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# Concussion Reporting and Safeguarding Policy Development in British American Football: An Essential Agenda

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10

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28 **Abstract**

29 The objective of this study was to examine concussion reporting and safeguarding policy in British  
30 American Football (BAF). Data were collected via an online survey tool. The data presented are part of  
31 a broader study that examined the injury profiles, reporting concussion behaviours and medical  
32 provision in BAF. When asked about overall playing experience, concussion like symptoms were found  
33 in over half (58.8%) of participants. Of those, 36.4% reported they had previously been formally  
34 diagnosed with a concussion whilst playing BAF. Just under half of participants (44.7%) had suspected  
35 they'd had a concussion, although this was not formally diagnosed, and 23.5% of participants had  
36 previously hidden concussion symptoms. Fifty eight percent of teams reported they did not have a  
37 regular game day medic, with a range of hired medical personnel who attended games. Prominent  
38 barriers to consistent medical hire included; budget, institutional barriers, lack of medic reliability and  
39 game knowledge. BAF is a developing sport with a clear vision for growth of participation. Yet, the  
40 current concussion and medical provision policy do not address the sport's welfare needs. Through  
41 discussion of these policies in the context of this study's findings, we highlight vital areas for concern  
42 in policy and practice that the British American Football Association need to address in their medical  
43 and concussion policies.

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## 62 Introduction

63 American football (AF) is one of the most popular sports in the United States (US) with approximately  
64 5.16 million tackle players and 6.57 million non-contact flag football players in 2018 (Statista, 2021).  
65 The sport regularly attracts numbers of around 500,000 spectators per team across the National Football  
66 League (NFL) season (Statista, 2021). In the United Kingdom (UK), the game is less popular, yet  
67 growing. According to the UK national governing body, the British American Football Association  
68 (BAFA), there were 462 registered teams in the 2019/20 season.

69 American Football was first popularised in the UK in the early 1980s (Maguire., 2011) and soon a  
70 league was developed under the title of the American Football League (UK) (Needham., nd), which  
71 was replaced by BAFA in 2010 (Crawford., 2016). AF was first played at university level in 1985 as a  
72 four team league (Bayram et al., 2020). Since this time, the game is now played under the British  
73 Universities and Colleges Sport (BUCS) umbrella. In the 2019/20 season this league encompassed over  
74 80 teams (BUCS, 2021).

75 Following recent changes to the governance of BAFA a ‘10-year vision to professionalise British  
76 American football and inspire people to play the game’ was outlined (BAFA, 2020). This vision  
77 statement includes (but is not limited to); ‘accessible, inclusive, safe and enjoyable’ participation  
78 growth across all levels, long term athlete development and supporting the quality and quantity of game  
79 day staff (BAFA, 2020). As part of this professionalisation, BAFA have developed a number of policies,  
80 including medical provision and concussion policies to support the safe participation of players.

81 The 2017 medical policy for tackle AF highlights 5 key areas for minimum standards:

- 82 1) the professional body the first aider is registered to,
- 83 2) the first aider should not be a team member,
- 84 3) a risk assessment should be carried out by the first aider,
- 85 4) a ‘suitable’ first aid kit which is ‘approved by the professional practitioner’ must be available
- 86 5) a telephone with signal should be available.

87 The policy states that these are minimum medical guidelines for teams to manage. Games will be  
88 suspended if these guidelines are not met. Additionally, BAFA’s concussion policy states it is the shared  
89 responsibility of player, coaches and club management to oversee the recovery of an athlete following  
90 a concussion.

