DANES HILL SCHOOL

Contact Sport & Head Injury Policy

Author responsible:	Director of Sport & Nursing Manager	**Date of Review:**	01/09/2025
Reviewed by:	Deputy Head (Organisation & Co-Curricular)	**Date of next Review:**	01/09/2026

CONTENTS	
1.	Introduction
2.	Policy Aims
3.	Key Terms
4.	The Risks
5	Preventative Steps (to reduce the risks)
6	Processes and Protocols
7.	Head Injuries with Potential C-Spine Injury
8.	CONCUSSION – recognition, signs & symptoms
9.	Immediate Management Of A Suspected Concussion
10.	Recover And Return After Concussion Diagnosis
11.	Graduated Return to Activity (education/work) & Sport Pathway
12.	Breeches of the Policy
13.	Head injury at a non-Danes Hill activity
14	General Recommendations
A1	Useful resources
A2	Concussion Management Tool (CRT6)

1. Introduction

1.1. We take the welfare of our pupils extremely seriously, both on and off the sports field. We have comprehensive policies in place to ensure that if a pupil sustains an injury, they receive the appropriate management. That includes this policy, which specifically addresses head injuries.

1.2. A head injury could happen in any area of school life. This policy focuses on sport activities (both contact sports and non-contact sports) where the risk of head injuries happening is higher but can be used for head injuries which occur in another context.

1.3. The School's Medical Centre oversees the management of head injuries that occur at School, completing initial assessments for those that occur on site, collecting information from staff and parents if they occur off site or at non-school activities. The Nurses update the head injury log and issue letters to parents and informing staff.

1.4. **This policy is expected to be available to all key stakeholders including parents so that they may make informed decisions regarding consent for their child to participate in contact sports.**

1.5. The policy sits alongside the Schools' other policies such as First Aid & Risk Assessment policies, which covers the specifics of how injuries and risks are management, respectively. The following information has cited the latest guidance[1] from various NGBs (national governing bodies) such as the RFU, especially the 'Headcase' initiatives. Additionally, the Sport & Recreation Alliance who have produced 'concussion guidelines for the education sector' which included members from major NGBs such as RFU, ECB, FA, RFL, England Hockey.

2. Policy Aims

2. The aims of this policy are to:

2.1 Ensure an understanding of the ***key terms*** used in describing the link between head injuries and brain injuries.

2.2 Identify the sports that carry a ***risk*** of head injury.

2.3 Highlight the ***preventative steps*** taken to reduce the risks.

2.4 Provide clear ***processes and protocols*** used when a head injury is sustained.

2.5 Make some ***general recommendations*** to help with the management of head injuries.

2.6 To ensure that all staff have a clear understanding of how to deal with someone who has sustained a head injury.

2.7 To demonstrate the protocol used by the Medical Centre to manage concussion.

[1] https://www.sportengland.org/news/new-concussion-guidelines-grassroots-sport

3. Key Terms

3.1. The following terms are used in this policy to describe incidents around head injuries/concussion, with reference to the ISBA policy:

3.3.1. *Head injury*: means any trauma to the head other than superficial injuries to the face.

3.3.2. *Traumatic Brain Injury (TBI*): is an injury to the brain caused by a trauma to the head (head injury).

3.3.3. *Concussio*n: is a type of traumatic brain injury (TBI) resulting in a disturbance of brain function. It usually follows a blow directly to the head, or indirectly if the head is shaken when the body is struck. Transient loss of consciousness is not a requirement for diagnosing concussion and occurs in less than 10% of concussions.

3.3.4. *Transient Loss of consciousness*: is the sudden onset, complete loss of consciousness of brief duration with relatively rapid and complete recovery. It can also be referred to as 'being knocked out' or a 'blackout.'

3.3.5. *Persistent loss of consciousness*: is a state of depressed consciousness where a person is unresponsive to the outside world. It can also be referred to as a coma.

3.3.6. *Chronic Traumatic Encephalopathy (CTE*): is one type of degenerative and progressive brain condition that is thought to be caused by TBIs and repeated episodes of concussion. CTE usually begins gradually several years after receiving TBIs or repeated concussions. The symptoms affect the functioning of the brain and eventually lead to dementia.

3.3.7. *Contact sport*: is any sport where physical contact is an acceptable part of play for example rugby, football, and hockey.

3.3.8. *Non-contact sport*: is any sport where physical contact is not an acceptable part of play but where there are nonetheless potential collisions between players and between players and the ball, for example cricket and netball.

