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Disclaimer

The RFL has taken every care to ensure that the content of this document is current and correct at the time of going to print and it has been produced in good faith. However, the RFL cannot guarantee its correctness and completeness and no responsibility is taken for any errors or omissions.

The information provided in this document has been provided to assist those with responsibility for running clubs and providing first aid cover and related medical issues in the Rugby League Community Game, in doing so it, by necessity, touches on Health & Safety and Risk Assessment but is not intended to be a guide to either of these topics. The final section of this booklet gives information about how to find out more about the areas of Health & Safety and Risk Assessment.

NB The term FA &/or EFA is used throughout this document when the information is relevant to both First Aiders and Emergency First Aiders. Where information is specific to either a First Aider or an Emergency First Aider the title is written in full.

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 has a legal duty of care to ensure that appropriate health & safety and first aid cover is available for protection of players. In addition, a club has certain legal obligations to volunteers and if it allows the public access to its premises there are wider obligations to ensure their safety. 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 which 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 organisation of matches (which in practice usually means the Management Committee), is responsible for ensuring that it conducts all of the following steps:

- Completes a risk assessment to determine the appropriate level of first aid provision
- Draws up a First Aid Emergency Action Plan (EAP)
- Ensures that any FA&/or EFAs hold valid qualifications, are appropriately trained 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 followed
- Ensures no volunteer acts beyond the scope of their qualification
- Makes sure that recording and reporting of incidents takes place
- Ensures that suitable first aid facilities and equipment are available
- Makes sure that FA&/or EFAs, 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, Emergency Action Plan and procedures
- Follow the relevant RFL policies
- Be aware of their own Duty of Care to players and other volunteers

2 RISK ASSESSMENT & RISK MANAGEMENT

Clubs and other bodies who run clubs or organise matches have responsibilities with respect to health and first aid as follows:

2.1 Risk Assessment

During any activity, 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:

- Playing and non-playing hazards and risks.
- The club's and individual team 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) and distribution of the players (size of site or more than one site).
- The remoteness of the site from emergency medical services.
- 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, disabled players.

2.2 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 appropriate qualifications (preferably a First Aider rather than an Emergency First Aiders) to take day to day responsibility for First Aid
- 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 (for further guidance on emergency procedures visit Appendix 1.
- 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.
- Regular training of personnel in assisting FA &/or EFAs should be carried out.
- 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.

2.3 First Aid Emergency Action Plan (EAP)

Clubs will now be in a position to draw up an EAP (see Appendix 2 for a template)

All Rugby League clubs should have a clearly documented plan that outlines the actions and processes that need to be fulfilled in all possible examples of emergency situations, for home and away matches and on training sessions.

Having a simple, safe and systematic approach to an incident could make a tremendous difference to the outcome of an emergency at a home or away event

Once an EAP has been created it must be communicated to coaches, FA &/or EFAs and any other relevant volunteers. It is strongly recommended to share the EAP with your opponent's ahead of the matchday.

Creating & Implementing an EAP:

Decide who is going to take responsibility for the EAP, its creation, implementation, and review. A First Aider(s) with a First Aid at Work (one-day course) qualification would be the usual choice.

Please refer to the HSE link for information on the appropriate qualifications.

<https://www.hse.gov.uk/pubns/geis3.htm>

- 1 Ensure a system is in place for ensuring that FA &/or EFAs have relevant qualifications and a system to record these qualifications, keep a track of expiry dates and make sure that refresher training is undertaken.
- 2 The responsible person needs to make sure they are familiar with the club's risk assessments, the main ground and any other areas used for matches and/or training.
- 3 Prepare notices referencing key points of contact, signposting to stored First Aid Equipment and basic instruction in line with the EAP to be displayed on noticeboards (particularly in the dressing room area), given to volunteers, visiting teams and FA &/or EFAs and stored in first aid kits. These should have all appropriate emergency information on them. An example of an EAP is shown in Appendix 2.

3 FIRST AID PROVISION

3.1 FIRST AID & EMERGENCY ACTION TEAM RESPONSIBILITIES CHECKLIST

The following is a sample list of the Emergency Action Team's responsibilities which should be covered by the EAP and those who will deliver the EAP (lead by the FA &/or EFA). Clubs will of course amend this to reflect their own risk assessments and EAP.

