Sport Duty of Care Review: call for evidence from the Department for Culture, Media & Sport

Submission by
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We welcome the opportunity to respond to this important and timely review on the duty of care to athletes and participants in sport and in particular the interpretation of safeguarding of young people in sport as the prevention of harm, abuse and neglect in its widest sense. Our submission concerns the evidence of harms, both psychological and physical, to young people playing sport in schools.

In March 2016 we were signatories to an open letter to the Chief Medical Officers, Children's Commissioners and Ministers for sport and education in the four countries of the UK, calling for a ban on tackling in school rugby. [1] The responses to that letter highlight the serious gaps that still exist in the thinking and policy approaches adopted by UK governments in respect of the protection of children from harms of sport. The responses from government departments and Sport England to our letter highlight how Ministers and policy makers conflate the benefits of sport with physical activity and ignore the need for injury surveillance to inform prevention strategies and policies and risk assessment.

Our submission covers five areas i) how government policy conflates the benefits of sport including contact sport with physical activity in general and in the school curriculum; ii) that sports and contact sports such as rugby should not be compulsory in schools; iii) the lack of monitoring and data on injury and participation rates in sport to inform prevention; iv) the rights of the child and health and safety legislation; v) primary prevention with regards to injury and concussion should be a priority, management of injury is secondary prevention.

i) Conflation of benefits of physical activity with benefits of sport

Our previous evidence to the Health Select committee in 2014 has noted that a clear distinction must be made between the benefits arising from physical activity to those specifically from sport. We argue that this distinction must be maintained not least due to the commercial pressures of sport governed by corporate sporting bodies. (Pollock AM and 16 other members of the Child Sport Participation Workshop, 2014, Pollock and Kirkwood, 2016). In our view, if children are to be protected, governance of the sport including the rules of play in schools should be determined by the country's Department for Education and not sporting bodies.

ii) Compulsory participation in school sport

Physical education is compulsory in primary and secondary schools across Europe including the UK. (EuropeanCommission/EACEA/Eurydice, 2013) In England, physical education forms part of the national curriculum. In Scotland, state schools have autonomy to choose the activities required to meet the curriculum requirement whereas in England, Wales and Northern Ireland it is compulsory

[1] http://www.sportcic.com/resources/Open%20Letter%20SportCIC%20March7%202016.pdf

for state schools to provide activities within the broad categories of Athletics, Dance, Games, Gymnastics, Health and Fitness, Outdoor and Adventure, Swimming and Winter Sports. Schools are given wide discretion over the choice of sports but there is little evidence that children are given choice over sports. In England, whereas faith schools must follow the national curriculum, academy schools and free schools can set their own curriculum, as can private schools. The Association for Physical Education takes the view that parents should be informed which sports a school provides and base their choice of school on that information; further they expect children to be "asked" to participate in those sports should they attend that school [2]. However, no guidance is given to parents whose children find themselves at a school where they are "asked" to play a sport which they believe may be dangerous or potentially harmful to health or they actively dislike. In many schools, sport is compulsory and there is no choice. The Children's Commissioner for Wales, Sally Holland, states that in her view children should not be forced to play any sport.[3] In our view children and parents should be able to exercise choice as to whether they play particular sports within school and should be free to do so without any coercion or pressure.

We would draw attention to the practice in some schools to make some sports, including collision sports such as rugby, compulsory; no choice or information on risks is offered and there is a need for clear advice from the government to ensure information on risks accompanies a choice of sport in all schools. For example, in a 2015 survey of 116 private schools, 76% were found to have compulsory full contact rugby (Polly Brandon unpublished survey).

iii) Injury monitoring and risk assessment to inform prevention and management

We would also draw attention to the failure of all governments across the UK to put in place comprehensive injury surveillance systems in order to communicate the harms and risks of injuries from sport at grassroots level and in schools. Injury data are vital for prevention and risk assessment, without them the relevant authorities cannot comply with their obligations in respect of health and safety legislation and the United Nations Convention on the Rights of the Child (see Appendix 1).