4. The Risks

4.1. No activities are devoid of risk. The benefits gained from participating in contact sport activities warrant inclusion within our educational programme. Ensuring that the benefits outweigh the risks is our overriding objective. Rather than eliminate the risk by stopping those activities, risk needs to be identified and then managed.

4.2. Playing contact and non-contact sport increases an individual's risk of collision with objects or other players.

4.3. Collisions can cause a head injury, which can cause a traumatic brain injury such as a concussion.

4.4. It is especially important to recognise that a student can have a concussion, even if they are not 'knocked out.' Transient loss of consciousness is not a requirement for diagnosing concussion and occurs in less than 10% of concussions.

4.5. Children and young adults are more susceptible to concussion than adults because their brains are not yet fully developed and thus more vulnerable to injury.

4.6. The current evidence suggests that repeated episodes of concussion, even where there is no transitory loss of consciousness, can cause significant changes to the structure and function of the brain in a condition known as Chronic Traumatic Encephalopathy (CTE).

Section Owner (1,2,3,4):	**Andrew Murfin, Deputy Head (Organisation & Co-Curricular)**

5. Preventative Steps (to reduce the risks)

5.1 At Danes Hill, the pupils are at the heart of everything we do. This policy is part of that enhanced duty of care to ensure our pupils are safeguarded, as far as is practicably reasonable, from risk.

Risk Assessment:

5.2 ***Risk assessments***: Any person responsible for the undertaking of a sporting activity must ensure a suitable risk assessment for the specific sport activity is created. Sporting risk assessments will be completed by the Director of Sport, who may delegate this responsible to Head of various Sports whom, in turn, will have specific areas of expertise. Our risk assessment policy supports those writing risk assessments. The risk assessment will:

5.2.1 Identify the specific risks posed by the sport/activity, including the risk of players sustaining head injuries.

5.2.2 Identify the level of risk posed (likelihood x severity of injury).

5.2.3 State the control measures and reasonable steps taken to reduce the risks.

5.2.4 Identify the level of risk with the with the control measures applied.

5.3 All staff that are coaching Sport/Games/PE lessons will be first aid trained, have undertaken concussion awareness training, and have countersigned the risk assessment to acknowledge the control measures in their areas.

5.4 The school reserve the right to update these through the year, without notice, as the need arises. The risk assessments for all sports offered within the Danes Hill programme are available and will include any sport-specific guidance provided by the sport's NGB, including:

5.4.1 The Sport and Recreation's Alliance UK Concussion Guidelines for Grassroots Sport: http://sramedia.s3.amazonaws.com/media/documents/9ced1e1a-5d3b-4871-9209-bff4b2575b46.pdf

5.4.2 The RFU (Rugby): https://keepyourbootson.co.uk/wp-content/uploads/2019/04/U19-Concussion-Management-Guidelines-2018.pdf; https://www.englandrugby.com/participation/playing/tackle-height

5.4.3 The FA (Football): https://www.englandfootball.com/concussion

5.4.4 The EHA (Hockey): https://www.englandhockey.co.uk/governance/duty-of-care-in-hockey/safe-hockey

5.4.5 (Netball): Safeguarding Policies and Documents - EN knowledge Centre - England Netball Knowledge Centre

5.4.6 The ECB (Cricket): https://www.ecb.co.uk/about/policies/concussion

Practices/Session Management:

5.5 ***Practical measures*** to reduce the risk of players sustaining head injuries also include:

5.5.1 Having a sporting programme that offers a large degree of breadth of choice (including contact and non-contact sports) and, where contact sports are compulsory, there are non-contact versions of those sports available.

5.5.2 Structuring training and matches in accordance with current guidelines from the governing body of the relevant sport (see above).

5.5.3 Removing or reducing contact elements from contact sports, for example offering 'touch rugby' (non-contact) or 'rugby-ready' (reduced contact) as part of the rugby offering. This would include liaising with opposition schools to offer different tiers of fixtures based on level of contact e.g. a rugby-ready A-team training match rather than full-contact, B-teams to play touch rather than full contact.

5.5.4 Ensuring that there is an adequate ratio of coaches to players.

5.5.5 Staff receive awareness training in managing the level of contact in a sport and concussion protocols.

5.5.6 Delivering a coaching specification that is focused on technical development to ensure the safe playing techniques; especially in high-risk situations like rugby tackles.

