FIRST AID STANDARDS

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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:

- 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 are appropriately trained and keep up to date with refresher courses as recommended by the qualification body
- Ensures that RFL policies relating to injuries are followed
- 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
- 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 of 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.

2.3 First Aid Emergency Action Plan (EAP)

Clubs will now be in a position to draw up a 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 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.

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 (three-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
- 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
- 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
    - 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.

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

HSE Three Day First Aid at Work (or equivalent) & the RFL Concussion Course. Further support on this is offered on the RFL website HERE

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 themself 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

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

Emergency First Aider – Duties on Match Day

As for First Aider see above.

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
- Flash light
- 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 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 he 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 numbers provided below: -

- Kelly Barratt 07739 819750
- Laura Fairbank 07595 520184

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

Head injuries are serious and potentially life threatening. 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 coach must undertake the Concussion module within the CoachRight qualification on Our Learning Zone and 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 Level 3 First Aid HSE qualification.

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.

FA &/or EFAs should be aware of the presentation and 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. It is not a FA &/or EFA responsibility to diagnose concussion, however, they should be aware of signs, symptoms and mechanisms which can cause concussion.

IF IN DOUBT SIT THEM OUT!

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 any of the following symptoms, 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;

- A headache that is getting worse
- Vomiting or prolonged nausea
- 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
- Impaired coordination and/or balance disturbances
- Increased confusion or trouble with memory
- 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

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. It may be caused either by an impact to the head, which maybe a direct or indirect transfer of force to the head such as to the neck or elsewhere on the body. This causes the brain to be shaken inside the skull. Concussion is more serious in children and young people (under the age of 19) where the brain is still developing. It differs from a structural injury as no damage can be reliably seen on scans or laboratory testing.

Concussion can lead to a temporary impairment of the brain's function, and is an evolving injury, so may not be immediately apparent. As there is no reliable test for concussion, therefore if it is suspected, safety is paramount, and the player should be removed from all activity immediately. Symptoms should not be ignored as they may be the only indication.

6.2.2 How is concussion identified?

RECOGNISE

It is difficult to recognise concussion and is based on detailed clinical examination. Only trained medical staff should attempt to do so. Coaches and FA &/or EFAs must presume in all situations where a player has suffered an impact to the head that the player is concussed. In addition, if the 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 **POCKET CONCUSSION RECOGNITION TOOL** (see Appendix 7 or available as a resource from the RFL).

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

Any of the following may be signs of concussion:

The player:

- Is disorientated, such as they don't know the venue, last scorer, opposing team or the score
- Shows signs of confusion or is easily distracted
- Cannot remember things that happened before and/or after the injury
- Has a delayed response to verbal commands
- Is not playing as well as expected
- Has been (or may have been) knocked out
- Headache/localised pain
- Pressure in the head
- A fit or convulsion (arms and legs jerking uncontrollably)
- Dizziness/light-headedness/dazed expression
- Unsteady on feet/loss of balance/uncoordinated movement
- Falls to ground without preventative mechanism to break fall
- Sensitivity to light
- Sensitivity to noise
- Feels slowed down
- Feels in a 'fog'
- Doesn't feel 'right'
- A blank stare/glassy eyed
- Change of vision, seeing double or blurred vision, seeing stars or flashing lights
- Ringing in the ears
- Nausea and/or vomiting
- Slurring of speech
- Poor concentration
- Drowsy, fatigued, or low energy
- Strange or inappropriate emotions (laughing, crying, getting angry easily)
- Sad and emotional
- Nervous and anxious

- Generally feeling unwell

NB FA &/or EFA must always consider there is an overlap with signs and symptoms of structural brain injuries and concussion. Ruling out structural brain injuries takes priorities where signs and symptoms are present, rather than making an assumption that the player has suffered a concussion.

If ANY of the following are reported then the player should be transported for urgent medical assessment at the nearest hospital:

- Severe neck pain
- Weakness or tingling / burning in arms or legs
- Seizure/convulsion or limb twitching or lying rigid/motionless due muscle spasm.
- Deteriorating consciousness (more drowsy)
- Severe or increasing headache
- Increasing confusion or irritability
- Double vision
- Repeated vomiting
- Unusual behaviour change

6.2.3 Why is it important to diagnose Concussion?

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

- It isn't clear when a head injury is a concussion or a structural brain injury so they must be removed for their safety, in case the injury is more complicated that initially it appears. Serious injury or death may occur due to an unidentified structural brain injury such as bleeding on the brain or a fracture to the skull
- A second concussion within a short time frame of a first 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, team mates 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 my 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.
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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 What to do when Concussion is suspected?