The Rights of the Child and health and safety legislation are underpinned by a need for information and in particular **injury data to inform risk assessment and prevention strategies for the protection of children.**

The UK has a poor record of collecting injury data. The home and leisure injury surveillance system (HASS / LASS) was discontinued in 2002; in any case it lacked sufficient detail on sport, setting, mechanism and context. This situation may improve if the NHS implements the emergency care data set (ECDS)[4] which provides detailed coding for injuries by individual sport within the NHS for the first time in England.

In the example below we use two different sources of data to show how head injury data from the pilot injury data collection exercise for ECDS in Oxfordshire can be compared with sport participation data using data from the 2014/15 "Taking Part" household activity survey which list sport participation rates over the previous 4 week period (see tables 1 & 2 below) for 5 to 10 year olds and for 11 to 15 year olds.[5]

[2] http://www.afpe.org.uk/news-a-events/1102-afpe-fully-supports-the-inclusion-of-rugby-within-national-curriculum-physical-education

[3] Response to SCIC open letter, Sally Holland Children's Commissioner for Wales 29th March 2016

[4] https://www.england.nhs.uk/ourwork/tsd/ec-data-set/

[5] https://www.gov.uk/government/statistics/taking-part-201415-annual-child-release

Table 1. Sport related emergency department (ED) attendances for head injury 5-10 year olds, Oxford University Hospitals NHS Foundation Trust, Jan 2012 to Mar 2014 and participation rates from Taking Part Survey 2014/15.

Sport	Head Injuries		Taking Part Survey (Out of School)	
	Number of ED Attendances	Rank	Participation Rate	Rank
Trampoline	19	1	15.6%[1]	5
Football	17	2	33.5%	2
Cycling	8	3	30.4%	3
Ice-Skating	6	4=	3.1%	21
Rugby[2]	6	4=	3.3%	20
All Other Sports	39			
Total	95			

1 - Gym, gymnastics, trampolining or climbing frame; 2 – Rugby Union and Rugby League as type of rugby not specified in Taking Part Survey

Table 2. Sport related emergency department attendances for head injury 11-15 year olds, Oxford University Hospitals NHS Foundation Trust, Jan 2012 to Mar 2014 and participation rates from Taking Part Survey 2014/15.

Sport	Head Injuries		Taking Part Survey (In or Out of School)	
	Number of ED Attendances	Rank	Participation Rate	Rank
Rugby[1]	60	1	19.6%	15
Football	41	2	52.7%	1
Hockey	14	3	14.2%	17
Horse-Riding	12	4	2.9%	24
Skateboarding	10	5	7.8%[2]	20
Ice-Skating	8	6	6.0%	21
Trampoline	5	7	28.5%[3]	3
All Other Sports	57			
Total	207			

1 – Rugby Union and Rugby League as type of rugby not specified in Taking Part Survey; 2 - Roller skating/blading or skate boarding; 3 - Gym, gymnastics, trampolining or climbing frame

Table 2 shows high numbers of attendances for head injury in 11-15 year olds compared with participation rates e.g. rugby (ranked 15th participation) and ranked 1st for head injury profile. Other sports with higher head injury profiles compared to participation are hockey, horse-riding, skateboarding, and ice-skating. For younger children (5-10 years) trampolining also stands out. These tables show why data collection on injury rates and participation rates are important and need to be considered together.

iv) Safeguarding policies should be grounded in the United Nations Convention on the Rights of the Child and Safeguarding and Health and Safety Legislation.

We would argue that compelling children to play any sport, failing to inform them about the risks of injury and the absence of injury monitoring systems and primary prevention strategies places the government in dereliction of its duties under the UN Convention on the Rights of the Child (see appendix). We would recommend a greater onus be placed on the Health and Safety Exec to protect children from inadequate risk assessment and to monitor sports injuries.