5.5.7 Encourage and ensure that sportsman-like conduct and mutual respect for both opponents and fellow team members is paramount (reduced emphasis on results ahead of development).

5.5.8 Using equipment and technology to reduce the level of impact from collision with physical objects and players (e.g. using padding around rugby posts, not overinflating footballs, gumshields, helmets etc).

5.5.9 Ensuring that the playing and training areas is safe (for example, which is not frozen hard, and there are suitable run-off areas at the touchlines).

5.5.10 Ensuring that a medical professional is easily accessible during training and matches that take place at Danes Hill.

Section Owner (5):	**Chris Shaw, Director of Sport**

6. Processes and Protocols

[This section is taken from the School's Medical Handbook and its Concussion Policy; updated with Updated with UK Concussion Guidelines for Non-Elite Sport November, 2025].

6.1 Danes Hill has a Medical Centre that is staffed by registered Nurses from 1000-1600 weekdays. For out of hours there is pitch-side cover on-site by first aiders or outside companies booked by the sports department.

6.2 All head injuries are potentially dangerous and require proper assessment and management. If a pupil sustains a head injury, even if thought to be minor, they must not be left alone and must always be assessed by the Medical Centre if within working hours. They should be escorted there by staff or witnessing pupils, or they must seek immediate adult assistance. If the injured pupil cannot be escorted, then the Nurses should be called to assess the pupil at the site of the accident.

6.3 Staff should take the decision to call for an ambulance if they suspect the injury is serious, prior to the Nurse arriving, or if it is out of Medical Centre hours, or at Bevendean.

6.4 If the child is unconscious, has lost consciousness or a neck or spine injury is suspected they should be sent to A&E by ambulance with an adult escort. **They must not be moved.** The parents or guardian should be informed as soon as possible, and the schools accident reporting procedures followed.

6.5 Potentially serious complications can develop up to 24 hours after an apparently-minor head injury. Urgent medical assessment must be sought if any of the following occur:

6.6 RED FLAGS (list not exhaustive)

- Headache which persists or is severe.
- Drowsiness leading to unconsciousness.
- Irritability
- Confusion and loss of concentration or amnesia for events before or after injury
- Repeated Vomiting
- Convulsions
- Blurred vision
- Weakness of limbs or irregular movement
- Severe neck pain

6.7 The Medical Centre publication: ***Head Injury, Advice from the Medical Centre*** will be given to a pupil who has sustained any type of head injury at the Main School, followed by ***Graduated Return to Sport, RFU guidelines*** if appropriate. (Appendix resource 1 & 2)

7. Head Injuries with Potential C-Spine Injury

7.1 With any head injury consider the possibility of a spinal injury. Attempt and maintain full cervical spine immobilisation for patients who have sustained a head injury and present with any of the following risk factors unless other factors prevent this:

- Neck pain or tenderness
- Focal neurological deficit

- Paraesthesia in the extremities
- Any other suspicion of cervical spine injury

8. CONCUSSION

8.1 Decisions on care will be made according to nationally published guidelines that incorporate the UK Concussion Guidelines for Non-Elite Sport[2] and professional medical judgement.

8.1.1 All concussions should be regarded as potentially serious and should be managed in accordance with the appropriate guidelines.

8.1.2 If an individual is suspected of having a concussion, they must be immediately removed from play for 24 hours. IF IN DOUBT, SIT THEM OUT. No one should return to sports, training, or exercise within 24 hours of a suspected concussion.

8.1.3 Players suspected of having concussion must be medically assessed.

8.1.4 Players suspected of having concussion or diagnosed with concussion must go through a graduated return to sport (GRAS)

8.1.5 Players must receive medical clearance before returning to play.

8.1.6 Parents must advise school if their child sustains a suspected or confirmed concussion outside of school.

8.1.7 Headguards do not protect against concussion.

8.1.8 Bear in mind: Symptoms severity does not correlate to severity of injury.

8.1.9 Bear in mind: Symptoms recovery is not the same as brain recovery.

8.1.10 Staff must familiarise themselves with the necessary steps to:

- RECOGNISE the signs of concussion.
- REMOVE anyone suspected of being concussed immediately and;
- RETURN safely to daily activity, education and ultimately, sport.

How to recognize a concussion

8.2 Concussion can affect people in four principal areas:

- Physical, (e.g. headaches, dizziness, vision changes)
- Mental Processing, (e.g. not thinking clearly, feeling slowed down)
- Mood, (e.g. short tempered, sad, emotional)
- Sleep (e.g. not being able to sleep of sleeping too much).