91 Unlike in the US where players are brought up playing the game from a young age (Findler, 2015), few  
92 UK athletes begin playing AF until later into their teens or early adulthood. Indeed, in their review of  
93 UK BUCS AF player injuries, Bayram et al (2020) found 39.5% of players had no playing experience  
94 before the season began, and over 80% of athletes started playing the sport at university that year. One  
95 potential risk of limited knowledge and experience of playing the game is increased injury incidence  
96 requiring medical intervention. Bayram et al. (2020) have reported that UK university AF injuries to be  
97 comparably different to US collegiate football athletes. Specifically, UK university players were found  
98 to have greater risk of concussion and more severe injuries. Running backs and line-backers were found  
99 to have the highest injury rates, potentially due to their involvement in high-speed tackles (Ward et al.,  
100 2018; Edwards et al., 2018). Moreover, injury rates in offensive and defensive linemen were  
101 proportionally higher than US collegiate athletes (Bayram et al., 2020; Badgeley et al., 2013; Dompier  
102 et al., 2015). It is proposed that these findings are due to small roster sizes found in the UK game, thus  
103 meaning more game time for individuals. Furthermore, the provision of strength and conditioning,  
104 funding, coaching, officiating and medical facilities are far from comparable to that of the US sport  
105 (Bayram et al., 2020).

106 AF exposes athletes to frequent collisions and high-velocity movement, placing the athlete at  
107 considerable risk of both musculoskeletal (MSK) injury and head injuries (Edwards et al., 2018). For  
108 example, during the 2019 NFL preseason and regular season there were 224 diagnosed concussions  
109 (Battista., 2020) and during the 2012 and 2013 seasons 262 concussions were reported in collegiate  
110 players (Dompier et al., 2015). Comparably, Bayram et al (2020) reported 3 times the risk of concussion  
111 in UK university football to collegiate football in the USA. However, due to a significant shortfall of  
112 research in the British game, we do not know the extent of injuries within British American Football  
113 (BAF) across all levels. More importantly, our knowledge of reporting behaviours, injury profiles,  
114 physiological demands, injury management protocols and knowledge of these protocols among BAF  
115 players and staff continues to be sparse. As such, the concussion incidence rate could be higher. The  
116 tendency for players to under-report injury (Kroshus et al., 2015; Cranmer and LaBelle, 2018) is  
117 particularly concerning in light of the emergence of Chronic Traumatic Encephalopathy (CTE) as a  
118 potential long term effect of concussion (Omalu et al., 2010) and second-impact syndrome, the  
119 consequence of a second head impact which can lead to severe neurological consequences, and even  
120 death (Jordan 2013).

121 Concern for the secondary effects of concussion have led to increased scrutiny from key game  
122 stakeholders regarding the safety of players. Indeed, media, sports fans, athletes and academics have  
123 called for abolishment of the sport, arguing that football is now too dangerous a game to play (Findler.,  
124 2015). Recent years have seen a decline in US youth football participation. This decline is reportedly  
125 due to concerns over head injuries sustained during participation (The National Federation of State and  
126 High School Associations., 2019; Pielke., 2020). In light of this, the NFL and USA Football (USA's  
127 AF national governing body) have taken various steps to make the sport safer. These steps include  
128 implementation of baseline concussion tests and concussion evaluations that help medics determine  
129 whether or not a concussion has occurred (McDaniel.,2019). Additionally, there are now strict 'return  
130 to play' policies at all levels of the sport for those athletes who have had a suspected concussion, and  
131 helmet-to-helmet hits have been banned. The 'Heads Up Football' tackling programme was introduced  
132 by USA Football and there is a limit on the number of full-contact practices that can take place in one  
133 season (Findler et al., 2015). However, at present, the British game has not taken the same steps to  
134 reduce injury and suppress the anxieties of those involved in its own game. Rather, it has signposted  
135 the aforementioned resources from USA Football which may not be suitable to the British game due to  
136 potentially different rates of injury compared to US AF (Bayram et al., 2020) and game day staff  
137 provision. Furthermore, BAFA's minimum medical requirements provide basic life support only, rather  
138 than consider the inclusion of MSK injury and concussion care. This is evidenced in the concussion  
139 policy which is an educational document for the athlete (how to recognize concussion and safely return  
140 to play) rather than an informative medical policy for the medical practitioner. Yet, as seen in the  
141 aforementioned studies conducted in the UK, BAF players are at greater risk of MSK and head injury  
142 (Bayram et al., 2020) than cardiac arrest. Thus, if the BAF game wishes to develop, steps should be  
143 taken to support player welfare in light of data from its own population. This is particularly important  
144 when smaller team rosters mean greater game time which could lead to an increase in injury incidence  
145 and severity (Bayram et al. 2020).