- Creating and maintaining the necessary emergency communication documents
- Making sure all FA &/or EFAs 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 in situ is visible and helpful to those unfamiliar with the site
- Distributing the Emergency Communication 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
- Undertaking periodic checks of first aid kits to ensure they are fully stocked & that all contents are within their expiry date
- Distribution of relevant processes and protocols from the RFL to the wider FA and EFA team from time to time
- Assess who will cover the FA/EFA role in the event of treatment being given to another player, with consideration to monitoring play
- Understanding that team FA&/ EFA will work together with opposition FA's and volunteers to assist in the treatment of a player, including listening to observations.
- Ensuring FA &/or EFA are aware not to act beyond their level of qualification and competence.
- Ensuring sufficient numbers of qualified FA &/or EFAs are on duty on training days, home matches and away matches
- Having a timetable making sure that the FA &/or EFA role is always allocated
- Defining the roles and responsibilities of the FA &/or EFA and make sure that they have the full support of the club for decisions that they choose to make.
- Making sure that all FA &/or EFAs:
 - 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
 - have their first aid kit with them at all times that they are acting as a FA &/or EFA and have checked that it is fully stocked
 - understand what actions need to be completed after an incident has taken place
 - understand the RFL First Aid Standards with particular emphasis on the Concussion Rules
 - 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
 - wear a tabard to clearly identify themselves as the FA &/or EFA
 - introduce themselves to visiting teams (including Match Officials) as the duty FA &/or EFA and make sure that their contact number is entered into the necessary person's phone
 - have the postcode and directions to the club ground and any other pitches which are used
 - will provide details of local hospitals and directions if necessary
 - will provide names and contact details of key club officials if necessary
 - will hold the contact details of next of kin, provided and stored in a GDPR compliant manner

3.2 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.

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

- An Emergency FA &/or EFA 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) FA &/or EFAs must be appropriately trained persons and a list of all qualified FA &/or EFAs should be displayed and registered on LeagueNet. NB It is the responsibility of each Club to check each FA or EFA hold valid qualification and find alternative cover if this cannot be evidenced.

3.3 DIFFERENT LEVELS OF FIRST AID COVER

First Aid falls into three main categories: First Aiders, Allied Health Care Professional and Health Care Professionals and Emergency First Aiders holding a valid qualification.

3.3.1 First Aiders

First Aiders - Role Description

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

First Aiders - Relevant Courses

First Aiders must have completed an Emergency First Aid Course, which is HSE approved, together with 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 on the course by visiting the activfirst website <https://www.activfirst.co.uk/product/rfl-firstaid/>

3.3.2 Emergency First Aider

Emergency First Aider - Role Description

An Emergency First Aider will have been trained to:

- 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 the RFL Concussion Rules.
- Look after the first aid equipment, e.g., restocking the first aid box and removing and replacing any expired items.

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

Emergency First Aider - Relevant Courses

FA Level 1 – Introduction to First Aid in Football (IFAiF)

RFL Emergency First Aid

HSE EFAW Course

Equivalent Emergency First Aid course to the RFL Emergency First Aid course

FA &/or EFA– Duties on Match Day

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

- Have immediate access to a charged mobile phone in case of emergency 999 request.
- If using a mobile phone check that it has reception

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- Have details of the address and directions to venue for emergency services
 - Have list of other essential phone numbers e.g. parents of under 18's, local health centre, NHS Direct, venue caretaker.
 - Have appropriate first aid kit and access to first aid room during an event

3.3.3 Allied Health Professional & Health Care Professional

Clubs may have access to an Allied Health Professional and/or Health Care Professional who is prepared to act in a voluntary (or paid) capacity. This includes Sports Therapists, Sports Rehabilitators, Paramedics, Nurses, Physiotherapists, doctors, osteopaths, and chiropractors. In each case they should be members of the appropriate professional body, have appropriate indemnity cover and have appropriate experience and training in First Aid. In this case they may provide First Aid cover acting within their competencies.

3.4 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.

For FA &/or EFAs 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 a FA &/or EFA or Health Care Professional – clubs must always check.

3.5 INSURANCE & LIABILITY

In a medical emergency, it is recommended to avoid any delay 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 own medical indemnity must cover any care provided). As such volunteer FA &/or EFAs will have protection under the policies.

3.6 POSITION ON MATCH DAYS

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

3.7 DBS DISCLOSURES

FA &/or EFAs (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.

4 FIRST AID EQUIPMENT & FACILITIES

4.1 FIRST AID KIT

A fully equipped first aid kit should be available for each FA &/ or EFA. Please note FA &/or EFAs should only use those parts of a first aid kit for which they have received training. Clubs should make sure that no items in the first aid kit are past their expiry or use by date.

A well-stocked first aid box should contain the following:

- Guidance card
- Adhesive dressing tape (to hold dressings in place or to hold the loose end of bandages)
- Pins and clips (to fasten loose ends of bandages)
- Minimum of 4 pairs of latex free (nitrile) disposable gloves
- Hand sanitiser/alcohol gel
- Face-shield or pocket mask (disposable resuscitation aid)
- 'Tufcut' scissors
- Gauze pads/swabs
- Minimum of 6 crepe bandages (2x5cm/2x10cm/2x15cm)
- Gauze tubular bandages
- Elasticated gauze tubular bandages
- Cotton wool roll (or Gamgee)
- Minimum of 4 Sterile dressing pads
- Minimum of 2 large, sterile, unmedicated wound dressings (non-adhesive)
- Minimum of 6 medium, sterile unmedicated wound dressings (non-adhesive)
- Minimum of 1 roll tape (to secure wound dressings)
- Minimum of 20 plasters (assorted sizes and types e.g., waterproof, fabric, clear, blister etc.) which are sterile, individually wrapped, hypoallergenic.
- Minimum of 4 triangular bandages
- Minimum of 4 packs of Roller bandages
- Sterile, saline cleansing wipes
- Minimum of 2 sterile eye pads
- Minimum of 5 sterile water "sachets"/"pods"
- Minimum of 1 litre sterile water (normal saline) in a sealed disposable container
- Minimum of 2 yellow disposable clinical waste bags
- Material and foil blanket
- Umbrella
- Pen/notebook
- Flashlight
- Information sheet (EAP) including details of local hospital and directions to the ground.
- CPR Step by Step Guidance Leaflet for children and adults