8.3 Spotting head impacts and visible clues of concussion can be difficult in fast moving sports. It is the responsibility of everyone: players, coaches, teachers, referees, and spectators to watch out for individuals with suspected concussion and ensure they are immediately removed from play.

8.4 Remember that the primary aim is to protect the individual from further injury by immediately removing them from play.

Visible signs of concussion – What you may see (list not exhaustive)

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

- Dazed, blank, or vacant look
- Lying motionless on ground / slow to get up.

[2] https://www.sportengland.org/news/new-concussion-guidelines-grassroots-sport

- Unsteady on feet / balance problems or falling over / poor coordination.
- Loss of consciousness or responsiveness
- Confused / not aware of play or events.
- Grabbing / clutching of head
- Seizure (fits)
- More emotional / irritable than normal for that person
- Vomiting

Symptoms of concussion – What you are told or what you should ask about (list not exhaustive)

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

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

8.7 Playing on with symptoms of concussion can make them worse, significantly delay recovery, and, should another head injury occur, result in more severe injury and in rare cases death (known as second impact syndrome). **This is why it is so important to remove anyone with suspected concussion from the at-risk activity immediately**.

Onset of symptoms

8.8 The symptoms of concussion typically appear immediately, but their onset may be delayed and can appear over the first 24-48 hours following a head injury. Over several days, additional symptoms may become apparent (e.g. mood changes, sleep disorders, problems with concentration).

8.9 If a player does not show immediate signs or symptoms of a concussion but the force of the injury is such that a concussion is a possibility, then they must not return to competition, training, or exercise within 24 hours. ***"When in doubt, sit them out."***

8.10 Every child who has a head injury must be assessed to determine severity and appropriate care. The child's medical notes, if possible, will be checked and any previous history of head injury must be noted. A history of previous concussion increases the risk of sustaining a further concussion, which may then take longer to recover from.

Immediate Management Of A Suspected Concussion

9.1 Anyone with a suspected concussion should be immediately removed from play.

9.2 Once safely removed from play they must be assessed by a Nurse (or First Aider if out of hours). The witness to injury should note all signs and symptoms of concussion to hand over.

9.3 The Nurses can be called pitch-side, or the child can be accompanied to the Medical Centre as appropriate.

9.4 At weekend fixtures the child will be assessed by pitch-side first aiders; however qualified healthcare professionals should only diagnose concussions.

9.5 The Pocket Concussion Recognition Tool (CRT6[3]) symptom and signs check list can be used to assess players and is available to download here.

9.6 The pupil cannot return to play until cleared by a Health Professional or until they have completed a Graduated Return to Activity (education) and Sport (play) or 'GRAS' programme.

9.7 If a neck injury is suspected, the child should only be moved by Healthcare Professionals with appropriate training.

Following A Suspected Concussion – Roles:

9.8 The **Teacher or Coach** that is supervising the activity will:

- Safely remove the child from play and ensure they do not return to play in that game even if they say their symptoms have resolved.
- Observe the child or assign a responsible adult to monitor them. Seek assessment from the Nurses.
- Ensure that the parents are notified. (The Nurses will do this if involved)
- Complete an accident report form.

9.9. The **Medical Centre** will:

- Ensure an adult will be supervising the child over the next 24-48 hours.
- Ensure an accident report form is completed by the witness or supervising staff member.
- Initiate the GRAS protocol.
- Communicate to parents via email if a concussion is diagnosed and provide written guidance using the Medical Centre's own leaflets and guidance.
- Communicate to relevant SLT members and staff who teach the child if a concussion is diagnosed.

9.10 The **Parents** are expected to:

- Follow school guidelines and GRAS for their child including for out of school activities.
- Inform the school of any concussion sustained at out-of-school activities.

Recover And Return After Concussion Diagnosis

10.1 **Anyone with suspected concussion needs to go through the Graduated Return to Activity and Sport (GRAS) programme pathway.**

[3] https://keepyourbootson.co.uk/wp-content/uploads/2022/03/CRT-6.pdf

10.2 The majority (80-90%) of concussions resolve in a short (7-10 days) period in adults but this may be longer in children as they:

- are more susceptible to brain injury.
- take longer to recover and returning to education too early may exacerbate symptoms and prolong recovery.
- have more significant memory and mental processing issues.
- are more susceptible to rare and dangerous neurological complications, including death caused by a second impact before recovering from a previous concussion.

