England Cricket Association for the Deaf
Concussion Policy

1. OBJECTIVE

England Cricket Association for the Deaf (ECAD)takes its responsibilities for the welfare of all members, both adult and juniors, extremely seriously and this policy seeks to address the dangers of player concussion.

Post injury management is very important to protect players, particularly young people from the risks of repeat incidents. This policy is meant to ensure that players who suffer concussion are managed effectively to protect their short and long-term health and welfare.

Application of this policy by the officials and players of ECAD is to be considered mandatory for both home and away matches as well as training,

In the case of juniors the obligations are extended to parents/carers for compliance to minimum rest periods and GRTP protocol and engagement of medical professionals as appropriate and for ensuring communication to school. Parents/carers are also responsible for informing ECAD of any head injury incurred outside of ECAD which may be subject to minimum rest periods and GRTP.

2. POLICY STATEMENTS

- **RECOGNISE** – all ECAD officials must be aware of the signs and symptoms of concussion.

- **REMOVE** - All players with a suspected concussion must be removed from the field of play and not return to play or train on the same day.

- **ASSESS** – All players removed from the field of play with suspected concussion should seek medical assessment at the earliest opportunity. ECAD officials have a duty of care to strongly recommend this course of action to players and in the case of Juniors, their parents.

- **MANAGE** - Adult players suspected of concussion are to be encouraged by Team Captains not to drive until medically assessed, and it is strongly recommended they are supervised in the intervening period. Junior players suspected of concussion are to be supervised by a responsible adult until either handed over for medical assessment or into parental care.

- **INFORM –** ECAD officials are responsible for informing the Safeguarding/Wefare Officer of all suspected concussion cases the same day. In addition for juniors a parent/carer should be verbally informed as soon as possible and in a similar way for adults a partner/friend/family member. In both cases a strong recommendation of medical assessment and downloading of this policy from the ECAD website for details of concussion symptoms, minimum rest and GRTP protocol must be given.

- **GRTP -** All players with suspected (or diagnosed concussion) must go through a graduated return to play (GRTP) protocol in line with the guidelines for their age (see later for details).

- **MINIMUM REST -** After a head injury if a doctor is unable to confirm a diagnosis of concussion, then given the reasonable probability of delayed symptoms, as a precautionary measure, the minimum rest period is to be invoked for the relevant age of the player. Minimum rest periods (symptom free) are: U15 – 2 weeks, U18-U16 – 1 week, U19+ - 48 hours (Note this is double the guidelines but reflects a reasonable time window for concussion symptoms to appear and reflects the challenges of professional medical support within a volunteer club).

- **RETURN TO PLAY -** Players, or in the case of juniors their parent/carer, must confirm completion of the GRTP to the Safeguarding/Welfare Officer, without any recurring symptoms of concussion, before returning to play for diagnosed concussion. Head injury with undiagnosed concussion requires players, or in the case of juniors their parent/carer, to confirm to the Safeguarding/Welfare Officer that the minimum rest period has been completed without any concussion symptoms observed. Ideally confirmation of this would be obtained by the player, or junior parent, via a doctor prior to feedback to the Safeguarding/Welfare Officer.

- **LONG-TERM –** Players with repeated suspected concussion within a rolling 12 month period, as monitored by the Safeguarding/Welfare Officer's concussion register, default to the U15 minimum rest and GRTP protocol, unless supported by suitably qualified medical support.

- **PRECAUTIONARY PRINCIPLE –** If anyone has symptoms that need to be investigated quickly– ie they were knocked out (NHS custom and practice is to send everyone who has had a loss of consciousness), they are vomiting post head injury, blurred vision, confusion etc they need to go to A&E ASAP where they are scanned. All ECAD officials have a responsibility to ensure this course of action if followed.

3. WHAT IS CONCUSSION?

- Concussion is a brain injury caused by either direct or indirect forces to the head.
- Concussion typically results in the rapid onset of short-lived impairment of brain function.
- Loss of consciousness occurs in less than 15% of concussion cases and whilst a feature of concussion, loss of consciousness is not a requirement for diagnosing concussion.
- Concussion results in a disturbance of brain function (e.g. memory disturbance, balance problems or symptoms) rather than damage to structures such blood vessels, brain tissue or fractured skull.
- Typically standard neuro-imaging such as MRI or CT scan is normal.
- CONCUSSION MUST BE TAKEN EXTREMELY SERIOUSLY.
- Concussion is only one diagnosis that may result from a head injury. Head injuries may result in one or more of the following:

- Superficial injuries to scalp or face such as lacerations and abrasions
- Subconcussive event – a head impact event that does not cause a concussion
- Concussion - an injury resulting in a disturbance of brain function
- Structural brain injury - an injury resulting in damage to a brain structure for example fractured skull or a bleed into or around the brain. Structural brain injuries may present mimicking a concussion. In this instance the signs and symptoms of a structural brain injury will usually persist or deteriorate over time eg persistent or worsening headache, increased drowsiness, persistent vomiting, increasing confusion and seizures.