NB when using a 3G pitch it is also recommended that a proprietary eyewash is available

Under no circumstances should over the counter or prescription drugs be administered by FA &/or EFAs/or kept in the first aid box. Boxes should be clearly labelled and easily accessible.

4.2 RECOMMENDED ADDITIONAL ITEMS

4.2.1 Automated External Defibrillator (AED)

An AED (or defibrillator) is a relatively expensive piece of equipment; however, it is easy to use and can save lives. Clubs that run a large of teams and/or attract significant numbers of spectators may wish to fund raise in order to purchase one for the club. Where a club has access to an AED it is important that key personnel including FA &/or EFAs know where it is stored and how to use it. It should be checked in good time prior to training and matches that the device is in good working order and all elements including the battery and pads are in date. The UK Resuscitation Council Position Statement on the use of AED's states that:

"An AED can be used safely and effectively without previous training; its use should not be restricted to trained rescuers. Training should however be encouraged to help improve the time to shock delivery and correct pad placement".

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

4.2.2 Bleach Solution

The recommended spray container with 15mls of standard washing-up liquid and 32mls of standard household bleach should be present on the touchline and in both dressing rooms for use on game days and present at during training for use by FA &/or EFAs and kit-room staff. This solution should be made up fresh prior to each training session or match. This solution may be used for cleaning bodily fluids from surfaces as required.

4.2.3 Soiled Dressings & Strapping

Please be aware of the club's duty of care to other volunteers at the Club such as ground staff and cleaners who may come into contact with 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. The use of Personal Protective Equipment (PPE) and yellow clinical waste bags for disposal of such items in line with HSE guidance is required.

4.3 FIRST AID ROOM

Where clubs have a First Aid room this should be well signed and should be kept clean and tidy at all times. All surfaces must be cleaned with the bleach solution following treatment in the first aid room.

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 &/or EFA can call for an ambulance or other assistance immediately so a FA &/or EFA should have a fully charged mobile phone and check that there is a signal prior to the match. If the ground does not have mobile phone receptions an alternative means of emergency communication must be arranged. In addition, calls may need to be made to the casualties' parents, guardian or next of kin.

4.6 DIRECTIONS

It is vital that FA &/or EFAs have details of the postcode and directions to the ground/training facility as 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 may be worthwhile having a volunteer at the entrance to the ground to direct the ambulance on arrival.

Where matches are played on pitches away from the clubhouse make sure that FA &/or EFAs operating on those pitches have the correct postcode. Mobile apps such as 'what3words' maybe useful where there are issues in advising emergency services of your location.

5 RECORDS

5.1 Recording Injuries

It is Best Practice for the Club's FA &/or EFAs to record any injuries they deal with. 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 be found [HERE](#) on the HSE website. Use of the accident book required under the Health & Safety at Work Regulations is a good option to use. Alternatively use the RFL Injury Template (see Appendix 5). As a minimum FA &/or EFAs should record:

- Date, time and place of incident
- Name (and age if under 18) of the injured or ill person
- Details of the injury and the first aid given
- What happened to the person immediately after the incident eg continued playing, went to hospital etc
- Name & signature

This information should be provided to the Club Management Committee on a regular basis to inform its risk assessment and risk management processes. The reporting of concussion is contained within RFL Head Injury Form in Appendix 8.

5.2 Information about Players

All players should complete Consent & Medical forms which ask for information about any relevant medical conditions and give FA &/or EFAs 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. Where a player has a medical condition, it would be good practice to ask for any further information (such as medication and location of medication e.g., inhalers) which would assist in the event of an emergency and make sure this is available for FA &/or EFAs.

5.3 Reporting Death or Serious Injury

When a player has died or has been admitted to hospital (not admitted to A&E when he/she is subsequently discharged) or has suffered a life altering injury the RFL should be notified immediately using the emergency number provided below: -

- Kelly Barrett 07739 819750

Please make sure the RFL has the name of the player, where possible contact details for the player's family, and any initial prognosis.