10.3 Pupils who sustain two or more concussions in a 12-month period should be referred to their doctor for a specialist opinion in case they have an underlying pre-disposition.

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

10.5 After initial assessment and confirmation of concussion by an appropriate Healthcare Professional, advice on the graduated return to activity (education) and sport programme will be provided by the Medical Centre. The amount of time at each step of the return will be under the supervision of an appropriate Healthcare Professional and will depend on the severity of symptoms and the types of symptoms and difficulties that are present. This can vary from person to person and is not a 'one size fits all' process.

10.6 Teachers are expected to observe the pupils for the following and report any concerns back to the Nurses throughout the GRAS process, including:

- Drop in academic performance- difficulties with schoolwork or problem solving.
- Poor attention and concentration in class
- Unusual drowsiness or sleeping during class.
- Inappropriate emotions
- Unusual irritability
- Increased anxiety or nervousness

10.7 After a 24–48-hour period of relative rest, a staged return to normal life (education) and sport at a rate that does not exacerbate existing symptoms, more than mildly, or produce new symptoms is the main aim. This is before return to sport is contemplated.

10.8 It is acceptable to allow pupils to return to school activities, and subsequently school part-time (e.g. reintroduce prep> half day (with rest)>full day (with rest)>full day), even if symptoms are still present, provided that symptoms are not severe or significantly worsened. The final stage of return to school or work activity is when the individual is back to full pre-injury mental activity, and this should occur before return to unrestricted sport is contemplated.

10.9 Similar to the return to education progression, the return to sport progression can occur at a rate that does not, more than mildly, exacerbate existing symptoms or produce new symptoms. It is acceptable to begin light aerobic activity (e.g. walking, light jogging, riding a stationary bike etc.), even if symptoms are still present, provided they are stable and are not getting worse and the activity is stopped for more than mild symptom exacerbation. Participating in light physical activity is beneficial and has been shown to have a positive effect on recovery. Symptom

exacerbations are typically brief (several minutes to a few hours) and the activity can be resumed once the symptom exacerbation has subsided.

10.10 Although symptoms may resolve following a concussion, it takes longer for the brain to recover. The aim is to: ***Rehabilitate the person – give the brain time to recover.***

10.11 If symptoms persist for more than 28 days, individuals need to be assessed by an appropriate Healthcare Professional – typically their GP.

10.12 Ongoing communication between parents, academic teachers and nurses is essential to ensure symptoms are shared and monitored throughout. The medical centre will take the lead with monitoring the symptoms through the progression through the progression of the GRAS pathway.

10.13 **It must be emphasised that these are minimum return to play times and in players who do not recover fully within these timeframes, these will need to be longer.**

10.14 If any symptoms occur while progressing through the GRAS protocol, the pupil must be seen by the Nurses before returning to the previous stage and attempting to progress again, after a minimum 48-hour period of rest, without the presence of symptoms. The Nurses may refer back to the child's Doctor.

10.15 On completion of Stage 5 the pupil may resume full contact matches (Level 6) once s/he has obtained medical clearance from their own Doctor that is the parent's responsibility to organise; this medical clearance is important for parents in making an informed decision over their child's return to fully-competitive events.

Graduated Return to Activity (education/work) & Sport Pathway

11 GRAS Summary:

Stage 1 (0-1/2 days)	Relative rest for 24-48 hours – Minimise screen time – Gentle exercise*
Stage 2 (1-2 days)	Gradually introduce daily activities* – Introduce mental activities away from school – Very light activity (e.g gentle walks that shouldn't leave you breathless)
Medical Assessment To confirm diagnosis and give recovery advice	
Stage 3 (3-7 days)	Gradually return to schoolwork* – A stepwise re-introduction to schoolwork – Increase tolerance to exercise activities – Light aerobic exercise
Stage 4 (8-15 days)	Gradual return to exercise* – Full education/work – Low risk exercise and training (running, stationary bike, swimming with no predictable risk of head injury) – Gradual increase in exercise intensity
Medical Assessment To advise readiness to start a formal return to sport.	
Stages 5 (15-21 days)	Gradual return to sports training* (led by sports department) – A stepwise return gradually building up complexity and intensity. – E.g. Sport-specific drills>non-contact drills> introduction of contact drills>full contact practice.

