome'. This can result in death or severe brain damage. Just a single concussion and make someone more like to have another sport related injury for a year after.

Concussion is more serious in children and young people where the brain is still developing. Children are more susceptible to having concussion, having complicated returns from concussion and rare neurological complications.

There is no reliable test for concussion and there is no head injury assessment process in the community game, therefore if any possible signs/symptoms of concussion are seen or reported, safety is paramount, and the player MUST be removed from all activity immediately. Continuing to play when concussed while the brain isn't functioning normally can lead to poor decision making which puts the player, teammates and opposite at risk of increased injury from reckless actions, or slow reaction times, as well as further injury.

6.2.2 Roles and responsibilities

It is encouraged that both Team's bench staff work together, ask questions on what they have observed and share information for the wellbeing of all participants, alongside Match Officials. If there is concern regarding a player and suspected concussion, this must be raised with the First Aider or Coach of the opposing side and Match Official(s).

First Aiders, Coaches, Teachers and Volunteers

Be aware of the signs of symptoms of concussion and if in doubt – sit them out!

- Be cautious in your approach. If in doubt – sit them out!
- Welfare over competition, always.
- Be aware of the signs of symptoms of concussion.
- Safely remove any individual from the field of play if you see any possible signs of concussion, or they report any possible symptoms.
- Ensure no one returns to activity or play even if they say that their symptoms have resolved, or they disagree with your decision.
- Listen to those around you and act on reliable information.
- Do not act beyond the scope of your qualification.
- Monitor the player or assign a responsible adult to monitor the individual once the player is removed.
- If player is under 18 years old, contact parent/guardian to inform them of the possible concussion.
- Provide written information regarding concussion, its management and red flags to watch out for. Such as a copy of RFL Head Injury advice sheet and passport provided by the Club
- Arrange for the player to get home safely. They should not drive themselves home or ride a bike.
- Arrange for a responsible adult to supervise the player over the next 24-48 hours.
- Advise anyone with a suspected concussion to be assessed by an appropriate healthcare professional, such as 111 or other NHS services.
- Ensure any relevant injury report form is completed and stored by the club/school/organisation.
- Follow a graduated return to activity (education/work) and sport programme with an emphasis on initial relative rest and returning to education/work before returning to training for sport.

Match Officials

- Be aware of the signs of symptoms of concussion.
- You stop the match if you witness possible signs of concussion, or a player reports them to you
- Inform the First Aider of your observations including any mechanism which may have caused the suspected concussion and anything you have seen or heard that raised your concern.
- If you are clear and confident that you have observed a **suspected** concussion, ask for the Player to be removed from the field and do not allow play to continue should the player not leave the field or attempts to return.
- Report the matter on your Match Report, upload HeadCam footage if available.

Parents & Carers

- Be aware of the signs of symptoms of concussion.
- Arrange for a responsible adult to supervise the player over the next 24-48 hours to monitor for worsening signs and symptoms of head injury. Do not leave your child alone for the first 24 hours.
- Ensure anyone with a suspected concussion to be assessed by an appropriate healthcare professional, such as 111 or other NHS services. Ensuring full details of the incident are relayed to the medical professional.
- Encourage initial rest/sleep as needed and limit smartphone/ computer and screen use for the first 24-48 hours.
- Inform school/work/other sports clubs of the suspected concussion to avoid activity that would impair recovery and risk worse injury.
- Follow a graduated return to activity (education/work) as the priority, and alongside this but not before a return to sport.

Players

- Be aware of the signs of symptoms of concussion.
- Be honest with how you feel and report any symptoms of possible concussion immediately to your coach, medic and/or parent.

- Stop playing/training immediately if you experience any possible symptoms of concussion.
- Be aware that delays in reporting symptoms of concussion are associated with a risk of delayed or incomplete recovery of the brain.
- Be aware than longer recovery can led to a delayed return to school and work, which could have financial consequences.
- If you have continuing symptoms, do not return to training or sport activities until evaluated by an appropriate Healthcare Professional.
- Inform your school/work/sports clubs of your concussion
- Follow the graduated return to activity (education/work) and sport programme.
- During training and matches always watch out for teammates and encourage them to be honest and report any concussion symptoms.
- If you think another player may have signs or symptoms of possible concussion, report this to the coach, match official or FA.

6.2.3 Recognising Concussion

Concussion is a challenging medical condition to diagnose, formally diagnosing concussion should be left to trained specialists only - this is not the role of the responsibility of the first aider or coach.

The responsibility of the first aider and the coach is:

1. Be aware of the signs and symptoms of concussion
2. **Remove** the player from training or a match **immediately** if there are **possible** signs of concussion- you do not need to be sure there is a concussion**, if in doubt sit them out.**
3. **Do not let them return** to the match/training session – even if they or a parent says they are fine.
4. Respect the decisions of Match Officials who are also trained to recognise the signs and symptoms of a potential concussion. They may insist a player leaves the field and does not return.
5. Ensure anyone with a suspected concussion to be assessed by an appropriate healthcare professional, such as 111 or other NHS services.
6. Ensure the player follows the Graduated Return to Activity and Play unless a health care professional has advised they are not concussed.
7. Do not apply any pressure to the player or parent to return sooner that is appropriate either within the Graduated Return to Activity and Play timelines, or as symptoms dictate.

Not every concussion is easy to see. Less than 1 in 10 concussions result in a person losing consciousness. Symptoms should not be ignored as they may be the only indication of injury to the brain.

Concussions can affect people in 4 main ways: physical, mental processing, mood and sleep.

Signs of concussion – What you see

Any one or more of the following visible clues can indicate a concussion:

- Loss of consciousness or responsiveness
- Lying motionless on ground/slow to get up
- Unsteady on feet/balance problems or falling over/ incoordination
- Dazed, blank or vacant look
- Slow to respond to questions
- Confused/not aware of plays or events
- Grabbing/clutching of head
- An impact seizure/convulsion

- Tonic posturing – lying rigid/ motionless due to muscle spasm (may appear to be unconscious)
- More emotional/irritable than normal for that person
- Vomiting

Symptoms of concussion at or shortly after injury

What you might be told and what you should ask about
Presence of any one or more of the following signs & symptoms may suggest a concussion:

- Disoriented (not aware of their surroundings e.g. opponent, period, score)
- Headache
- Dizziness/feeling off-balance
- Mental clouding, confusion or feeling slowed down
- Drowsiness/feeling like 'in a fog'/ difficulty concentrating
- Visual problems
- Nausea
- Fatigue
- 'Pressure in head'
- Sensitivity to light or sound
- More emotional
- Don't feel right
- Concerns expressed by parent, official, spectators about a player

FA must always consider the possibility of structural brain injuries and concussion as sometimes they can look the same initially. This is why monitoring of players is important for the initial 24-48 hours. Coaches and/or FA may also use the Concussion Recognition Tool 6 (CRT6) to help support them in identifying potential concussion.