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147

## 148 **Methodology**

### 149 *Study design and procedures*

150 Data reported here are part of a broader study that examined the injury profiles, reporting concussion  
151 behaviours and management of these injuries in BAF. The present data aimed to examine concussion  
152 reporting and safeguarding policy in BAF.

### 153 *Procedure*

154 Ethical approval was granted by Hartpury University ethics committee prior to commencing the study.  
155 Potential participants were approached via email and social media (Twitter, Facebook and Instagram)  
156 in order to reach participants nationally. Both non-validated surveys were made available via Online  
157 Surveys and the link shared via previously stated methods. Consent to participate was required prior to  
158 proceeding with the questionnaires and participants were guaranteed that neither their identity nor their  
159 team's identity would be disclosed.

160 The first questionnaire explored the profile of players across leagues in BAF, their injury status and  
161 concussion reporting behaviour. This questionnaire included sections on player demographics (14  
162 questions), concussion history (6 questions) and reporting behaviour (4 questions). Data were collected  
163 from 226 participants (mean age  $24.0 \pm 5.7$ ) across the BAF leagues. Participants were excluded if they  
164 were under 18 years old. The majority (83.2%) of participants reported that they had played between 0-  
165 6 years of AF.

166 Table 1 shows participant profile across the leagues.

167 The second survey evaluated the medical provision and policy compliance in the 2019/20 BUCS AF  
168 season, and comprised of twenty four questions. This survey was completed by the BUCS club  
169 representative deemed most appropriate to complete the survey e.g. general manager, head coach or  
170 medic. Those who answered the survey participated in the sport from across the BUCS league.

171 Thirty one teams completed this survey: Premiership (19.4%, n=6), Division 1 (35.5%, n=11) and  
172 Division 2 (45.2%, n=14).

173 In addition to the closed questions, optional commentary sections were included at the end of each  
174 section to allow participants to expand upon their experiences. A thematic analysis was conducted to  
175 highlight the most recurrent and prominent themes. Descriptive statistics were calculated for both  
176 questionnaires.

177

## 178 **Results**

### 179 *Concussion*

180 Concussion like symptoms were reported in over half (58.8% n=133) of participants. Of those one  
181 hundred and thirty three, 36.4% (n= 82) reported they had previously been formally diagnosed with a  
182 concussion whilst playing BAF, and 54.9% (n=54) indicated that they had experienced more than one  
183 concussion. Of those who reported experiencing concussion like symptoms, 37.8% (n=17) reported  
184 they had experienced 2 concussions per playing career, and 15.6% (n=7) reported they had experienced  
185 5 or more concussions.

186 Just under half of participants (44.7%, n=101) reported they had suspected they'd had a concussion,  
187 however they were not formally diagnosed with one. Of these 101 participants, 52.5% (n= 53) reported  
188 this had been the case once, 28.7% (n=29) reported their suspected concussion had gone un-diagnosed  
189 twice and 5.9% (n= 6) reported that their suspected concussion had gone un-diagnosed 5 or more times.

190 Only 32.3% of teams reported conducting baseline concussion testing each new season and fewer  
191 (22.6%) carried this out with each new player who joined the team. One team commented that they  
192 have 'no concussion training at all'.

193

### 194 *Concussion and injury reporting behaviour*

195 When asked about their reporting behaviour, the hiding of concussion/s from the coach or medical staff  
196 was reported by 23.5% (n=53) of participants. Yet more participants (62.8% n= 142) reported to have  
197 previously hidden injury symptoms from coaches or medical staff. Out of those players who hid their  
198 injury symptoms, 59.9% (n=85) downplayed the injury, 35.2% (n=50) ignored the injury and 4.9% (N=  
199 7) denied any injury.