Medical Assessment To assess fitness to return to unrestricted sport, including matches.	
Stage 6 (Day 21 earliest)	Return to competitive sport/matches • Only if symptom free at rest for at least 14 days and has completed gradual return to sports training without any recurrence in symptoms.

**rest until the following day if this activity more than mildly increases symptoms.*

N.B. If a pupil is not able to return to school or fully engage with lessons at 1 week post-injury or has persistent symptoms at 2 weeks (unless a clear trajectory of improvement) then further medical treatment must be sought.

Section Owner (6,7,8,9,10,11):	**Anna Corbett, Nursing Manager**

Breaches of this policy

12 The School takes its duty of care very seriously. The School will take appropriate action against any person found to have breached this policy. For example:

- if a **pupil** attempts to return to play in breach of their GRAS programme, the School will consider the matter under the School's Behaviour Policy;
- if a **member of staff** fails to report a head injury, the School would consider the matter under the School's staff disciplinary policy;
- if a **parent fails** to report to the School a head injury their child sustains outside of School, the School will consider the matter under the terms of the School parent contract.

Head injury at a non-Danes Hill activity:

13.1 Danes Hill acknowledge that pupils will also play sports outside of school and a range of activities as part of a healthy lifestyle.

13.2 The management of head injuries across school-based activities and out-of-school activities requires management. It is therefore particularly important that the School, pupils, and their parents take an integrated approach to the management of head injury causing concussions and cooperate with regards to sharing information.

13.3 Repeat Concussions, known as 'Second Impact Syndrome' (SIS), or Chronic Traumatic Encephalopathy (CTE), where another concussion occurs following the return to play, are likely to involve a lengthy absence from activity. There is evidence that players are more susceptible to a second concussion following the initial event.

13.4 If a second concussion is diagnosed within the same term, after the routine medical centre assessment, the GRAS is followed BUT further contact sport will not be allowed at the school.

13.5 **Injuries sustained away from Danes Hill must be communicated to the School's Medical Centre by parents.** Where a pupil sustains a head injury which has caused a concussion whilst participating in an activity outside of the school, the parents should promptly provide sufficient details of the incident,

13.6 The School will determine the appropriate way forward on receiving a notification of this nature. That might include reviewing any GRAS plan already established by the external club, or if no such plan has been put in place, the School will review the head injury and if a concussion is diagnosed – begin the GRAS.

13.7 In turn, the School (medical centre) will inform parents when a student has sustained a head injury causing a concussion at School. Any guidance on GRAS should apply to school and out-of-school activities.

General Recommendations:

14.1 All rugby staff must have completed the ***RFU's on-line concussion module,*** and a record held by the School (Director of Sport) as part of the risk assessment, and an updated certificate stored in Cascade.

14.2 All pupils to have access to the '***RFU's Headcase card.'***

14.3 All staff to have access to the pocket-version ***'Concussion Recognition Tool'*** (see appendix).

14.4 A meeting with Deputy Head (Organisation & Co-Curricular), Director of Sport and our concussion management team at the Medical Centre to take place, annually, to discuss concussion protocols; These should be cascade to coaches via meetings within the Sport department**.**

14.5 Letter to players & parents, annually, highlighting the School's policy which highlights the collective responsibilities.

14.6 This Contact Sport & Head Injury Policy to be part of the School's wider safeguarding policy & available on the School's intranet/internet.

14.7 All medical, academic and sports staff must complete mandatory concussion training annually.

14.8 The School position is regularly checked with its insurers and will retain all policies and documents in the event of future claims to check the policy cover that is in place at the time.

14.9 Danes Hill will gain a parents' ***informed consent*** to participate in contact sports as part of our duty to demonstrate reasonable care. The parental T&Cs[4] will specifically reference contact sports and make this policy available to allow parents to make informed decisions about consent. [Our policy stance remains an 'opt-out' situation and will move to an 'opt-in' policy statement when required].

14.10 Danes Hill would never compel a pupil to play contact sports where their parents have not consented for them to play. The school's T&Cs are signed when a child is not Gillick competent however a pupil can withdraw themselves from contact sports, trumping a signed set of T&Cs when they are ***Gillick competent***. [This is likely to be when the reach the U16 level, with enough intelligence, competence and understanding to consent].

The management of head injuries, concussions and involvement in contact sports requires a holistic approach. Like safeguarding, it is everyone's responsibility.