School pupils are considered by the Health & Safety at Work etc. Act 1974 (HASAWA) [6] to be members of the public; section 3 of the Act imposes a duty on schools to ensure, so far as is

[6] http://www.legislation.gov.uk/ukpga/1974/37

reasonably practicable, that pupils are not exposed to risks to their health and safety. Regulation 3 of The Management of Health and Safety at Work Regulations 1999 [7] requires that a school makes a suitable and sufficient risk assessment of risks to pupils. There are two statutory instruments which require a school to take the safety of pupils seriously. However, a rugby injury would not routinely be within the compass of this protective legislation, as participation in rugby is deemed to be a matter of *"volenti non fit injuria"*, which holds that there is an acceptance of risk by the pupil and that there cannot subsequently be redress for injury sustained. This doctrine is often used in defence against tort actions resulting from sports injury.

The HSE will not investigate sports injuries which are deemed to result from "the normal rough and tumble of the game" [8], so there is no obligation for a school to report them, this means, in practice, that other criteria would trigger the requirement for an investigation. It is striking that HSE will only prosecute schools under Section 3 of the HASAWA in areas of the school curriculum whereby a pupil has been injured as a consequence of inadequate management of a work related activity[9] such as design and technology, but will not investigate rugby injuries on the same basis. The failure to investigate sports injuries in schools and to respond to requests from parents for investigations does not provide for effective protection of pupils and the meaningful accountability of schools.

Section 7 of HASAWA[10] which relates to the General Duties of employees which requires an employee:

- to take reasonable care for the health and safety of himself and of other persons who may be affected by his acts or omissions at work; and
- as regards any duty or requirement imposed on his employer or any other person by or under any of the relevant statutory provisions, to co-operate with him so far as is necessary to enable that duty or requirement to be performed or complied with

Similarly, Section 8[11] confirms:

- No person shall intentionally or recklessly interfere with or misuse anything provided in the interests of health, safety or welfare in pursuance of any of the relevant statutory provisions.

Health and Safety Policy Statement

The HASAWA (Section 2.3) requires schools to produce a policy statement which sets out its general policy for health and safety and arrangements for putting policy into practice. This confirms, *inter alia*, a commitment to providing adequate control of risks arising from work activities, consulting with employees on matters affecting their health and safety, providing information and training so as to promote employee competence, and preventing accidents.

The Health and Safety Executive's 2016 Strategy Document "Helping Great Britain Work Well"[12] has two core principles:

[7] http://www.legislation.gov.uk/uksi/1999/3242/made
[8] http://www.hse.gov.uk/pubns/edis1.pdf
[9] http://www.hse.gov.uk/prosecutions/breach/breach_details.asp?SF=BID&SV=4370145001
http://www.hse.gov.uk/prosecutions/case/case_details.asp?SF=CN&SV=4423927
[10] http://www.legislation.gov.uk/ukpga/1974/37/section/7
[11] http://www.legislation.gov.uk/ukpga/1974/37/section/8
[12] http://www.hse.gov.uk/strategy/assets/docs/hse-helping-great-britain-work-well-strategy-2016.pdf

- Those who create risks have a responsibility to manage those risks
- Action should be proportionate to the risks that need to be managed

It is, therefore, essential that schools plan to manage sports and rugby risk within an organisational framework which provides structured direction, monitoring and accountability rather than one which, if there is no framework, simply leaves all management decisions to practitioners whose predominant skills lie in coaching rugby and not necessarily in the skilled and informed management of safety. (John Ridge- unpublished paper)

v) Primary prevention of injury including concussion should be the priority while management of injury protocols must also be evaluated.

While concussion awareness and return to play protocols (although these are often untested and unvalidated) are important, prevention of concussion and other more serious traumatic brain injuries is essential, but not the primary focus of schools.