#### 200 *Medical personnel*

201 Fifty eight percent of BUCS teams reported they did not have a regular team medic. Of those who did  
202 have a regular team medic, 100% attended home games, 61.5% attended away games and 7.7% attended  
203 training.

204 There were a range of medical personnel who attended BUCS BAF games. These included  
205 physiotherapists, graduated sports therapists, paramedics, St Johns Ambulance first aiders and a sports  
206 rehabilitator. In the majority of cases (61.3%, n=19), the highest qualification of the team medic was  
207 unknown by the club representative completing the survey.

208 Of the 61.5% of teams who did not have a regular medic who attended training, their medical provision  
209 was provided by; a coach with first aid training (54.8%), a player with first aid training (32.3%), 'other'  
210 (12.9%, reported as facility/ground staff, students studying medical degrees or coaches with first aid)  
211 and 9.7% reported using an external paramedics company.

212 When teams were asked about the confidence in their medics' ability to safely remove a player's helmet  
213 and pads in an emergency (e.g. access to airways) thereby preventing inadvertent movement of the head  
214 or neck which could further compromise the athlete, 22.6% reported 'somewhat confident' and 22.6%  
215 reported 'unsure'. When asked about the confidence in their coaching staff to remove a player's  
216 equipment, 35.5% reported 'confident' and 32.3% 'somewhat confident.'

217 Positively, 83.9% reported that they would be interested in football specific first aid training.

#### 218 *Thematic analysis*

219 The commentary of participants on medical provision highlighted some common barriers to this  
220 including; expense of hiring, the shortfall of institutional support and medical personnel with a lack of  
221 reliability and experience of the game. However, two university teams highlighted their successful use  
222 of an external business in providing medical provision, although it was acknowledged that this was  
223 uncommon. These themes will be explored further in the discussion.

224

#### 225 **Discussion**

226 This preliminary study is the first to look at concussion reporting and medical provision within the BAF  
227 league, providing a grounding for further research in the field. These findings highlight some key  
228 concerns within the sport which need to be addressed by key stakeholders. As such, the results will be  
229 discussed alongside BAFA's concussion and medical provision policies to explore the significance of  
230 these findings.

231 Under the current BAFA concussion policy and medical provision requirements, individual teams are  
232 responsible for implementing their own medical management plans, which only need to meet BAFAs  
233 minimum requirements i.e. ensuring clubs have 'adequate first aid cover'. This may result in  
234 compromises in player safety when management of medical provision is left to individual teams.  
235 Indeed, one participant commented that 'all costs are met by competitors. They choose to afford  
236 minimal coverage' and another commented 'I am happy with our coverage but for away games tend to  
237 have the bare minimum required'. There appear to be two issues highlighted here. Firstly, it is unfair

238 and unsafe to place responsibility for deciding the level of medical cover on the athlete given that they  
239 may not understand the serious implications of injury and concussion (Guskiewicz et al., 2007).  
240 Secondly, the reliance on teams to self-manage their own medical provision creates disparity within the  
241 leagues and, from the comments made, could indicate that when teams are given minimal guidance in  
242 providing medical cover, teams choose the most affordable option; minimum medical requirements.  
243 However, since '[home] game management is responsible for the provision and suitability of medical  
244 facilities', travelling teams have little/no power to influence the level to which the guidelines are met.  
245 Additionally, this finding leads us to question the degree to which teams conform to the current BAFA  
246 concussion policy and their interpretation of 'adequate first aid' Thus, without stronger central  
247 governance there may be teams which fail to protect the safety of the players. As Malcolm (2019) states,  
248 it is sports governing bodies ethical responsibility at all sporting levels to ensure coaches comply with  
249 concussion policy.