The RFL will:

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

5.4 Witness statements.

Following incidents where a potential insurance or personal injury claim may arise, clubs are advised to retain on file witness statements for 6 years and in line with UK GDPR and DPA 2018. 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

6 MANAGING HEAD INJURIES & CONCUSSION IN RUGBY LEAGUE

All head injuries are serious and potentially life threatening. All head injuries are not concussion. If a head injury is not treated properly this may lead to persistent symptoms, and in some cases can be fatal. Traumatic injuries to the brain can be divided crudely into concussion (impairment in the way the brain functions but no currently identifiable structural damage) and **structural brain injuries (for example brain tissue contusions or bleeding within the skull)**. Everyone in the game has a responsibility to understand what can cause head injuries and how they should be managed safely. Every licenced coach must undertake the Concussion module within the CoachRight qualification annually on Our Learning Zone, Club Leaders must undertake the Concussion Awareness module on Our Learning Zone to assist in the recognition and recovery of concussion, and the safe removal of head injuries and potential concussions from the field of play or training. Each FA &/or EFA must undertake the Concussion in Sport Module alongside their First Aid HSE qualification.

Every Coach and First Aider at the Club must complete the Concussion education module on Our Learning Zone and revisit as instructed to do so by the RFL.

The RFL will roll out education modules for various stakeholders in the community game – it will be made clear where these are mandated. Failure to attend mandated sessions as set out by the RFL is classed as off field misconduct.

FA &/or EFAs should be aware of the signs and symptoms of and the effective management of concussion and structural brain injuries, as their initial appearances are similar and can be delayed. Caution must be applied where any symptom is present, and players must be removed and remain off the field of play. **IF IN DOUBT SIT THEM OUT!**

It is not a FA &/or EFA, coach or any volunteer's responsibility to diagnose concussion, however, everyone should be aware of signs, symptoms and mechanisms which can cause concussion in order to act in an appropriate manner they must be removed from the field and remain off the field.

6.1 STRUCTURAL BRAIN INJURIES

A player who suffers an impact to head may develop a structural brain injury- such bleeding or swelling inside the brain, these injuries can be fatal.

Symptoms vary greatly depending on the severity of the head injury. If a player has one or more of the following symptoms after a head injury or is currently taking treatment to thin the blood or are intoxicated (alcohol or drugs) they should be referred to a hospital immediately either via 999 or transported if there is unacceptable delay. They must be accompanied by a responsible adult, and they should not personally drive under any circumstances. Symptoms may include the following.

- Problems with memory, before or after the event.
- A persistent severe headache, particularly if getting worse
- Repeated vomiting
- Drowsy or can't be woken
- Develops slow or noisy breathing
- Slurred speech or difficulty in speaking or understanding
- Abnormal behaviour/restlessness/irritability/aggression
- Weakness, numbness in arms or legs
- Impaired coordination and/or balance disturbances
- Increased confusion
- Loss of, or reducing consciousness
- A fit or convulsions (arms & legs jerking uncontrollably)
- Acutely painful/stiff neck which increases in severity
- Sensitivity to light and/or noise
- Blurred or double vision or pupils which vary in size
- Clear fluid coming out of ears or nose
- Deafness in one or both ears
- Symmetrical bleeding around both eyes, or behind the ear
- Previous brain surgery or bleeding disorders

Anyone with 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 disturbance to brain function. 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.

Concussion is more serious in children and young people (under the age of 18) where the brain is still developing. Children are more susceptible to having concussion, having complicated returns from concussion and rare neurological complications. It differs from a structural injury as no damage can be reliably seen on scans or laboratory testing.

As concussion can lead to a temporary impairment of the brain's function, and is an evolving injury, so may not be immediately apparent. This is called delayed onset of symptoms – FA &EFA and coaches must be aware of this and continue to monitor players during training and/or matches. Some symptoms may arise immediately after the injury, whilst others may take 24 – 48 hours.

As there is no reliable test for concussion, therefore if it is suspected, safety is paramount, and the player **MUST** be removed from all activity immediately. Symptoms should not be ignored as they may be the only indication.

Not every player who suffers a head impact is concussed or will demonstrate the signs or symptoms listed below, however, where a player is observed to have had contact with the head or indirect contact must be checked and continued to be monitored. If signs and/or symptoms are observed, they must be removed from the field immediately and must not return.

If a player reports or demonstrates any of the below features related to concussion even if a head impact has not been seen, the player removed from play for his own protection as a precaution. Coaches and/or FA &/or EFAs may also use the CRT6 (Concussion Recognition Tool)

6.2.2 Roles and responsibilities

First Aiders, Coaches, Teachers and Volunteers

Ensure all qualifications are valid and in date - any education and CPD is complete.

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

- Be cautious in your approach.
- Welfare over competition, always
- Listen to those around you and obtain as much information as possible on the circumstances.
- Do not act beyond the scope of your qualification.
- Safely remove the individual from the field of play and ensure that they do not return to play in that game even if they say that their symptoms have resolved.
- Observe 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.
- Arrange for the player to get home safely.
- Arrange for a responsible adult to supervise the player over the next 24-48 hours.
- 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

- Look out for the signs and symptoms of concussion.
- Stop the match and call the First aider and or coach for assistance – report your observations to them including any mechanism which may have caused the suspected concussion and anything you have seen or heard in relation to signs and symptoms.
- 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

- Obtain full details of the incident.
- Do not leave your child alone for the first 24 hours.
- Have your child assessed by an appropriate Healthcare Professional onsite within 24 hours or by accessing the NHS by calling 111.
- Monitor your child for worsening signs and symptoms of concussion for at least 24-48 hours.
- 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.
- Support your child to follow a graduated return to activity (education/work) and sport programme

Players

- Stop playing/training immediately if you experience any symptoms of concussion.
- Be honest with how you feel and report any symptoms immediately to your coach, medic and/or parent.
- Delays in reporting and under-reporting of symptoms have been associated with a longer recovery and delayed return to activity and could risk incomplete recovery of the brain.
- 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.
- 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 question whether another player may have symptoms of concussion, report this to the coach, match official or appropriate Healthcare Professional.