6.2.4 Remove

Where a player is observed to have a mechanism consistent with possible concussion, such as a head impact or indirect contact with a big whiplash effect, the player must be checked and continued to be monitored to make sure they aren't feeling any symptoms even if none were seen.

If any possible signs and/or symptoms are observed, the player must be removed from the field immediately and must not return to activity unless cleared by a health care professional such as 111. Importantly, if a player reports or demonstrates any of the features above related to concussion but a clear head impact has not been seen, the player must be removed from play for their own protection as a precaution, this would be enough to be considered doubt to sit them out. It is very possible the injury event can be missed in a dynamic game of rugby league, and we must not assume to have seen everything.

IF IN DOUBT SIT THEM OUT!

Sometimes head injuries and neck injuries can occur together, if there is a neck injury suspected, or the player doesn't have a normal level of consciousness, they should only be moved by trained health care professionals. This may mean waiting in place where the injury occurred for an ambulance.

Anyone with a suspected concussion should:

- Be removed from play immediately.
- Be honest with how you feel and report any symptoms of possible concussion immediately to your coach, medic and/or parent.
- Get assessed by an appropriate Healthcare Professional within 24 hours of the incident – even if the symptoms may have resolved. Such as calling 111, or other NHS service.
- Rest & sleep as needed for the first 24-48 hours – this is good for recovery. Easy activities of daily living and walking are also acceptable.
- Minimise smartphone, screen and computer use for at least the first 48 hours. Limiting screentime has been shown to improve recovery
- Avoid stressful situations as can make symptoms worse

Anyone with a suspected concussion should not:

- Be left alone in the first 24 hours.
- Consume alcohol in the first 24hours or if symptoms persist.
- Drive a motor vehicle within the first 24 hours. Commercial drivers (HGV etc.) should seek review by an appropriate Healthcare Professional before driving
- Consume alcohol in the first 24 hours and/or if symptoms persist as this can worsening any underlying unidentified structural brain or concussion.
- Take medication which may mask or minimise the symptoms of concussion unless directed to do so by a Health Care Professional
- Return to play that day or in timeframes sooner than following the Graduated Return to Activity and Sport process

All players who have been suspected to have experienced a concussion must seek medical support from 111 or other NHS service within 24 hours of injury. This is to provide a diagnosis of concussion, given best and safe medical advice by a trained professional, and guided through an appropriate recovery. It is possible that following this assessment a person may be told they do not have a concussion. **If a First Aider, Coach, Club Welfare Officer or any other volunteer has confidently observed signs or symptoms of suspected concussion, despite the NHS service saying a concussion wasn't present the Club should take a safe and cautious approach to instruct the player through full Graduated Return to Activity and Sport. If there was no reason to doubt the decision by the NHS assessment, then return to sport can be permitted without a Graduated process.**

6.2.5 RECOVERY

The graduated return to activity (education/work) and sport programme (Sport Recreation Alliance, 2024)

Generally, a short period of relative rest (24-48 hours) followed by a gradual stepwise return to normal life and then subsequently sport is the cornerstone of concussion management. In the first 24-48 hours, it is ok to perform mental activities like reading, and activities of daily living as well as walking.

After initial assessment and confirmation of concussion by calling 111 or other NHS service, the graduated return to activity (education/work) and sport programme typically can be self-managed, although severe or prolonged symptoms (over 28 days) should be under the supervision of an appropriate Healthcare Professional and management will depend on the severity of symptoms and the types of symptoms and difficulties that are present. This varies from person to person and is not a 'one size fits all' process.

After a 24–48-hour period of relative rest, a staged return to normal life (education/work) and sport at a rate that does not exacerbate existing symptoms, more than mildly, or produce new symptoms is the main aim. **This is before return to sport is contemplated**. It is acceptable to allow students to return to school or work activities, and subsequently school or work part-time (e.g. half-days or with scheduled breaks), even if symptoms are still present, if symptoms are not severe or significantly worsened. The final stage of return

to school or work activity is when the individual is back to full preinjury mental activity, and this should occur before return to unrestricted sport is contemplated.

Similar to the return to education/work progression, the return to sport progression can occur at a rate that does not, more than mildly, exacerbate existing symptoms or produce new symptoms. It is acceptable to begin light aerobic activity (e.g. walking, light jogging, riding a stationary bike etc.), even if symptoms are still present, provided they are stable and are not getting worse and the activity is stopped for more than mild symptom exacerbation. Symptom exacerbations are typically brief (several minutes to a few hours) and the activity can be resumed once the symptom exacerbation has subsided.
Although symptoms may resolve quickly following a concussion, it takes longer for the brain to recover. The aim is to rehabilitate the person and give the brain time to recover.

Concussion Recovery Time

Concussion recovery time varies. Most symptoms of a concussion resolve by two to four weeks, but some can take longer. Everyone is unique in their recovery duration which is why completion of a graduated return to activity (education/work) and sport programme is important to reduce the risks of a slow recovery, further brain injury, and longer-term problems.

Children and adolescents may take longer to recover than adults. If symptoms persist for more than 28 days, individuals need to be assessed by an appropriate Healthcare Professional – typically their GP.

Please note that headaches can persist for several months or more, well after the acute injury from the concussion has resolved. They may resemble migraine and may be associated with nausea and sensitivity to light and/or sound. Sometimes they are from a neck injury. Persisting symptoms are not usually due to a more severe brain injury and, if the headache is not increased by mental or physical activity and the frequency and intensity is managed adequately, it should not preclude an individual from returning to school, work and physical activity.

There must be no pressure applied to players, parents, coaches or other volunteers to return a player early from a concussion and/or advise them to mask symptoms. This is serious misconduct.

The RFL recommends where a player has suffered two concussions within a 12-month period that the player is referred to a specialist prior to returned to contact sports participation.

6.2.6 Return

Graduated Return to Activity (education/work) and sport

The graduated return to activity (education/work) and sport programme is designed to safely allow a return to education, work and sport after concussion for the overwhelming majority of people who will not benefit from individualised management of their recovery. Where a Community Player is on a Scholarship, Academy or Dual Registration program their Return to Sport must be managed by their Professional Club who have professionals experienced in sports concussion management who take responsibility for an individualised, structured, multimodal, multidisciplinary management plan to include medical, psychological, cognitive, vestibular and musculoskeletal components. Athletes who are managed in such Enhanced Care pathways may be formally cleared for an earlier return to competition only by their Professional Club.