250 It is not uncommon for coaches to be involved in concussion management due to the rare presence of  
251 health-care practitioners during practice (Follmer et al., 2020) yet they cannot be relied upon to manage  
252 concussion injuries due to their own responsibility for the team's success (Dillion, 2011; Partridge,  
253 2013). Research also suggests that coaches expect players to willingly put themselves at risk of injury  
254 and continue to play injured for the good of the team (Malcolm and Sheard., 2002). Thus, putting the  
255 onus on teams to manage concussion is a risk to player welfare.

256 The diagnosis of sports related concussion is perhaps one of the most challenging tasks facing sports  
257 medicine clinicians due to the uncertainty of biological markers and the need to rely heavily on the  
258 reporting of player symptoms (McCrory et al., 2017). Findings of this study indicate that 58.8% of  
259 participants believed they had previously had concussive symptoms, however 44.7% had not received  
260 a medical diagnosis. It is unclear whether these reported concussions occurred in training or during a  
261 game. As we see in the BUCS BAF game, there are inconsistencies in the medical provision at games  
262 and training. Further research should look to understand whether players who suspected they had a  
263 concussion chose not to disclose this or whether the inconsistencies in medical cover meant there was  
264 no one to disclose this injury to. This could also include investigations of the assessment of player's  
265 and game-day staff's knowledge of concussion signs and symptoms. Furthermore, baseline concussion  
266 assessment could be implemented to support diagnosis of suspected concussions (McCrory et al., 2017).  
267 Findings suggest that only 32.3% of teams carried out baseline concussion testing each season. At  
268 present, BAFA concussion policy recommends use of the Sports Concussion Assessment Tool version  
269 3 (SCAT3) in the assessment of concussion only. However, as we understand there to be inconsistencies  
270 in medical provision, implementation of SCAT in a baseline capacity might support both players and  
271 medics in the assessment of concussion and Graduated Return to Play (GRTP) process.

272 Current BAFA concussion policy states that all those involved in the game should be aware of the signs  
273 and symptoms of concussion to allow for early recognition. Yet, as BAF is an amateur sport, it cannot  
274 be presumed that all those involved in the game are familiar with indicators of concussion. Indeed one  
275 participant noted they have 'no concussion training at all'. Similar studies examining combat sport  
276 suggest that coaches are unfamiliar with recognising concussion prior to implementation of educational  
277 programmes and instead, source information from unreliable sources (Follmer et al., 2020). With 54.8%  
278 of teams reporting that the coach is the designated first aider at training, it would imply that (in this  
279 setting) they are the primary source of concussion and injury information. Behaviour such as this might  
280 exacerbate reliance on teams to manage concussion rather than medical professionals.

281 All game day staff (e.g. coaches, referees) have a duty of care to their players, therefore it is their  
282 responsibility to report the suspicion of injury (including concussion) to the game day medic. However,  
283 difficulty arises when the hired medical provision cannot be relied upon. The findings from this study  
284 suggest that BAF staff have a lack of confidence in game-day medics, calling them 'unreliable'. For  
285 example, one participant noted 'Our AU [Athletic Union] try to use the same pool of people who  
286 gradually have developed a limited experience of the sport but subject to availability, it may sometimes  
287 be someone who has no experience of the sport or the sport-specific injuries.' This is most concerning  
288 for the player's welfare because a single diagnosed concussion can have considerable health



289 implications such as a variety of neurologic and cognitive symptoms (Edwards and Bodle, 2014).  
290 Moreover, undiagnosed concussions are associated with higher post-concussion symptoms scores and  
291 higher loss of consciousness rates with further incidences of concussion (Meehan et al., 2014). While  
292 BAF's status as a new and emerging sport may mean that there are only a small pool of practitioners  
293 with specific and appropriate training in this field who are able to support the game, withholding  
294 medical cover raises significant questions for player welfare and duty of care.