Medical assessment of a concussion or a head injury where the diagnosis is not apparent is recommended to exclude a potential structural brain injury.

All head injuries should be considered associated with cervical spine injury until proven otherwise.

Different ages

It is widely accepted that children and adolescent athletes (18 years and under) with concussion should be managed more conservatively. This is supported by evidence that confirms that children:

- are more susceptible to concussion
- take longer to recover
- have more significant memory and mental processing issues.
- are more susceptible to rare and dangerous neurological complications, including death caused by a second impact syndrome

4. DIAGNOSIS AND ASSESSMENT OF CONCUSSION

Visible clues of potential concussion - what you see.

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

- Dazed, blank or vacant look
- Lying motionless on ground / Slow to get up
- Unsteady on feet / Balance problems or falling over / Incoordination
- Loss of consciousness or responsiveness
- Confused / Not aware of plays or events
- Grabbing / Clutching of head
- Convulsion
- More emotional / Irritable

Symptoms of potential concussion - what you are told

Presence of any one or more of the following signs and symptoms may suggest a concussion:

- Headache
- Dizziness
- Mental clouding, confusion, or feeling slowed down
- Visual problems
- Nausea or vomiting
- Fatigue
- Drowsiness / Feeling like “in a fog“ / difficulty concentrating
- “Pressure in head”
- Sensitivity to light or noise

Questions to ask - what questions to ask

Failure to answer any of these questions correctly may suggest a concussion:

- “What venue are we at today?”
- “Which half is it now?”
- “Who scored last in this game?”
- “What team did you play last week / game?”
- “Did your team win the last game?”

If a player has signs, or symptoms of a possible concussion that player must be:
RECOGNISED AND REMOVED and IF IN DOUBT, SIT THEM OUT.

Players REMOVED are to be classified as a **suspected concussion** case at ECAD

On field or pitch side management

A player with a signs or symptoms of concussion must be removed in a safe manner in accordance with relevant local emergency management procedures and medically assessed.

If a cervical spine (neck) injury is suspected, the player should only be removed by emergency healthcare professionals with appropriate spinal care training.

Team mates, coaches, match officials, team managers, administrators or parents who observe an injured player displaying any of the signs or symptoms after an injury event with the potential to cause a concussion MUST do their best to ensure that the player is removed from the field of play in a safe manner.

Players with suspected concussion should be safely escorted and supervised by team-mates, parents/carers or other responsible parties with the recommendation of immediate professional medical assessment.

Onset of symptoms

It should be noted that the signs and symptoms of concussion can present at any time but typically become evident in the first 24-48 hours following a head injury.

It is essential that ECAD ensure a parent, partner or equivalent are informed of the suspected concussion case to be on alert to any deterioration, that medical assessment is recommended and that typical symptoms can be found in this policy to look for when downloaded from the club website.

5. RECOVERY FROM CONCUSSION

Recovery from concussion is spontaneous and typically follows a sequential course. The majority (80–90%) of concussions resolve in a short (7–10 day) period, although the recovery time frame may be longer in children and adolescents.

Players must be encouraged not to ignore symptoms at the time of injury and must not return to play prior to the full recovery following a diagnosed concussion. The risks associated with premature return to play include:

- a second concussion due to increased risk
- an increase risk of other injuries because of poor decision making or reduced reaction time associated with a concussion
- reduced performance

- serious injury or death due to an unidentified structural brain injury
- a potential increased risk of developing long-term neurological deterioration

Comprehensive medical assessment and follow up is required until a concussion has fully resolved.

Players must be honest with themselves and medical staff for their own protection. ECAD recognises the heightened risk of head injury and concussion and its complications in children and adolescent (18 years and under) players. Extra caution must be taken to prevent such players returning to play or continuing playing or training if any suspicion of concussion exists.

A second head impact in a player who has not fully recovered from concussion could lead to dangerous neurological complications, including death.

6. MANAGEMENT OF CONCUSSION

Players with a professional medical diagnosed concussion must go through a graduated return to play protocol (GRTP).

ECAD recommends different minimum rest periods and different length GRTP stages for differing age groups - protecting our young athletes.

A summary of the minimum rest periods and different length GRTP stages for different ages is shown below:

Players 15 years and under

- Minimum rest period 2 weeks and symptom free
- GRTP to follow rest, with each stage lasting 48 hours
- Earliest return to play - Day 23 post injury

U/16 - U/19 - Players 16, 17 and 18 years of age

- Minimum rest period 1 week and symptom free
- GRTP to follow rest, with each stage lasting 24 hours
- Earliest return to play - Day 12 post injury

Adult - 19 years and over

- Minimum rest period 24 hours and free of symptoms
- GRTP to follow rest, with each stage lasting 24 hours
- Earliest return to play - Day 6 post injury

A GRTP should only commence if the player:

- has completed the minimum rest period for their age
- is symptom free and off medication that modifies symptoms of concussion.