Generally, a short period of relative rest (first 24-48 hours) followed by a gradual stepwise return to normal life (education, work, low-level exercise), then subsequently to sport is safe and effective.

Progression through the stages below is dependent upon the activity not more than mildly exacerbating symptoms. Medical advice from the NHS via 111 should be sought if

symptoms deteriorate or do not improve by 14 days after the injury. Those with symptoms after 28 days should seek medical advice via their GP.

Participating in light physical activity is beneficial and has been shown to have a positive effect on recovery after the initial period of relative rest. The focus should be on returning to normal daily activities of education and work in advance of unrestricted sporting activities.

If symptoms continue beyond 28 days remain out of sport and seek medical advice from a GP.

The instructions and timelines apply to all Rugby League Players and are not age-specific. Extra care and caution must be taken with players with physical disabilities.

None of the timelines listed are not a target but a minimum timeframe, all recoveries must be led by the individuals' symptoms. The timelines are; however, a minimum and players must not progress through faster than the timeframes at each stage set out.

GRTP Tables

The instructions and timelines apply to all Rugby League Players and are not age-specific. Extra care and caution must be taken with players with physical disabilities.

Please note that if a First Aider, Coach, CWO or any other volunteer has observed signs or symptoms of a suspected concussion, despite the information from an HCP/111 the Club should enforce a cautious approach and instruct the player to follow a full GRTP for the wellbeing of the player.

None of the timelines listed are a target/maximum, all recoveries must be led by the individual's symptoms. The timelines are; however, a minimum and players must not progress through faster than the timeframes at each stage set out.

Please note where a Community Player is on Scholarship, Academy or Dual Registration their GRTP must be managed by their Professional Club who have HCPs who monitor the player's progress and provide a high level of care to the players. GRTP information may be shared with the Community Club to assist with progress and avoid players returning to activity too early – with written consent from the player or their parents.

RETURN TO SPORT	Day zero Day of injury	Stage 1 Rest	Stage 2 nts Increase exercise	Stage 3 Light aerobic exercise	Stage 4 Non-Contact training	Stage 5 Contact training	Stage 6 Return to competition
Timeframe	**Day zero**	**Days 1 – 2 following injury minimum**	**Day 3 – Day 7 Between Stages 2 – 3 - Each stage must take a minimum of 24 hours. Player cannot progress to Stage 4 before day 8.**		**Day 8 – 14 minimum**	**Day 15 – 21 minimum**	**Day 21 minimum (remember the day of injury is day 0)**
Permitted exercise	None – recognise and remove from play	• Sleep and rest. • Gentle everyday activity (such as walking) for no more than 15 minutes at a time. • Minimise screen time	• Increase activities such as short walks • Chores at home • Moving about the house	• Light jogs • Swimming • stationary cycling or equivalent. • No rugby • No resistance training, weightlifting, jumping or hard running.	• No activity where increased risk of head impacts or head injury • Intensity of exercise and resistance training can be increased • Simple movement activities (e.g. kicking, running drills) • Limited body and head movement • Increase drills which encourage return to contact, without any contact.	• Normal training activities (including tackle shield work, wrestle etc) • Gradual increase in difficulty in opposed sessions. • Introduction to participation in drills which encourages decision making. • Check player is using good technique.	• Player can now play in matches
			Progressing too quickly through stages 3 - 5 whilst symptoms are significantly worsened by exercise may slow recovery. Although headaches are the most common symptom following concussion and may persist for several months, exercise should be limited to that which does not more than mildly exacerbate them.				
Duration	N/A	15 minute timeframe max	15 minute timeframes max	Increased from 15 mins in 15 minute segments, to 45 minutes timeframe max	Increase to max 60 minutes timeframe	Contact training should only make up max 30 mins	N/A
Objective	Rest	Rest and Recover	Increase in daily activity	Increase heart rate	Co-ordination and skills/tactics alongside increased intensity of exercise	Restore players confidence and assess functional skills by coaches	Return to play
Remember!	• There is no HIA in the Community Game • Remove the player as	• Call 111 and be alert to worsening symptoms • A person with suspected concussion	• If this Stage is commenced and symptoms get worse, rest and only resume once they have subsided, ideally until the following day.	• Stage 3 can only commence once symptoms are no more than mild and are not getting worse.	• If symptoms more than mildly increase, or new symptoms appear, cease activity and	• **Player must be symptom free for 14 days prior to progressing to this stage**	• This stage can only be reached where there are NO SYMPTOMS PRESENT AT REST in the last 14 days recovery.

	quickly as possible • Monitor them for signs of worsening conditions which may indicate Red Flags which require 999 • DO NOT allow them to return to play	shouldn't be left alone in the first 24 hours. • Don't drive or drink alcohol		• If this Stage is commenced and symptoms get worse, rest and only resume once they have subsided.	rest briefly until they subside • Resume at a reduced level of exercise intensity until able to tolerate it without more than mild symptoms occurring.	• If resumption of contact training results in concussive symptoms the player must be removed from training.	• The player must be symptom free during contact training at stage 5.
ANY PLAYER WHO EXPERIENCES SYMPTOMS BEYOND 28 DAYS MUST SEE A GP WHO MAY REFER TO A SPECIALIST. <u>THEY MUST REMAIN OUT OF SPORT.</u> <u>REMEMBER</u> these timeframes are a minimum and not a target for the fastest return to play.							
RETURN TO ACTIVITY	**Day zero**	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	
	Rest	Relative Rest Period	Return to normal daily activities outside of school or work.	Increasing tolerance for thinking activities	Return to study and work	Return to full academic or work-related activity	
Permitted activity	• Rest	• Any mental activity should be limited to 15 minutes maximum at a time • Screentime to be kept to an absolute minimum	• Increase in mental activity such as reading. • Introduce school and work activity at home gradually • Limit screen time • Activity can be increased gradually provided it does not more than mildly increase symptoms	• Once normal level of daily activities can be tolerated then explore adding in some home-based school or work-related activity, such as homework, longer periods of reading or paperwork in 20 to 30-minute blocks with a brief rest after each block. • Discuss with school or employer about returning part-time, breaks, doing limited hours etc each week from home	• May need to consider a part-time return to school or reduced activities in the workplace (e.g. half-days, breaks, avoiding hard physical work, avoiding complicated study).	Return to full activity and catch up on any missed work.	

6.2.7 Concussion Prevention

It is important to minimise the risk of exposure of players to concussion and incidents where the head moves at speed, causing potential injury to the brain to reduce potential risk of longer-term poor brain function. In a collision sport the risk cannot be completely eliminated therefore it is important players and coaches are aware of how they can optimise the safety of those playing rugby league.