295 The British American Football Coaches Association (BAFCA) does not at present require coaches to  
296 have first aid certification and current BAFA concussion policy simply encourages club personnel to  
297 complete first aid courses 'appropriate to their role' (a statement which is open to interpretation). Yet,  
298 to rely on a first aid provision by a coach, (with presumably no medical background) to recognise a  
299 concussion is unsafe. Moreover, there may be a conflict of interest given the coach's focus on  
300 performance. For example, one participant commented, 'some players who were injured or had suffered  
301 illnesses felt pressured to play while recovering from injuries or while still being ill'. As evident in the  
302 findings, players are willing to hide concussion from game day staff. Moreover, coaches may be  
303 reluctant to remove a player despite recognised signs and symptoms, due to the possible detriment to  
304 team performance (Dillion, 2011). Similar concerns are held with the 32.2% of teams who reported first  
305 aid provision came through a player at practice sessions. Current BAFA policy advises that 'clubs must  
306 ensure that they have adequate first aid cover available for all practice sessions where contact will take  
307 place', yet what determines 'adequate' is unclear. Furthermore, the policy does not stipulate whether  
308 this refers to both flag-football and tackle football, as concussion occurs in both versions of the game  
309 (Kaplan et al., 2013; Prien et al., 2018). Thus, current 'policy' may be deemed a haphazard approach to  
310 medical cover than outline true policy directives.

311 Despite the current BAFA concussion policy which states that 'players must remember their duty to  
312 inform their coach of their condition and any recurrence of it', this study shows that a 'headstrong'  
313 mentality (the willingness to conceal and play through injury (Liston et al., 2018)) is present in BAF.  
314 The results of this early study suggest that players may have greater respect for concussion injury when  
315 compared to the reporting of musculoskeletal injuries, as players reported they are more likely to hide  
316 injury symptoms (62.8%), whereas only 23.5% reported hiding concussion. A possible explanation for  
317 this is the increased media coverage of both the long and short term implications of repeated head  
318 trauma (Gardner et al., 2014). Another reason could be likened to copy-cat behaviour from that seen in  
319 the NFL and other contact sports played in England such as rugby, or the cultural practice of conforming  
320 to masculine norms (Kroshus et al., 2017) when playing through pain and injury are highly valued and  
321 positively reinforced (Atkinson, 2010; Fenton and Pitter, 2010).

322 Despite the threat that concussion poses to the National Governing Body (for example potential lawsuits  
323 from players seeking compensation for medical negligence), BAFA are yet to outline a detailed policy  
324 against this potential medico-legal action. Currently, BAFA policy on concussion has been taken from  
325 existing policies in other sports. The formation of a policy unique to BAF is required and should include  
326 consideration of the leagues, as well as a clear (GRTP) process for concussion. Yet, there are difficulties  
327 with this, for despite the sports understanding and vision to professionalise the game, there is a worry  
328 that if the policy is too detailed, participation in the sport will decrease. We understand from this study's  
329 findings that cost is a determining factor when considering the hiring of medical provision, indicating  
330 that some teams may already be financially stretched, particularly if membership numbers are low.  
331 However we should ask the question as to whether we can compromise player safety for expense.  
332 Indeed, when research suggests that UK BUCS BAF players hold 3 times the risk of acquiring a  
333 concussion during a season compared to US American football athletes (Bayram et al., 2020), action  
334 should be taken to reduce this risk. If BAFA is capable and willing to enforce rules regarding playing  
335 (including during the COVID pandemic) then we would hope that similar emphasis could be taken to  
336 address concussion policy. This is particularly important at a time when collision sports are coming  
337 under criticism for their 'contact' nature, but increasing participation and long term athlete development  
338 is part of BAFAs 10-year development/strategic plan. Putting medical regulations in place that 'do  
339 enough' but don't restrict play are required. For example, if more rigorous medical cover regulations  
340 were put in place that included sanctions for breach of minimum medical standards, this could help

341 protect player safety. What this policy eventually covers requires in-depth discussion, including how  
342 compliance will be monitored.