6.2.3 RECOGNISE

Concussion can be a challenging and difficult medical condition to diagnose, even for Health Care Professionals. Formally diagnosing concussion should be left to trained specialists - this is not the role of the responsibility of the first aider or coach. The responsibility of the first aider and the coach is to

1. Be aware of what the signs and symptoms of concussion look like and feel like to players - this may indicate a concussion is present.
2. **Remove** the player from training or a match **IMMEDIATELY**.
3. **Not let them return** to the match/training session – even if they or a parent says they are OK.
4. Ensure the player follows the Graduated Return to Activity and Play within the timescales set out and do not apply any kind of pressure to the player or parent to return sooner.

Match Officials are also trained to recognise the signs and symptoms of a potential concussion and will help support club staff in recognising a potential concussion. If Match Official calls time off for a suspected concussion – ask them for information on what they have observed. They may insist a player leaves the field and does not return.

It is important to realise that a player does not need to be 'knocked out' (lose consciousness) to have a concussion. Less than 10% of concussion cases involve a person losing consciousness.

If it is not clear if symptoms were present (were not observed as not seen or not displayed/reported) and the Player appears unwell, this would be classed as doubt and that individual MUST be removed from the field and stay off the field. Caution is paramount.

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 are told/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

Why is it important to be cautious where suspected concussion is concerned and remove the player from match or training

FA &/or EFA must always consider there is an overlap with signs and symptoms of structural brain injuries and concussion. All players who have been suspected to have experienced a concussion must seek medical support from 111 within 24 hours of injury. In the case of the above red flags, or any concerns, players must be advised to attend A&E.

- Players who continue to play or return to play before they are recovered from concussion face significant risks such as a Second concussion within a short time frame of a first which could cause 'Second Impact Syndrome', this is rapid swelling of the brain, it may result in death or at least severe brain damage.
- 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.
- A study in rugby union found even in cases of a well-managed concussion the risk of subsequent (any) injury in the following 12 months was increased by approximately 60%.
- Repetitive head injuries may result in changes to a player's mental health and longer-term functional impairment of the brain. Research in this area is evolving. Until further research gives absolute clarity it is everyone's responsibility reduce the risk of repetitive head injuries and be cautious in the management of suspected concussions.
- A recent concussion can result in other musculoskeletal injuries
- Previous concussions present a higher risk of sustaining further concussions
- Delays in reporting or under-reporting can lead to a prolonged return following concussions

In order that players can be diagnosed for concussion and guided through an appropriate recovery, further information can be found on the NHS Website

This is supported by the information provided to primary care practitioners on the CKS website [Scenario: Head injury](#) | [Management](#) | [Head injury](#) | [CKS](#) | [NICE](#)

6.2.4 REMOVE

If it is suspected that a player has a head injury, they must be removed from play straightaway. They must not return to activity that day.

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.

IF IN DOUBT SIT THEM OUT!

In the event of a suspected concussion FAs &/ EFAs and Coaches must follow the principles below.

Anyone with a suspected concussion should:

- Be removed from play immediately.
- Get assessed by an appropriate Healthcare Professional onsite or access the NHS by calling 111 within 24 hours of the incident – even if the symptoms have resolved.
- 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
- Ensure the player and responsible adult have a copy of RFL Head Injury advice sheet and passport provided by the Club

Anyone with a suspected concussion should not:

- Be left alone in the first 24 hours.
- Not let them return to play that day or in the timeframes following the GRTP process
- Consume alcohol in the first 24 hours and/or if symptoms persist as this can worsen 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
- Drive a motor vehicle within the first 24 hours. Commercial drivers (HGV etc.) should seek review by an appropriate Healthcare Professional before driving

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

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).

6.2.5 RECOVERY

Concussion recovery - The graduated return to activity (education/work) and sport programme

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 an appropriate via NHS by calling 111, 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.

Where a player has suffered two concussions within a 12-month period, it is recommended that the player is referred to a specialist prior to their GRTP.

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.

6.2.6 RETURN

Graduated return to activity (education/work) and sport

- 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.

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 suspected concussion, despite the information from a HCP/111 the Club should enforce a cautious approach and instruct the player follows a full GRTP for the wellbeing of the player.

None of the timelines listed are a target/maximum, all recoveries must be lead 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.