Laws
The rules of rugby league are designed with safety in mind, therefore safe tackle technique is important for the ball carrier and tackler. Encouragement to play within the rules, creating a culture where high tackles, dangerous throws, shoulder charges and spear tackles are discouraged.

Training
Minimising amount of unnecessary contact training players are exposed to, beyond what is needed for safe and effective performance. Importantly, being aware of the activity participants engage in aware from rugby league, with special consideration to participants who play multiple sports such as Rugby Union, both in respect to how much contact training they may be exposed to, but also the greater opportunity for injury. Meanwhile, tackle technique is an important focus. Most concussion in rugby league occur during the tackle event, to the tackler, and most commonly due to contact with their (and their opponents) head. Encouraging contact to the safe zone below the shoulders and above the waist would help minimise concussion risk.

Playing surface
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.

Head guards
The RFL is aware of ongoing research into head guard technology and its potential to reduce the risk of concussion, however, at the current time the overwhelming view of international experts in sport-related head injury is that soft helmets do not prevent brain injury. There is some suggestion they may paradoxically increase the head injury rates due to a change in player behaviour thinking they are safer. Because of this medical consensus, the RFL does not support the mandatory wearing of protective head guards in Rugby League. Head guards however can reduce the risk to superficial head injury such as cuts to the skin and scalp.

Sharing information
It is Best Practice to check before each match and training session with Players and Parents that they are well and have not suffered any concussions in or suspected concussions in general day-to-day life or other sport – before their participation.

Sharing information following a concussion is important to protect players' brains to avoid someone with a recent concussion being involved in inappropriate activities in school or professional club.

6.3 REPORTING CONCUSSIONS

In the Community Game Concussion Survey, 43% of players reported they did not disclose symptoms of concussion as they did not want to miss a match or let the team down. It is the Club's responsibility to provide and maintain an environment where players feel comfortable in reporting concussions and not be unduly pressured to return before they are fully recovered and a Graduated return to activity (education/work) and sport completed.

Concussions must be reported to the RFL within 48 hours of the injury, by the Club Volunteer set out in their EAP, in the manner prescribed by the RFL.

6.4 CONCERNS ABOUT CONCUSSION MANAGEMENT?

The RFL welcome and encourages reporting on concussion management and takes the matter seriously.

If a player, coach, FA, volunteer or parent is worried about concussion management either at their club or at another this concern should be raised with club officials or match officials

at the time if they feel comfortable to do so. Concerns must also be reported to the RFL Community Game Delivery Department at competitions@rfl.co.uk. Also, report any concerns regarding under-18s or vulnerable adults to safeguarding@rfl.co.uk.

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Please provide as much information as possible to allow thorough investigation at the time of reporting, and you may be contacted by an RFL representative for more details.

7 HYGIENE AND INFECTION CONTROL

7.1 Rugby league is a close-contact sport, where there is a risk of passing on infections from person to person. Having good infection control practices and following the guidance below will reduce this risk for all.

Good hygiene practices, by Clubs and individuals, will be essential in stopping the spread of infectious diseases. Infectious diseases are commonly spread through the air (coughs, sneezes etc), through bodily fluids (blood, saliva, mucus etc.), direct contact with infected surfaces (skin-to-skin contact or shared equipment) or through contaminated water and food.

The below lists considerations of maintaining good hygiene and infection control in line with the information from Hygiene for sport and physical activity | Sport England.

- Encourage all to undertake good personal hygiene at home and within Rugby League.
- Ensure clean hands, washing hands for 20 seconds with antibacterial soap. Avoid touching your face.
- Cover coughs and sneezes, dispose of tissues in the bin and wash hands after.
- Clean surfaces and equipment regularly with disinfectant wipes or a disinfectant solution.
- Clean and cover any wounds and change soiled clothing
- Avoid equipment sharing and touching personal equipment of others, particularly water bottles and towels
- If individuals are unwell, they should stay at home until symptoms have resolved. If the individual has attended their GP because of their symptoms, the GP advice should be followed.
- Correct use and disposal of PPE by FA
- Encourage all members at the Club to stay up to date with screening and vaccination programmes and promote positive hygiene messages for example with posters.

7.2 BLOOD BOARD DISEASE (BBD) GUIDELINES - MATCHES & TRAINING

Although contact with blood is a possible occurrence whilst playing rugby league, it is important this is minimised by adhering to the BBD protocols. There are several infections that can be passed through bodily fluids, including blood. The most common in the UK are Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus (HIV). These will be referred to as Blood Borne Diseases. As these infections can be passed on from contact with the blood and bodily fluids of an infected person or carrier, there is a very small risk of these being transmitted during contact sport such as rugby league if present. It is possible to be immunised against Hepatitis B to reduce the risk of infection, but not Hepatitis C or HIV. The RFL recommends that Players, Match Officials and Volunteers who may come into contact with blood through their role are vaccinated against Hepatitis B, which is initially a three-vaccine course with 5 yearly boosters. Advice should be sought from the individual's GP or Sexual Health Clinic. It is also available to purchase through travel clinics.

7.3 BLOOD BORNE INFECTIOUS DISEASES - RULES

This is a synopsis of the most relevant regulations; the full Rules are available on the RFL website.

The RFL has adopted these Blood Borne Diseases (BBD) Rules ("the Rules") to protect the rights and the health and safety of all participants in the sport.

These Rules shall only apply to BBD (including HIV and Hepatitis B and C) and shall apply to all Participants.

A Participant who becomes aware that they have been diagnosed as having contracted and/or have contracted a blood borne disease shall notify the Blood Borne Diseases Officer (BBDO) currently RFL Head of Medical and Integrity at medical@rfl.co.uk, of their medical status as soon as possible.

Where any Club Official is advised that a Participant has contracted a BBD, they shall notify the BBDO of this as soon as possible. When the BBDO is informed that a Participant is suffering from a BBD, the BBDO shall issue a Provisional Suspension preventing participation in the game until the matter has been investigated.

In that case a BBD Tribunal will carry out a risk assessment as to whether or not the Participant should be permitted to participate in the sport having regard to the need to protect the rights and the health and safety of other participants in the sport. Until the Blood Borne Disease Tribunal has issued its decision the Provisional Suspension shall continue.

The Participant may have a review of the decision or appeal depending on the circumstances.

It is the responsibility of each Participant to:

- be as fully aware of their medical condition as is reasonable in all the circumstances
- ensure that they protect the rights and the health and safety of other participants in the sport.