343 At present, the BAFA concussion policy has limited guidance for the medical practitioner with regards  
344 to GRTP following removal from the field due to concussion (i.e. who they should refer the care of the  
345 athlete to). Limitations in this current policy can be seen where teams have non-consistent medical  
346 personnel at training and games. The onus of the return to play (RTP) process is then placed upon the  
347 athlete themselves and/or the coach, neither of which may have the knowledge to safely go through the  
348 GRTP steps. As such, on game day medical practitioners (unfamiliar with the team/athlete) may  
349 experience pressures from players who dispute their diagnosis or readiness to RTP (Malcolm, 2019).  
350 Furthermore, concussion symptoms are unique to the individual (McCrory., 2017). Thus, if teams have  
351 inconsistent medical support, the recognition of these changes in a player can be tougher if the  
352 practitioner is unfamiliar with their normal behaviour e.g. recognising aggression in an athlete who is  
353 otherwise normally calm tempered. This places the medical practitioner in a difficult position and leaves  
354 them open to dispute with the athlete and coach about their removal from the game (Channon et al.,  
355 2020). It is here where we see that it is the initial diagnosis rather than the rehabilitation process that  
356 becomes an issue (McNamee et al., 2016). Therefore, this may lead to practitioners feeling pressure  
357 about the decision to diagnose concussion in the first place, risking un-ethical practice (Partridge, 2014;  
358 Malcolm, 2019). As such, when forming future policy serious consideration should be given to protect  
359 both players and practitioners.

360 Key findings suggest that only 32.3% of teams carried out baseline concussion testing each season, a  
361 method advised for interpreting suspecting post-concussion scores (McCrory et al., 2017) and  
362 advocated by other sporting bodies such as the National Collegiate Athletic Association (NCAA)  
363 (NCAA., nd). Despite literature which suggests there are limitations to the Sports Concussion  
364 Assessment Tool's (SCAT) validity and utility, it may be of use in the GRTP of a player post-  
365 concussion (Yengo-Kahn et al., 2016). However, BAFA's concussion policy recommends the use of  
366 the SCAT-3 in the assessment of concussion only, suggesting that policy should be updated to include  
367 this new recommendation which would support player welfare.

368 BAFA states that one of its core missions is to develop a 'safe and enjoyable player-focused  
369 environment' (BAFA, 2020). However the current concussion policy comes with the caveat that it is  
370 the team's responsibility to manage concussion and its education. A regulatory body which was  
371 established (in part) for the purpose of protecting the safety of its members and whose claimed mission  
372 is to promote safe play, appears to provide meagre guidelines for its league to follow.

### 373 *Limitations*

374 While this material provides an illustration of the incidence of concussion and current BUCS medical  
375 provision in BAF, this study is limited by comparisons across the different leagues and number of  
376 participating teams. However these findings should not be discredited.

377

### 378 *Conclusions*

379 To the author's knowledge, this is the first study to provide an evaluation of BAF concussion reporting  
380 and safeguarding policy. The findings provide an illustration of the incidence of concussion and current  
381 medical provision in BAF and raise questions regarding policy suitability. Through discussion of this,  
382 we provide a grounding for further research in this field in support of policy development.

383

### 384 **Conflict of Interest**

385 The authors declare that the research was conducted in the absence of any commercial or financial  
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### 392 **Contribution to the Field Statement**

393 This article discusses the injury reporting behaviours of athletes playing American Football in the UK  
394 as well as safeguarding policy development issues we see in this sport which might impact on these  
395 reporting behaviours. Not only does this add to the critical literature of concussion in a rarely  
396 discussed sport, it highlights vital areas for policy development which would be helpful in the  
397 governing body's need to grow and sustain safe participation in the sport.

398

399 *Table 1*

Version of Game	
Contact/Tackle Football	197 (87.2)
Flag/Non-tackle Football	18 (8)
League	
University Football	102 (45)
Senior men's league	74 (32.7)
Women's league	26 (11.5)
National programme	16 (7.1)
Youth league	8 (3.5)

\*Brackets denote percentage of responses in each category

400

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