Please note where a Community Player is on Scholarship, Academy or Dual Registration their GRTP must be managed by their Professional Club who have HCP's who monitor the players 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 earlier – 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 | <ul style="list-style-type: none"> Sleep and rest. Gentle everyday activity (such as walking) for no more than 15 minutes at a time. Minimise screen time | <ul style="list-style-type: none"> Increase activities such as short walks Chores at home Moving about the house | <ul style="list-style-type: none"> Light jogs Swimming stationary cycling or equivalent. No rugby No resistance training, weightlifting, jumping or hard running. | <ul style="list-style-type: none"> 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. | <ul style="list-style-type: none"> 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. | <ul style="list-style-type: none"> 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 |

| | | | | | | | |
|---|---|--|--|--|---|---|---|
| <p>Remember!</p> | <ul style="list-style-type: none"> There is no HIA in the Community Game Remove the player as 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 | <ul style="list-style-type: none"> Call 111 and be alert to worsening symptoms A person with suspected concussion shouldn't be left alone in the first 24 hours. Don't drive or drink alcohol | <ul style="list-style-type: none"> If this Stage is commenced and symptoms get worse, rest and only resume once they have subsided, ideally until the following day. | <ul style="list-style-type: none"> Stage 3 can only commence once symptoms are no more than mild and are not getting worse. If this Stage is commenced and symptoms get worse, rest and only resume once they have subsided. | <ul style="list-style-type: none"> If symptoms more than mildly increase, or new symptoms appear, cease activity and rest briefly until they subside Resume at a reduced level of exercise intensity until able to tolerate it without more than mild symptoms occurring. | <ul style="list-style-type: none"> Player must be symptom free for 14 days prior to progressing to this stage If resumption of contact training results in concussive symptoms the player must be removed from training. | <ul style="list-style-type: none"> This stage can only be reached where there are NO SYMPTOMS PRESENT AT REST in the last 14 days recovery. The player must be symptom free during contact training at stage 5. |
| <p>ANY PLAYER WHO EXPERIENCES SYMPTOMS BEYOND 28 DAYS MUST SEE A GP WHO MAY REFER TO A SPECIALIST. THEY MUST REMAIN OUT OF SPORT. REMEMBER these timeframes are a minimum and not a target for the fastest return to play.</p> | | | | | | | |
| <p>RETURN TO ACTIVITY</p> | <p>Day zero</p> | <p>Stage 1</p> | <p>Stage 2</p> | <p>Stage 3</p> | <p>Stage 4</p> | <p>Stage 5</p> | |
| | <p>Rest</p> | <p>Relative Rest Period</p> | <p>Return to normal daily activities outside of school or work.</p> | <p>Increasing tolerance for thinking activities</p> | <p>Return to study and work</p> | <p>Return to full academic or work-related activity</p> | |
| <p>Permitted activity</p> | <ul style="list-style-type: none"> Rest | <ul style="list-style-type: none"> Any mental activity should be limited to 15 minutes maximum at a time Screen time to be kept to an absolute minimum | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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). | <p>Return to full activity and catch up on any missed work.</p> | |



| | | | | | | |
|--|--|--|--|--|--|--|
| | | | | returning part-time, breaks, doing limited hours etc each week from home | | |
|--|--|--|--|--|--|--|

6.2.7 PREVENTION

It is important to minimise the risk of exposure of players to concussion and head acceleration impacts, though in a collision sport the risk cannot be completely eliminated. It is important players and coaches are aware of this and know what can be done to increase the safety of participating for themselves and others. One example would be limiting the amount of contact training players are exposed and also, pay special consideration to participants who play multiple sports (such as Rugby League and Rugby Union). Limiting individuals contact training and exposure in matches within Rugby League is important across the course of a players career.

It is Best Practice to check prior to 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 in other sport – prior to their participation. Sharing of information is important in protecting players brains – if a child plays on scholarship or within other sports, concussion information must be shared with parents to disseminate further, or with Professional Clubs, as necessary.

Encouragement to play within the rules and that high tackles, dangerous throws, shoulder charges and spear tackles are not allowed within their team. Tackling technique is also an important focus for coaches to make a big difference, and the tackle area is where the majority of concussive incidents occur in rugby league.

It is important that the playing surface is not too hard (frost or drought) and that there are no dangerous structures such as unpadding posts or fences close to the pitch.

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 GRTP completed.

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

6.4 CONCERNS ABOUT CONCUSSION MANAGEMENT?

The RFL welcome and encourage reporting on concussion management and take the matter seriously.

If a player, coach, FA &/or EFA, 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. Concerns should also be reported to the RFL Community Game Delivery Department at competitions@rfl.co.uk or safeguarding@rfl.co.uk for cases relating to those under the age of 18 or vulnerable adults. Please provide as much information as possible to allow for thorough investigation to take place.

7 BLOOD BORNE DISEASES

Contact with blood is a possible occurrence whilst playing rugby league and so it is important that this is minimised and managed in a safe way for all. There are several infections that can be passed through bodily fluids. Blood Borne Diseases (BBD) are a group of infections that can be passed on by coming into contact with the blood of an infected person or carrier, these include hepatitis B, hepatitis C, and human immunodeficiency virus (HIV).