Any Participant agrees to:

- be bound by and abide strictly by these Rules.
- provide all requested assistance to the RFL in the application and enforcement of these Rules.
- waive medical confidentiality only in so far as it is necessary to apply and enforce these Rules
- the processing of data, including sensitive and personal data, pursuant to the Data Protection Act 1998
- make him/herself available to undergo any necessary medical examination and or non-invasive test, including blood test, or sample collection, including blood sample collection.
- submit to the jurisdiction of the BBD Tribunal and/or Appeal Tribunal.

7.3.1 **Wounds and Bleeding Injuries**

Players must report all bleeding wounds and are responsible for wearing appropriate protective bandaging or strapping to prevent blood contamination of other players or volunteers when wounds occur.

If a player suffers a cut at training or during a match, the player must leave the field straightaway and blood bin procedures will apply

7.3.2 **Blood Bin Procedure**

The following procedure will apply in all cases where a Player is bleeding on their person, clothing or if equipment has been contaminated by blood:

- If the Referee notices a bleeding or blood contaminated Player the Referee will immediately stop play and signal to the FA attend to the Player.
- The FA will immediately enter the field of play to assess whether the Player can be quickly treated on the field or whether the Player will require treatment off the field.
- If the FA advises that the Player can be treated on the field, the Referee will instruct the player to drop out behind play for that purpose and the match will immediately recommence.
- If the FA advises the Referee that the Player will have to be treated off the field, the match will not restart until the player has left the field. The Player may be interchanged, or alternatively the team can elect to temporarily play on with 12 players. (Note: other than for the initial assessment, the match will not be held up while the bleeding player receives treatment or is interchanged).
- If the Referee stops play twice for the same player and the same wound, the Player must be taken from the field for treatment and either interchanged or the team may elect to play on with 12 players until the bleeding player returns.

- If a bleeding player has left the field for treatment and is not interchanged, they may return to the field of play at any time provided they do so from an on-side position. If

  the bleeding Player has been interchanged; they may only return to the field as a normal interchange player.
- A bleeding player returning to the field of play who has not been interchanged, is not to be regarded as a replacement/interchange player and therefore may take a kick for goal. Conversely, a bleeding player returning to the field of play who has been interchanged may not take a kick for goal at that time.

7.3.3 **Contaminated Clothing & Dressing**

Where a player has blood on themselves or their clothing the Player must be free of blood contamination before the Referee will allow them to rejoin play. This may involve changing the contaminated clothing. Until those steps have been taken, the Player shall, at the minimum, drop out behind play. Contaminated clothing, surfaces, and / or equipment should be treated with a solution of detergent and bleach.

Contaminated clothing/equipment must be sealed in a plastic bag within a clearly marked bin and laundered separately in a hot wash at a minimum temperature of 80°C.

Please be aware of the club's duty of care to other volunteers at the Club such as ground staff and cleaners who may encounter bloodstained dressings and strapping post-game/training. These volunteers should be trained in procedures to handle and dispose of such items and understand the risks involved and should be provided with adequate bleach solution as per regulations and disposable gloves.

7.3.4 **Use of Detergent/Bleach Sprays**

- A spray container with 15mls of standard washing up liquid and 32mls of standard household bleach should be standard equipment for each team, on the touchline and in the dressing rooms.
- Minor contamination of clothing and equipment must be sprayed and thoroughly soaked with the solution immediately after the player leaves the field.
- The decontamination solution should be in contact with the blood spill for between one and five minutes.
- Prior to return to the field, the area must be thoroughly rinsed off with water.
- All but minor blood contamination of clothing and equipment must result in the contaminated clothing and equipment being replaced prior to the player returning to the field.
- As standard household bleach deteriorates with time, the decontamination solution should be made up on the day of the game. Typically, a solution of one part household bleach to ten parts waters should be prepared fresh daily and used as a disinfectant for contaminated areas.
- A 0.5% concentration of bleach is not considered hazardous; however care must be taken to avoid contact with eyes or wounds and prolonged contact with the skin. Thorough rinsing with water will further reduce the risk.

7.4 **FACILITIES AND EQUIPMENT GUIDELINES**

7.4.1 **Dressing Rooms**

Hand basins, toilets, showers and benches should be cleaned with disinfectant after each training session and game.

Dressing rooms should be maintained well and kept clean. Sharing of equipment, including towels should be avoided. Communal baths are to be strongly discouraged.

7.4.2 **First Aid Room**

The first aid room must be cleaned after each match.
The rubbish bin must contain plastic liners, which are to be disposed of after each training session/match

7.4.3 **First Aid Kit**

The kit must contain disposable protective gloves, chlorhexidine handwash and plastic bags for disposal of contaminated equipment/clothing.

7.4.4 **Drink Containers**

Potentially life-threatening illnesses can be shared through saliva.

- Players are to bring their own and use their own drink containers which they must bring with them and use at every training session
- During matches, Players should ideally drink from individual labelled bottles. Where this is not possible Players must drink only from water containers possessing spouts whereby when they drink, making sure they do not make contact with or touch the nozzle, but squirt the water into their mouth.

7.4.5 **Team Kit Bag**

Spare jerseys, shorts and socks should be available in the event that blood contaminated clothing needs to be replaced. The kit bag should also contain plastic bin liners to bag up any blood contaminated clothing.

8 OTHER RELATED ISSUES

8.1 MEDICAL SCREENING

Players are recommended to obtain a medical assessment before participation in Rugby League, to review the personal risks in the context of their health background.

8.2 PLAYERS WITH AN EXISTING MEDICAL CONDITION

Where a player has an existing medical condition, it is the responsibility of the player to seek medical clearance to participate from their GP or other relevant overseeing clinician (i.e., hospital specialist) to advise whether he/she is medically fit to play Rugby League. If it is not clear from the medical notes provided if they could participate, please contact the RFL for review.

See Consent & Medical forms above.

8.3 CARDIAC SCREENING

Sometimes an individual may have a heart abnormality without any symptoms. Screening with an electrocardiogram (ECG) is aimed at identifying people with conditions such as heart muscles disorders or electrical faults of the heart. Players may wish to undergo cardiac screening to help reduce their risk of rare cardiac events playing sport causing sudden cardiac death (an umbrella term used for the many different causes of cardiac arrest in young people). This is particularly encouraged for anyone with a family history of heart related problems below the age of 60, or unexplained deaths from incidents such a s drowning or car accidents.

Player should be advised to contact their GP if they have any of the following:

- chest pain, especially during exercise.
- loss of consciousness.
- breathlessness.
- dizziness.
- heart palpitations or fluttering feeling.
- unexplained fainting, especially during exercise.