An association has been found between repeat concussions and poorer cognitive function in young adult male rugby players, at least three months after their last concussion. (Gardner et al., 2010) There is also evidence of an association between repeat concussions and depression, mild cognitive impairment, poorer memory and verbal fluency and electrophysiological abnormalities diagnosed in later life among former American football and ice hockey players. (Guskiewicz et al., 2007, Guskiewicz et al., 2005, De Beaumont et al., 2009, Tremblay et al., 2013) There have also been multiple autopsy findings of chronic traumatic encephalopathy (CTE), similar to that found in ex-boxers and military veterans, in the brains of former professional athletes in American football, ice hockey and wrestling (McKee et al., 2009, McKee et al., 2013, Gardner et al., 2014, Stern et al., 2011) and in the brains of former rugby players. (Gardner et al., 2014, BBC News, 2013, Lawton, 2014) Children are more likely to experience concussion than adults and take longer to recover. (Harmon et al., 2013, American Academy of Neurology, 2013, Zuckerman et al., 2012) There is evidence that concussion is a relatively more common injury among rugby playing children and adolescents than it is among adult players. (Yard and Comstock, 2006) Youth players are at increased risk of what is known as 'second impact syndrome', a potentially fatal phenomenon where a player sustains a second head injury without fully recovering from the effects of the first. (Halstead and Walter, 2010)

Games and sports which involve repetitive head trauma need to be made safe for children to play, protective equipment it has been shown has no role to play in this (McCrory et al., 2013, Benson et al., 2009), thus requiring rule changes. With respect to rugby, most injuries including concussion happen in the tackle phase of the game, mostly being tackled but also tackling. Overall, tackle, which includes tackling and being tackled, accounts for most injuries in rugby. Estimates range between 39.6% and 64% of rugby injuries in youth and children from tackles. (Freitag et al., 2015) With concussion specifically, it has been estimated up to nearly 90% could be associated with being tackled, tackling and rucks. (Collins et al., 2008) Being tackled is generally found to account for more injuries (16.5–65%) than active tackling (18.5–40%). (Freitag et al., 2015)

On the basis of the evidence we recommend removing the contact element of the game for children as the quickest and simplest way to make the game of rugby safer in schools. As a replacement, touch or tag rugby can be played by children to enable them to learn the rules and techniques of rugby, both union and league, in a safe environment.

The majority of cervical spine injuries in rugby are likely to be due to buckling of the cervical spinal column, with most occurring during open play, in particular during a tackle. (Kuster et al., 2012) Prior

to 2000 the scrum (either scrum engagement or scrum collapse) was the phase of play most associated with cervical spine injury. (Kuster et al., 2012) As outlined above a rule change around tackling in children would reduce the incidence of spinal injury and catastrophic injury more generally. Contact should not be reintroduced unless and until it has been shown to be safe to do so and that monitoring is also in place.

Recommendations

i Government policies for participation in physical activity in schools should not be conflated with sport and contact sport in particular.

ii No sport should be compulsory in any school and all UK governments should issue guidance to ensure that children are given a choice of physical activity.

iii Injury surveillance and monitoring of all sports must be undertaken by schools and sport injuries in school reported to Health and Safety Executive.

iv UK governments must implement injury data collection in accident and emergency departments and for all sports via the new Emergency Care Data Set for the NHS.

v The Health and Safety Executive should extend its scope to sports injury data collection and advice on and monitoring of risk assessment measures in schools and clubs. The HSE should be responsive to parents' and children's requests for investigation into school injuries

vi All schools should put in place dynamic risk assessment systems for sports with the named senior member of the school held responsible for implementing Health and Safety Strategy and policies through a robust governance structure which in turn holds the school to account.

vii The governance of sports for schools should be separated out and removed from the jurisdiction of sporting bodies to the Department of Education.

viii Primary prevention of injuries due to sport in children should be the focus of all relevant government departments, and sporting bodies and not just management of harms.

ix The contact element from the game of school rugby should be removed and not reintroduced unless and until the risks of injury are shown to be minimal and can be monitored.

x Concussion guidance and return to play protocols in all contact sports should be adopted at every level of play. All management protocols for injury and prevention should be evaluated to show whether they work or not.

Appendix 1

The United Nations Convention on the Rights of the Child was signed by the United Kingdom (UK) in 1990, and came into UK law in 1992.

Article 3 states that

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 13 states that

1. The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.

2. The exercise of this right may be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:
(a) For respect of the rights or reputations of others; or
(b) For the protection of national security or of public order (ordre public), or of public health or morals.

and Article 19 states that

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

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