REMOVE

If it is suspected that a player has a head injury, they must be removed from play straightaway.

IF IN DOUBT SIT THEM OUT!

- **Remove the player from play immediately**
- **Do not let them return to play that day or in the timeframes following the GRTP process**
- **They must not return to sport, work, driving or consume alcohol in the 24 hours following the suspected concussion**

RECOVER

- Those who have sustained a suspected concussion should be assessed by a Health Care Professional or access 111 within 24 hours of the incident.
- Don't leave them on their own. They must be supervised by an adult for 24 hours, or longer if the individual is not recovering well.
- If an individual experiences loss of consciousness, headaches and worsening headaches alongside any of the following: vomiting, confusion or a change in behaviour they should be referred to A & E or a doctor immediately
- Make sure they see a doctor or go to an A&E department
- Don't let them drive for 24 hours following, or longer if the individual is not recovering well or symptoms would impair their driving capability and compromise theirs or others safety.
- Advise them not to drink alcohol or use drugs as this can worsening any underlying unidentified structural brain or concussion.
- Do not take medication which may mask or minimise the symptoms of concussion unless directed to do so by a Health Care Professional
- Ensure they do not return to school, college or work until they feel they have completely recovered.
- Advise them to avoid the use of screens such as TV, video games and phones until they have completely recovered as the concentration and light can make symptoms worse and prolong recovery
- They should try to avoid stressful situations as can make symptoms worse

It is also important that parents, friends and/or family are informed so that they can ensure that the player can be supported with managing their concussion well and can raise any concerns if there is a deterioration in symptoms which might not be obvious to the player. Use the RFL Head Injury Form in Appendix 8.

6.2.5 How can players recover from a concussion?

It is important to ensure to optimise the recovery of players who sustain a concussion. The first part of this would be to allow initial symptoms to settle, this can be done by limiting your physical and cognitive (thinking) activity. Typically, symptoms of concussion last 10-14 days, and for this reason it is not recommended you return to any physical activity which could exacerbate symptoms for at least 14 days following your head injury, however research indicates that returning to normal day to day functions may assist in recovery when the individual is symptom free. Rest from screens and cognitive load is important, so time from work or school is really important to prevent a delay in recovery from these. Once symptoms have completely resolved, and a **minimum of 14 days** have passed it is recommended that a player is cleared to return to any exercise by a doctor, or health care professional trained in managing sports related concussion. Recommendation is through review, with a sign off from the player or parent following full completion of GRTP by a Healthcare professional.

Once symptom free and a recommended HCP review has been completed the below return to play can be started. This is designed to gradually and safely increase the physical and cognitive stress on the brain, so if symptoms develop suggesting incomplete recovery, this is not aggravated.

Please note, for children and young adults where the brain is still developing or those with previous head trauma, recovery can take longer.

The severity of the concussion, nature, timescale and recovery can affect the approach that is taken; some players may require an extended period out of the game. If a player has repeated concussions, it is recommended that they are seen by a doctor specialising in concussion management (through a GP referral).

6.2.6 What is a Graduated Return to Play (GRTP)?

RETURN

An individual should never return to any activity which involves a head injury risk, until they are completely recovered.

After a 24-48 hour period of rest, a staged return to normal life (work / education) at a rate that does not exacerbate existing symptoms or produce new symptoms is the main aim before return to sport is contemplated. It is acceptable to begin light aerobic activity (e.g., walking, light jogging, riding a stationary bike, etc.) even if symptoms are still present as long as they are stable and are not getting worse. Early introduction of exercise in this way has been shown to reduce the incidence of persistent post-concussive symptoms by 48%. A progressive return to sport with increasing levels of exertion and sport specific activities may be introduced and only when concussion symptoms and signs have resolved, should participation in sports which risk head impact be allowed.

GRTP is a system of gradually increasing physical exercise when returning from concussion, checking that the player doesn't have any concussion symptoms after each stage. Stage 2 can only be started when there is complete recovery from signs and symptoms experienced from a concussion and recommended clearance by a HCP.