The charity CRY http://www.c-r-y.org.uk/index.htm provides information and screening services. In addition, the Danny Jones Defib Fund may provide clubs with a grant towards the costs https://www.dannyjonesdefibfund.co.uk/

8.4 MOVING THE SERIOUSLY INJURED AND ABANDONING A MATCH

Where a player has suffered an injury which prevents them from being safely moved from the pitch then play should cease and ambulance assistance called. UNDER NO CIRCUMSTANCES should any pressure be put on the player or the FA to allow play to continue by removing the player from the pitch until it is safe to do so. Where necessary the match should be abandoned, player safety must be put before results or fixture backlogs.

Turning players over on the field of play

Players may, with all good intentions, attempt to turn an injured player onto their side following an injury, also known as 'the recovery position'. This can be an extremely dangerous act and could potentially make some injuries more severe, particularly in the case of spinal injuries. Coaches and FA should explain to all Players and other staff the potential hazards to injured players of attempting this and reassure players that injured players are not at risk of "swallowing their own tongue", which is a common misconception. Players should wait for the FA to attend to the player.

8.5 PROTECTIVE & OTHER EQUIPMENT

8.5.1 HEAD GUARDS

See section 6.2.7 Concussion prevention

8.5.2 MOUTH GUARDS

It is strongly recommended that players wear a mouth guard when playing or taking part in contact training sessions. It is recommended this mouthguard is custom fit made by a Dentist, rather than a generic mouth guard of the 'boil and bite' variety. Mouthguards reduce the risk of dental injury but are not recommended for reducing the risk of concussion, including instrumented mouthguards which provide data on head impacts.

8.5.3 TAGS AND MEDICAL DEVICES

Players may play with electronic tags and medical devices (such as blood glucose monitors and insulin pumps) providing these can be padded and strapped so as not to cause a danger to other participants or risk injuring the wearer. The Referee shall be the final arbiter in this regard.

8.5.4 SPORTS GOGGLES

The RFL conditionally permit the use of protective goggles for use in games and training within Rugby League providing the goggles have no rigid components which could cause harm to a Player. These goggles should usually be made of soft plastic with an elastic head band to keep them in place. The RFL recommend that head guards are worn by players wearing goggles to reduce the chance of the head band slipping from the head.

Any player wearing goggles should seek written clarification from their optician/equipment provider that the goggles are suitable for contact sport. This letter together with this RFL policy may prove useful on match days to reassure match officials and opponents. However, despite this policy, the final decision on the suitability of any player equipment is ultimately the referee's decision.

8.5.5 BOXES

Boxes may be worn provided that they have sufficient external padding not to cause a danger to opponents.

8.6 WEATHER

8.6.1 HOT WEATHER CODE

When a FA believes that the heat and/or humidity is such that players require additional water they should approach the Referee to request one or both of the special measures below. The Referee shall grant this request and shall ensure that both teams are aware of his decision.

- The positioning of water containers around the ground (ensuring that there is no danger to players or spectators) to enable players to help themselves.
- A two-minute break at an appropriate natural pause in the game approximately half way through the first and second halves to allow players to take on extra water.

FA should be familiar with recognising and managing heat related illnesses. Please refer to World Rugby Hot Weather guide for detailed advice. https://www.world.rugby/the-game/player-welfare/guidelines/hot-weather

8.6.2 SUNSCREEN

Research has shown that people do not apply sunscreen frequently enough. FA should reinforce messages about using high SPF sunscreen to all players and in particular juniors

and those with fair skin before training or playing outdoors, and at half time in matches. Cancer Research recommends using a sunscreen with a sun protection factor (SPF) of at least 30. Broad-spectrum sunscreens, which protect against harmful UVA and UVB rays are preferred, in addition to considering a waterproof nature given sweating during exercise. Sunscreen should be applied generously and regularly to remain effective. Be mindful, sunscreens have a shelf life of two to three years, refer to best before dates and expiry on the bottle.

In respect to skin cancer, the FA should advise their players on regular monitoring of skin for changes and seek GP review if there are any new changes or concerns.

8.6.3 COLD WEATHER CODE

Severe cold weather is infrequent but can provide a source of discomfort, impair sporting performance, and predispose to cold injury if players are unprepared. Frostbite, hypothermia, injury and exacerbation of pre-existing medical conditions can all be results of exposure to cold weather.

FA should be familiar with recognising and managing cold weather-related illnesses. Please refer to World Rugby Cold Weather guide for detailed advice.
https://www.world.rugby/the-game/player-welfare/guidelines/cold-weather

FAs should assess the activity due to be undertaken by the group and consider weather conditions including air temperature, wind chill, precipitation, and solar exposure. Location of the facility and time of activity should also be considered alongside forecasts for the day.

If possible, indoor facilities should be considered for activities such as fitness training. Attention should be given to appropriate clothing during activity (base, middle and outer layers) and post activity (warm, dry change of clothes). Minimise time spent still or not active can play a part in ensuring outdoor activity can continue safely.

Where pitches are frozen this should be assessed by the referee before the match and by coaches before training. Activity should not take place on frozen pitches.

8.7 MENTAL HEALTH

The RFL would recommend that all clubs have at least one volunteer who has attended Mental Health First Aid Lite. Details about this course are included in Appendix 8.

In addition, Rugby League Cares can deliver mental health literacy workshops for the following player groups:

- Juniors aged U12+
- Parents of all players
- Coaches of all players
- Open age teams.

For more information on workshop content and/or to book a workshop clubs should email info@rlcares.org.uk.

Further information on Mental Health, including signposting information for those in crisis or struggling can be found here – https://rlplayersportal.co.uk/need-help

Consider having a mental health emergency action plan in cases of a mental health crisis to ensure safe and effective action is taken.

9 ANTI DOPING

The RFL is committed to the principles of drug-free sport for the following reasons:

- To uphold and preserve the ethics of the Game.
- To safeguard the physical and mental health of players.
- To ensure that all players have an opportunity to compete equally.

To underpin that commitment the RFL will:

Provide information on its website and through other means of communication about the dangers of drugs and consequences of taking drugs or breaching the Anti-Doping Regulations.

- Comply with the WADA Code.

This is a summary of the information available in full on the RFL website.

9.1 Anti-Doping Rules

All sports including Rugby League are governed by the World Anti-Doping Code (WADA Code). All players, coaches and volunteers have to abide by the Code and are subject to the RFL Anti-Doping Regulations which can be downloaded from the RFL Website Rugby League (rugby-league.com). The Regulations allow the RFL to carry out anti-doping tests at any level of the game although in practice the majority of testing will be carried out at professional level.