Of particular importance is hepatitis B, a virus that causes an infection in the liver and can have serious consequences for health. Hepatitis B can survive for a relatively long period outside the body, with dried blood remaining transmissible for several days. This is one of the reasons the RFL have clear BBD Guidelines and Rules as set out below to prevent the spread of disease via infected blood and other bodily fluids.

7.1 BBD GUIDELINES - MATCHES & TRAINING

7.1.1 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 the course of a match, the player must leave the field straightaway and blood bin procedures will apply

7.1.2 Blood Bin Procedure

The following procedure will apply in all cases where a Player is bleeding on their person, clothing or 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 &/or EFA to attend to the Player.
- The FA &/or EFA 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 &/or EFA 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 &/or EFA 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.

7.1.3 Contaminated Clothing

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. 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.

7.1.4 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.

7.1.5 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.

7.2 BBD GUIDELINES BLOOD CONTAMINATION

7.2.1 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 water 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.

7.3 EQUIPMENT GUIDELINES

7.3.1 First Aid Kit

- The kit must contain disposable protective gloves, hibiscrub (or equivalent) and plastic bags for disposal of contaminated equipment/clothing.

7.3.2 Drink Containers

- 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 must drink only from recommended water containers possessing spouts and players should not make contact with or touch the nozzle of squeeze bottles.

WARNING: Potentially life-threatening illnesses can be shared through saliva, this includes of meningitis, glandular fever, Covid-19.

7.3.3 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.

7.4 HEPATITIS B VACCINATION

The RFL recommends that players and officials 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.

7.5 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 Rules ("the Rules") to protect the rights and the health and safety of all participants in the sport.

These Rules shall only apply to Blood Borne Diseases (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 Laura Fairbank, RFL Head of Medical Services and Integrity, of their medical status as soon as possible.

Where any Club Official is advised that a Participant has contracted a blood borne disease, they shall notify the BBDO of this as soon as possible.

When the BBDO is informed that a Participant is suffering from a Blood Borne Disease, the BBDO shall issue a Provisional Suspension preventing participation in the game until the matter has been investigated.

In that case a Blood Borne Disease 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 of 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 Blood Borne Disease Tribunal and/or Appeal Tribunal.

8 OTHER RELATED ISSUES

8.1 MEDICALS/CARDIAC SCREENING

Players are recommended to may wish to consider visit their GP for a medical assessment prior to participation in Rugby League.

Players may also wish to undergo cardiac screening. This is because some individuals may be at increased risk of sudden cardiac death from underlying heart problems that is yet to be identified. Sudden Cardiac Death is an umbrella term used for the many different causes of cardiac arrest in young people. 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/>

8.2 INFECTION CONTROL POLICY

Good hygiene practice, 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), through contaminated water and food.

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

- Encourage all to undertake good personal hygiene at home and within Rugby League. With a regular focus on hand hygiene
- Clean surfaces regularly with disinfectant wipes or a disinfectant solution
- Clean and cover any wounds and change soiled clothing
- Avoid equipment sharing, particularly water bottles
- 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 &/or EFAs
- Encourage all members at the Club to stay up to date with screening and vaccination programmes

8.3 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 are able to participate, please contact the RFL for review.

See Consent & Medical forms above.

8.4 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 &/or EFAs should explain to players 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 &/or EFA to attend to the player.

8.5 ABANDONING A MATCH

Where a player has suffered an injury which prevents them from being safely moved from the pitch then play should cease. UNDER NO CIRCUMSTANCES should any pressure be put on the player or the FA &/or EFA 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.

8.6 PROTECTIVE & OTHER EQUIPMENT

8.6.1 HEAD GUARDS

The overwhelming view of international experts in sport-related head injury is that soft helmets do not prevent brain injury (as opposed to superficial skin lacerations) and because a 'risk compensation' there is a possibility that encouraging helmet use in players may paradoxically increase the head injury rates due to feeling they are in some way safer or more protected. Therefore, at this current time, the RFL does not support the mandatory wearing of protective head guards in Rugby League.

8.6.2 MOUTH GUARDS

It is strongly recommended that players wear a mouth guard when playing or taking part in contact training sessions. It is recommended that Players wear a custom mouth guard which has been made by a Dentist, rather than a generic mouth guard of the 'boil and bite' variety. NB Instrumented mouthguards do not provide protection from concussion, they provide data on head impacts.

8.6.3 TAGS

Players may play with electronic tags as long as these can be padded and strapped so as not to cause a danger to other participants. The Referee shall be the final arbiter in this regard.

8.6.4 SPORTS GOGGLES

The RFL sanction 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 will 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 from the goggles sliding down the player's neck.

Any player wearing goggles should seek written clarification from their optician that the goggles are suitable for contact sport. This letter from the optician, 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.

8.6.5 BOXES

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

8.7 WEATHER

8.7.1 HOT WEATHER CODE

When a FA &/or EFA 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.

The FA should be update with recognising and managing heat related illnesses.