When progressing through the GRTP each step must be completed no sooner than 24 hours after the last for adults and 48 hours at each stage after the last for players aged 19 and under. This doesn't have to be on consecutive days and can take longer than the minimum time set out. Each step can be completed more than once if desired, but steps cannot be omitted. If symptoms were to develop again during the GRTP, this should be stopped immediately and a review by a medical professional advised before continuing.

Please be aware with prolonged time aware from exercise there can be an element of physical deconditioning. As fatigue is a risk factor for injury in collision sports, it is important when the GRTP is completed that consideration is make in addition to the players physical status to compete at the same level for the same duration as prior to injury, as there may need to be additional time built in for appropriate physical conditioning.

Most symptoms of a concussion resolve by two to four weeks, but some can take longer. Each individual is unique in their recovery duration and that which is why completion of a graduated return to activity and sport programme is important to reduce the risks of a slow recovery, further injury and longer-term problems. Children and adolescents may take longer to recovery than adults.

If symptoms persist for more than four weeks, individuals need to be assessed by a healthcare professional – typically a Primary Care Physician (their own GP).

ADULT GRADUATED RETURN TO PLAY (GRTP)				
Stage	**Minimum time at each Stage of GRTP**	**Activity Level**	**Suggested Exercise at each stage of GRTP**	**Objective**
1	14 days	No activity for 14 days	Symptom limited physical & mental rest	Recovery
Recommended review by an appropriately qualified Health Care Professional				
2	24 hours	Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum predicted heart rate.	Increase heart rate
3	24 hours	Sport specific exercise	Running drills – no impact.	Add movement
4	24 hours	Non-contact training drills	More complex training drills eg passing drills. May start progressive resistance training.	Exercise, co-ordination and cognitive load.
5	24 hours	Full contact practice	Normal training activity	Restore confidence & coaching staff to assess functional skills
Clearance by review through an appropriately qualified Health Care Professional recommended				
6	**Earliest RTP is 19 days**	Return to play	Normal training and/or match activity	Recovery complete

UNDER 19 & BELOW GRADUATED RETURN TO PLAY (GRTP)				
Stage	**Minimum time at each stage of GRTP**	**Activity Level**	**Exercise at each stage of GRTP**	**Objective**
1	14 days	No activity for 14 days	Symptom limited physical & mental rest	Recovery
Recommended review by Health Care Professional* Recommended				
2	48 hours	Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum predicted heart rate.	Increase heart rate
3	48 hours	Sport specific exercise	Running drills – no impact.	Add movement
4	48 hours	Non-contact training drills	More complex training drills eg passing drills. May start progressive resistance training.	Exercise, co-ordination and cognitive load.
5	48 hours	Full contact practice	Normal training activity	Restore confidence and coaching staff to assess functional skills
Clearance by review through an appropriately qualified Health Care Professional recommended				
6	**Earliest RTP is 23 days**	Return to play	Normal training and/or match activity	Recovery complete

***Health Care Professional is defined as a doctor or individual trained as a concussion specialist. NB This cannot be a first aider or physiotherapist.**

6.2.7 What can be done to prevent players getting concussed?

It is important to minimise the risk of exposure of players to concussion, 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.

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 unpadded posts or fences close to the pitch.

6.2.8 Concerns about concussion management?

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.uk.com

6.3 THE RFL HEAD INJURY CARD

FA &/or EFAs should complete the RFL Head Injury Card (attached and available to download on the RFL website HERE and make sure that a parent/guardian/relative/carer is given a copy. It is also recommended that if a suspected concussion has been sustained, the player liaises and report this to the GP to update their medical records accordingly for continuity of care.

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 should 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 INFECTIOUS DISEASE 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 EXISITING 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.

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, 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 9.

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). 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-estrongenic activity
- Diurectics & 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
- 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, methylhexaneamine, 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.

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 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

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)

APPENDIX 7 – POCKET CONCUSSION RECOGNITION TOOL

See RFL website and separate hand-out. Headcase Pitchside Advice Cards 2018.pdf (rugby-league.com)

APPENDIX 8 – 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: – 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:			
– Rest quietly – Not consume alcohol – Not drive a vehicle			

APPENDIX 9 – MENTAL HEALTH

A9.1 MENTAL HEALTH FIRST AID (MHFA) LITE

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.

A9.2 STATE OF MIND WORKSHOPS

State of Mind deliver workshops aimed specifically at rugby league players and/or volunteers which raise awareness about mental health issues. To book a workshop contact State of Mind through their website.

http://www.stateofmindrugby.com/cmspages/contact/contact-us/

CONTACTS

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