9.2 Responsibilities of Volunteers in Rugby League

All volunteers should support the principle of anti-doping and should:

- Make it clear to all players that doping in Rugby League is simply not acceptable and is not necessary to win
- Ensure that players understand the Anti-Doping Regulations of the RFL
- Discourage and challenge the use of “performance enhancing” or illegal substances or “legal highs” amongst all players
- Not put pressure on players to change their body shape (i.e. to bulk up or slim down) without giving clear direction how to achieve this in a healthy way without resort to doping
- Undertake education modules and seminars as mandated by the RFL and share relevant communications issued by the RFL from time to time.
- Ensure players who are retiring inform the RFL in writing directly.

Volunteers should not:

- Ignore possible evidence of doping in their team
- Avoid enforcing rules or enforce rules selectively
- Ignore doping because the team needs a particular player
- Ignore drug misuse by coaches or volunteers

For further information and advice please visit https://www.ukad.org.uk/

9.3 Prohibited Substances

The Prohibited List is available on WADA’s website: www.wada-ama.org Players and officials can also find out the status of a particular substance according to the rules by visiting the Global Drug Reference Online website at www.GlobalDRO.com

The current Prohibited List includes the following:

- Anabolic Agents
- Hormones & related substances
- Beta-2 agonists

- Agents with anti-estrogenic activity
- Diuretics & other masking agents
- Stimulants

9.3.1 Steroids

Steroids stimulate the development of male sexual characteristics and the build-up of muscle tissue. Perceived benefits of steroid use are increased muscle tissue leading to increased strength and power.

However, steroids affect the body's natural balance and can have very serious effects including:

- Increased violence, mood swings, depression and personality changes (Roid-Rage)
- Serious liver damage
- Increased risk of heart disease and kidney damage
- Increased risk of muscle injury – the muscle mass gets bigger, but the supporting tendons and ligaments do not and may not be able to cope
- Adolescents may stop normal growth
- Development of breasts in men
- Shrinking of the testicles
- Loss of hair
- Impotence & infertility

Steroids can be injected, and this poses other risks associated with syringes including infections, HIV and Hepatitis B.

9.3.2 Stimulants

Stimulants act on the central nervous system by speeding up parts of the brain and the body's reactions. Stimulants also suppress hunger and give the impression of increased concentration.

However, stimulants can cause difficultly sleeping, sweating, shaking, anxiety, depression and mood swings. Stimulants can also cause overheating of the body leading to organ failure, put undue pressure on the heart and lead to cardiac arrhythmias.

Some pre-workout/energy boosting supplements contain stimulants so players should be extra vigilant with supplements of that nature and should seek advice prior to using them.

Common stimulants are ephedrine, pseudoephedrine, methylhexanamine, cocaine, ecstasy, and amphetamines.

9.3.3 Social Drugs

In addition to being banned by WADA the following drugs are also illegal under the Misuse of Drugs Act.

Marijuana (cannabis, weed, hash) is usually smoked to give a relaxed (stoned) feeling, however it can lead to mental health problems including schizophrenia, paranoia and depression. It can also affect co-ordination and make users drowsy.

Cocaine (Coke, Charlie, Crack) can be snorted, smoked or injected in order to give users a "buzz" where they feel really alert followed by down periods after use. Cocaine can cause heart problems, overheating and convulsions.

Amphetamine (speed, whizz) has similar effects and risks to cocaine

Ecstasy gives a sense of energy, alertness and happiness but can induce panic attacks, raise body temperature to a dangerous level and put pressure on the heart.

Heroin (H, smack) is usually injected or smoked and is highly addictive. It gives a sense of relaxation and well-being but includes the dangers of lethal overdoses and infections.

9.4 SUPPLEMENTS

Community players should adopt an effective food first and training first approach to optimise performance factors. High-performance athletes may use supplements, after consulting with relevant experts, to optimise their nutrition for performance purposes. Supplements work in addition to a balanced nutritious diet, a good hydration strategy, effective training and plenty of rest. Without these factors there is limited benefits to taking supplements at this level of competition and these may come with unintended consequences to your health. The effectiveness of many supplements cannot be effectively proven, and players must also be aware that approximately 45% of positive drug tests have been linked to the use of contaminated supplements. Clubs must remind players of the Strict Liability regulation, and contaminated supplements may result in a Player committing an ADRV.

The RFL advises players to fully assess the need for, the risk and potential consequences of any supplements prior to use. If the Player deems them a necessary risk the informed sport website should be used to check that a supplement is batch tested. https://sport.wetestyoutrust.com

9.5 EDUCATION

It is mandatory that the Chair and Club Welfare Officer at each club has the UKAD Introduction to Clean Sport qualification. This course gives enough knowledge to allow that person to play an essential role in giving players important anti-doping information. It is a basic level of knowledge which will allow support personnel to provide accurate advice about key anti-doping issues and to signpost players to further resources (e.g., Global DRO). The course can be taken online by registering on the UKAD website and is valid for 2 years.

In addition, all Community Players over the age of 18 must be made aware of and undertake the education and awareness for Community players. This will be directly communicated to players; however, it is the Club's responsibility to ensure they are aware of the education and communications at the beginning of each Season. The Club Chair, Club Welfare Officer and Head Coach must also have completed the education module.

All at the Club must be aware of Strict Liability in relation to Anti-Doping. It means that each athlete is strictly liable for the substances found in his or her bodily specimen, whether or not the athlete intentionally or unintentionally used a prohibited substance.

10 APPENDICES

APPENDIX 1 – RISK ASSESSMENT

A risk assessment is simply a careful examination of what, in a club, could cause harm to people, so that club officials can weigh up whether they have taken enough precautions or should do more to prevent harm. Workers, volunteers and others have a right to be protected from harm caused by a failure to take reasonable control measures.

In order to create a safe environment, a club must carry out regular risk assessments. A risk assessment is a formal and recorded process to weigh up the suitability and safety of any activity by identifying the hazards that could potentially cause harm and taking the appropriate precautions or actions required to prevent harm or injury.

The following the links below contains useful information on creating an appropriate Risk Assessment:

https://www.sja.org.uk/course-information/guidance-and-help/completing-a-risk-assessment/
https://www.hse.gov.uk/entertainment/leisure/amateur-sports-club.htm
https://www.hse.gov.uk/simple-health-safety/risk/index.htm

A risk assessment enables a club to:

- Identify an unsafe condition
- Decide what corrective action is required
- Determine who is responsible for correcting it
- Follow up to ensure that it was corrected properly

The frequency of assessment will be determined by a number of factors, such as the nature of the group; experience of volunteers; location or weather. Therefore, risk assessments should be a regular process and not a one-off exercise.

The risk assessment should be undertaken by a competent person, although they do not have to be a health and safety expert. Ask other club members or committee members what they think as they may have noticed things which are not immediately obvious.