Medical clearance is required prior to commencing a GRTP.

The management of a GRTP should be undertaken on a case by case basis and with the full cooperation of the player. It is important that concussion is managed so that there is physical and cognitive rest (avoidance of activities requiring sustained concentration), until there are no remaining symptoms for a minimum of 24 consecutive hours without medication that may mask the symptoms.

7. THE GRADUATED RETURN TO PLAY PROGRAM

The GRTP Program contains six distinct stages:

- The first stage is the recommended rest period for the athlete's age
- The next four stages are training based restricted activity
- Stage 6 is a return to play
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Under the GRTP Program, the Player can proceed to the next stage if no symptoms of concussion are shown at the current stage (that is, both the periods of rest and exercise during that 24-hour period).

If any symptoms occur while progressing through the GRTP protocol, the player must return to the previous stage and attempt to progress again after a minimum 24-hour period of rest has passed without the appearance of any symptoms.

Prior to entering Stage 5, a Medical Practitioner or approved healthcare professional and the Player should first confirm that the player can take part in this stage.

The GRTP applies to all situations including 'multiple game-same day' tournaments.

Table 1: GRTP Protocol

Rehabilitation Stage	Exercise Allowed	Objective
Rest as per minimum rest period prescribed for player's age	Complete physical and cognitive rest without symptoms	Recovery
Light aerobic exercise Walking, swimming or stationary cycling keeping intensity, <70% maximum predicted heart rate. No resistance training.	Symptom free during full 24-hour period	Increase heart rate
Sport-specific exercise	Running drills. No head impact activities	Add movement
Non-contact training drills	Progression to more complex training drills, e.g. passing drills. May start progressive resistance training	Exercise, coordination, and cognitive load
Full contact practice	Normal training activities	Restore confidence and assess functional skills by coaching staff
Return to play	Player rehabilitated	Recover

Adolescents and children, 18 years and under, MUST NOT return to play without clearance from a medical practitioner or approved healthcare practitioner.

GRTP conclusion

It is recognised that players will want to return to play as soon as possible following a concussion. Players, coaches, management, parents and teachers must exercise caution to ensure that:

- all symptoms have subsided fully;
- the GRTP program is followed; and
- the advice of medical practitioners or approved healthcare practitioner is strictly adhered to.

In doing so, all concerned can reduce the risk to a player's career longevity and long term health **If no medical practitioner is available to manage a Graduated Return to Play (GRTP), irrespective of their age, the player MUST rest for a minimum of 2 weeks** and be symptom free. At the completion of this 2-week rest period, if the player is symptom free they can commence the GRTP with each stage progressing each 24 or 48 hours depending on the age of the player.

All involved in the process of concussion management must be vigilant for the return of symptoms or the possible development of psychological issues after a concussive event. If symptoms reoccur the player must consult a medical practitioner.

8. RECURRENT OR DIFFICULT CONCUSSIONS

Following a concussion a player is at an increased risk of a second concussion within the next 12 months. ECAD recommends that all concussions be taken seriously and that full recovery be achieved prior to re-introduction of exercise.

Players with:

- a second concussion within 12 month
- a history of multiple concussions
- unusual presentations or
- prolonged recovery should be assessed and managed by health care providers
- (multi-disciplinary) with experience in sports-related concussions.

If a medical practitioner experienced in concussion management or approved healthcare provider is unavailable the player with a recurrent or difficult concussion history should be managed using the GRTP protocol from the lower age group as a minimum.

Table 2: Factors impacting on the diagnosis and management of concussion

The factors listed below may predict the potential for prolonged or persistent symptoms. Players with these factors should be carefully monitored by experienced practitioners.

Factors	Exacerbating Factors
Symptoms	Number of concussions suffered historically Duration of current concussion symptoms (>10 days) Severity of current concussion
Signs	Prolonged loss of consciousness (>1 minute) Amnesia
Sequelae	Concussive convulsions
Temporal	Frequency – repeated concussions over time Timing – injuries close together in time "Recency" – recent concussion or traumatic brain injury
Threshold	Repeated concussions occurring with progressively less impact force or slower recovery after each successive concussion Age • Child (<10 years) and adolescent (10-18 years) Co- and premorbidities Migraine, depression or other mental health disorders, attention deficit hyperactivity disorder (ADHD), learning disabilities, sleep disorders
Medication	Psychoactive drugs, anticoagulants
Behaviour	Dangerous style of play
Sport	High risk activity, contact and collision sport, high sporting level