8.7.2 SUNSCREEN

FA &/or EFAs should reinforce messages about using high SPF sunscreen to all players and in particular juniors and those with fair skin. Cancer Research recommends using a sunscreen with a sun protection factor (SPF) of at least 30 with the higher the SPF, the better. Broad-spectrum sunscreens, which protect against harmful UVA and UVB rays are preferred, in addition to considering the water proof nature given sweating during exercise. Research has shown that people apply much less sunscreen than they need to with over reliance on high factor sunscreen not applied frequently enough with limitation on sun exposure. 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.

FA&/or EFAs should advise their players on regular monitoring of skin for changes and seek GP review and advise on skin cancer if there is any aspect of concern.

8.7.3 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.

FAs &/or EFAs 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. Players clothing for during activity (base, middle and outer layers) and post activity (warm, dry change of clothes) and increased levels of activity 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.

8.8 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, State of Mind can deliver workshops for players and/or volunteers to raise awareness about Mental Health issues see Appendix 9 for how to book a workshop.

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 \(rugby-league.com\)](http://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 in order 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 difficulty 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

Risk Assessments

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 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>

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

| RFL FIRST AID EMERGENCY ACTION PLAN | | | |
|-------------------------------------|--|---------------|--|
| Club Name | | | |
| Club Address | | | |
| | | Postcode | |
| Pitch address | | | |
| | | Postcode | |
| Pitch address | | | |
| | | Postcode | |
| FA&/OREFA INFORMATION | | | |
| NAME | | MOBILE NUMBER | |
| | | | |
| | | | |
| | | | |
| | | | |
| FIRST AID EQUIPMENT & FACILITIES | | | |
| ITEM | | LOCATION | |
| First Aid Kits | | | |
| AED | | | |
| Stretcher | | | |
| First Aid Room | | | |
| ACCESS ROUTES | | | |
| For Ambulance | | | |
| First Aid Room to Ambulance | | | |
| Pitch to Ambulance | | | |
| OTHER INFORMATION | | | |
| Nearest Hospital with A&E address | | | |
| Directions to hospital | | | |
| Journey time | | | |
| Nearest Walk In Centre Address | | | |

APPENDIX 3

To book on a Rugby League First Aid Level 3 course please go to the website [RFL Courses - Activfirst](#)

APPENDIX 4 – AED

Please contact the Danny Jones Defib Fund through the website
<https://www.dannyjonesdefibfund.co.uk/>

APPENDIX 5 – ACCIDENT OR INJURY REPORT FORM

| RFL ACCIDENT OR INJURY REPORT FORM | | | |
|---|-----|-----------------------|----|
| Date | | Time | |
| Match | | | |
| Venue | | | |
| INJURED PERSON'S DETAILS | | | |
| Surname | | First Name | |
| Address | | | |
| | | Postcode | |
| DOB | | Tel No | |
| DETAILS OF PERSON(S) ACTUALLY INVOLVED IN ACCIDENT OR INJURY | | | |
| Full name of person | | Contact number | |
| | | | |
| | | | |
| DETAILS OF WITNESSES WHO ACUTALLY SAW THE ACCIDENT OR INJURY | | | |
| Full name of person | | Contact number | |
| | | | |
| | | | |
| INCIDENT DETAILS | | | |
| Time | | Date | |
| DESCRIBE THE INCIDENT | | | |
| | | | |
| TREATMENT GIVEN | | | |
| | | | |
| Loss of consciousness? | Yes | | No |
| Person sent to hospital? | Yes | | No |
| Ambulance called? | Yes | | No |
| If yes which hospital | | | |
| | | | |
| DETAILS OF PERSON GIVING FIRST AID | | | |
| Name | | Role | |
| Signed | | Date | |

APPENDIX 6 – CONSENT & MEDICAL FORM

Please use this link to the RFL website.

[Safeguarding \(rugby-league.com\)](https://www.rugby-league.com/safeguarding)

APPENDIX 7 – 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 | | | |
| FA &/or EFA | | | |
| GP | | | |
| I have given a completed Head Injury Card to a parent/guardian/relative/carer of the player | | | |
| Name of FA &/or EFA | | | |
| Date | | | |
| IMPORTANT WARNING | | | |
| He/she should be taken to a hospital or a doctor immediately if any of the following occurs: | | | |
| <ul style="list-style-type: none"> - Vomiting - Headache develops or increases - Becomes restless or irritable - Becomes dizzy, drowsy or cannot be roused - Has a fit or convulsion - Anything else unusual happens | | | |
| FOR THE REST OF TODAY HE/SHE SHOULD: | | | |
| <ul style="list-style-type: none"> - Rest quietly - Not consume alcohol - Not drive a vehicle | | | |

APPENDIX 8 – MENTAL HEALTH

A8.1 MENTAL HEALTH FIRST AID AWARENESS (MHFA)

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

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 seen on their website <https://stateofmindsport.org/what-we-do/mental-health-first-aid-training/>

The course is ideal to allow volunteers to support players or volunteers who have identified that they may have mental health issues. The aims of the course are 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 on 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 Aiders or those who provide support in clubs especially where that club has had a State of Mind presentation.

The courses are limited to 16 people per session.

CONTACTS

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