Risk assessment process

The following is a suggested process intended as a guide to undertaking a risk assessment:

- Make an inventory of club activities and tasks.
- Identify the hazards for each of these activities – on and off site – and decide if the hazards are minor or significant.
- Evaluate the risks and decide whether the existing precautions are adequate or whether more should be done.
- Decide if the risk is acceptable and prioritise the significant hazards - identify whether the risk is high, medium or low by deciding which could result in serious harm or affect several people.
- Select method of control – check that all reasonable precautions have been taken to reduce the risk and avoid injury, however, be aware that even after all precautions have been taken, some risk usually remains.
- Record the findings – keep the written record for future reference, it can help if you become involved in any action for civil liability. It can also remind the Club to keep an eye on particular hazards and precautions.
- Implement measures to reduce the risk.
- Record and react to near misses
- Monitor – ensure that the standards are maintained.
- Regularly review – it is good practice to review the assessment to make sure that the precautions are still working effectively.

Risk Assessment Resources

The government's Health and Safety Executive has a useful risk assessments webpage and there is a downloadable Risk Assessment Template (PDF 52kB).

Also, to help clubs with risk assessment decisions, there is a Risk Probability Matrix (PDF 13kB).

APPENDIX 2 – FIRST AID EMERGENCY ACTION PLAN

The information in this plan should be shared with all coaches/teachers and relevant volunteers as well as all visiting teams

Club/School/College/University Name:	
EAP for: (Adult matches, youth & junior etc)	
Address & Postcode:	
Sat Nav Postcode / Additional location details for Emergency Services:	
EAP Lead (main contact):	
First Aider (if different from above):	

AGE GROUP/TEAM FIRST AIDERS

Name	**Contact Number**

AMBULANCE ACCESS POINT

First Aid Kit	
Defibrillator (AED)	
Stretcher (for use by trained individuals only)	
Other Equipment	

LOCATION OF LOCAL HOSPITALS/SERVICES

Accident & Emergency	
Minor Injuries	
Pharmacy	

EAP CHAIN OF COMMAND & PROCEDURES

OTHER RELEVANT INFORMATION

IN THE EVENT OF A MEDICAL EMERGENCY CALL THE EMERGENCY SERVICES AS QUICKLY AS POSSIBLE ON 999/112 GIVING AS MANY DETAILS AS POSSIBLE

APPENDIX 3 – ACCIDENT OR INJURY REPORT FORM

Date		Time			
Activity	If at a match provide the fixture				
Location					
INJURED PERSON'S DETAILS					
Surname		First Name			
Address					
		Postcode			
DOB		Tel No			
DETAILS OF PERSON(S) INVOLVED IN ACCIDENT OR INJURY					
Full name of person		**Contact number**			
DETAILS OF WITNESSES WHO ACTUALLY SAW THE ACCIDENT OR INJURY					
Full name of person		**Contact number**			
INCIDENT DETAILS					
Time		Date			
DESCRIBE THE INCIDENT					
TREATMENT GIVEN					
Did the person attend hospital		Yes by ambulance		No	
		Yes, self transfer			
If yes which hospital					

DETAILS OF PERSON GIVING FIRST AID			
Name		Role	
Signed		Date	

APPENDIX 4 – HEAD INJURY FORM

THE RFL HEAD INJURY CARD			
Name			
Address			
Tel No			
Time of Head Injury		Date of Head Injury	
Emergency Telephone Numbers			
Hospital			
Ambulance			
First Aider			
GP			
I have given a completed Head Injury Card to a parent/guardian/relative/carer of the player			
Name of First Aider			
Date			

IMPORTANT WARNING

If a player has one or more of the following **red flag** signs or symptoms after a head injury or they should have an urgent medical assessment in a hospital Accident and Emergency (A&E) Department using emergency ambulance (999) transfer if necessary:

They must be accompanied by a responsible adult, and they should not personally drive under any circumstances.

- Previous history of brain surgery or bleeding disorder
- Current 'blood-thinning' therapy
- Current drug or alcohol intoxication

Symptoms may include the following.

- Any loss of consciousness because of the injury
- Deteriorating consciousness- becoming more drowsy
- Develops slow or noisy breathing
- Problems with memory, before or after the event.
- Confusion following the injury
- Unusual behaviour such as restlessness, irritability, aggression
- Any changes in neurological function
  - Difficulty with understanding speaking, writing, reading
  - Decreased sensation in part of the body
  - Weakness in part of the body
  - Poor balance or coordination
  - Double or blurry vision
- Seizure/convulsion or limb twitching or lying rigid/ motionless due to muscle spasm
- Severe or increasing headache
- Repeated vomiting
- Severe neck pain
- Suspicion of a skull fracture: cut, bruise, swelling, depression, severe pain
- Clear runny fluid coming out of ears or nose after injury
- Deafness in one or both ears after injury
- Symmetrical bleeding around both eyes, or behind the ear

FOR THE REST OF TODAY HE/SHE SHOULD:

- Rest quietly
- Not consume alcohol
- Not drive a vehicle

APPENDIX 5 – MENTAL HEALTH FIRST AID AWARENESS (MHFA)

The RFL in conjunction with Rugby League Cares delivers the Mental Health First Aid (MHFA) Lite courses.

The course which lasts for 2-3 hours is aimed at club welfare officers, coaches, team managers, volunteers and those with an interest in learning about Mental Health issues and who have a role supporting the welfare of players and/or volunteers. The course is certificated by MHFA and is delivered by Rugby League Cares from time to time. More details about MHFA can be provided by emailing info@rlcares.org.uk, including the email title name 'MHFA booking'.

The course is ideal to allow volunteers to support players or volunteers who have identified that they may have mental health issues. The course aims to enable participants to:

- Gain a wider understanding, for the attendee and others, of some issues surrounding mental health
- Gain a greater understanding of how and why positive and negative mental health affects Rugby League – people and clubs
- Effectively support people experiencing mental health problems
- Communicate with and educate people

By the end of the course, attendees will be able to:

- Identify the discrimination surrounding mental health problems
- Define mental health & some mental health problems
- Relate to people's experiences
- Help support people with mental health problems
- Develop an understanding of managing after their own mental health

The course would also be particularly useful as a foundation for those who would like to go on to become Mental Health First. The courses are limited to 16 people per session.

CONTACTS

Rugby League Cares Portal Help Resource - https://rlplayersportal.co.uk/need-help
Drug Information Line: +44 (0) 800 528 0004
Drug Information Email: drug-free@ukad.org.uk
Confidential TUE Fax: +44 (0) 800 298 3362
TUE Email: tue@ukad.org.uk

APPENDIX 6 – CONCUSSION RECOGNITION TOOL

The Concussion Recognition Tool 6 (CRT6) (rugby-league.com)