Section Owner (12,13,14):	**Andrew Murfin, Deputy Head (Organisation & Co-Curricular)**

[4] Actioned November 2023

Appendix 1: Useful resources:

- Head Injury Leaflet: Available from the Medical Centre
- GRAS Concussion Guidelines Leaflet- Headcase Recognise and Manage a Concussion: https://keepyourbootson.co.uk/wp-content/uploads/2023/09/GRAS-Programe_Aug_2023.pdf
- RFU Pocket Concussion Recognition Tool, June 2023: https://passport.world.rugby/player-welfare-medical/concussion-management-for-the-general-public/pocket-concussion-recognition-tool/
- Headcase: Online Youth Coach Concussion Training: http://www.englandrugbyfiles.com/concussion/courses/youth-coaches/

Appendix 2: Concussion Management Tool (CRT6)

- https://www.sportengland.org/news/new-concussion-guidelines-grassroots-sport

CRT6™

Concussion Recognition Tool

To Help Identify Concussion in Children, Adolescents and Adults

What is the Concussion Recognition Tool?

A concussion is a brain injury. The Concussion Recognition Tool 6 (CRT6) is to be used by non-medically trained individuals for the identification and immediate management of suspected concussion. It is not designed to diagnose concussion.

Recognise and Remove

Red Flags: CALL AN AMBULANCE

If **ANY** of the following signs are observed or complaints are reported after an impact to the head or body the athlete should be immediately removed from play/game/activity and transported for urgent medical care by a healthcare professional (HCP):

- **Neck pain or tenderness**
- **Seizure, 'fits', or convulsion**
- **Loss of vision or double vision**
- **Loss of consciousness**
- **Increased confusion or deteriorating conscious state (becoming less responsive, drowsy)**
- **Weakness or numbness/tingling in more than one arm or leg**
- **Repeated Vomiting**
- **Severe or increasing headache**
- **Increasingly restless, agitated or combative**
- **Visible deformity of the skull**

Remember

- In all cases, the basic principles of first aid should be followed: assess danger at the scene, check airway, breathing, circulation; look for reduced awareness of surroundings or slowness or difficulty answering questions.
- Do not attempt to move the athlete (other than required for airway support) unless trained to do so.
- Do not remove helmet (if present) or other equipment.
- Assume a possible spinal cord injury in all cases of head injury.
- Athletes with known physical or developmental disabilities should have a lower threshold for removal from play.

If there are no Red Flags, identification of possible concussion should proceed as follows:

Concussion should be suspected after an impact to the head or body when the athlete seems different than usual. Such changes include the presence of **any one or more** of the following: visible clues of concussion, signs and symptoms (such as headache or unsteadiness), impaired brain function (e.g. confusion), or unusual behaviour.

CRT6 Concussion Recognition Tool

To Help Identify Concussion in Children, Adolescents and Adults

1: Visible Clues of Suspected Concussion

Visible clues that suggest concussion include:

- Loss of consciousness or responsiveness
- Lying motionless on the playing surface
- Falling unprotected to the playing surface
- Disorientation or confusion, staring or limited responsiveness, or an inability to respond appropriately to questions
- Dazed, blank, or vacant look
- Seizure, fits, or convulsions
- Slow to get up after a direct or indirect hit to the head
- Unsteady on feet / balance problems or falling over / poor coordination / wobbly
- Facial injury

2: Symptoms of Suspected Concussion

Physical Symptoms
Headache
"Pressure in head"
Balance problems
Nausea or vomiting
Drowsiness
Dizziness
Blurred vision
More sensitive to light
More sensitive to noise
Fatigue or low energy
"Don't feel right"
Neck Pain

Changes in Emotions
More emotional
More Irritable
Sadness
Nervous or anxious

Changes in Thinking
Difficulty concentrating
Difficulty remembering
Feeling slowed down
Feeling like "in a fog"

Remember, symptoms may develop over minutes or hours following a head injury.

3: Awareness

(Modify each question appropriately for each sport and age of athlete)

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

"Where are we today?"

"What event were you doing?"

"Who scored last in this game?"

"What team did you play last week/game?"

"Did your team win the last game?"

Any athlete with a suspected concussion should be - IMMEDIATELY REMOVED FROM PRACTICE OR PLAY and should NOT RETURN TO ANY ACTIVITY WITH RISK OF HEAD CONTACT, FALL OR COLLISION, including SPORT ACTIVITY until ASSESSED MEDICALLY, even if the symptoms resolve.