SCHEDULE 3: CONCUSSION & HEAD TRAUMA

DOCUMENT CONTROL

Name:	Concussion & Head Trauma Policy
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File location:	AMS and AC Performance Services ZenDesk
Document type (& enforceability):	Policy (mandatory)
Responsible parties:	Doctors, Physiotherapists, Match Officials
Beneficiaries:	All players and match officials participating in CA-sanctioned events; All players participating and match and training as part of an AC program; All players participating in Australian elite and pathway teams in Australian and Overseas.
Applicable settings:	Matches and training where beneficiaries participating.
Governance:	CMO receives data alerts. CA reviews data quarterly. Non-adherence will be followed up at the discretion of the CMO and/or Head of Performance Services.

RELATED DOCUMENTS & LINKS

Document Name	Location
2023 Amsterdam Consensus Statement on Concussion in Sport	*https://bjsm.bmj.com/content/57/11/695*
2024 AIS Concussion and Brain Health Position Statement	*https://www.ausport.gov.au/concussion*
2024 ICC Concussion Guidelines	*https://images.icc-cricket.com/image/upload/prd/gjlkxbm7zzswtgtpqp9i.pdf*
Sport Concussion Assessment Tool (SCAT) 6th edition (SCAT6)	*https://bjsm.bmj.com/content/57/11/622*
CA Playing Conditions	*https://australiancricket.sharepoint.com/CA/SitePages/POLICIES---PROCEDURES-%26-STANDARDS---GUIDELINES.aspx?web=1*
CA Relevant Clothing and Equipment Regulations	*https://resources.cricket-australia.pulselive.com/cricket-australia/document/2023/11/01/cbec4aae-0148-43f0-82e6-4978a3c0b71f/State-Clothing-and-Equipment-Regulations-2023-24-Season.pdf*

Document Name	Location
List of published research papers informing this policy	*ZenDesk*

1. PURPOSE

1.1 Australian Cricket (**AC**) considers it critical to pursue best practice in prevention and management of concussion and head trauma arising in the course of participating in Cricket Australia-sanctioned competitions and training sessions.

1.2 Cricket Australia (**CA**) endorses the 2023 Amsterdam Consensus Statement on Concussion in Sport (**Consensus Statement**), 2024 AIS Concussion and Brain Health Position Statement, and 2025 International Cricket Council Concussion Guidelines. It is the aim for this Policy to be consistent with these consensus statements and guidelines where possible, albeit that some aspects of these policies differ from each other

2. SCOPE

2.1 The concussion and management principles within this Policy applies to: (i) all male, female and elite pathway players and (ii) all match officials (collectively referred to as Participants):

a) participating in any CA sanctioned competitions and matches, or training for such competitions or matches; or training for international cricket competitions or matches (collectively, Elite Cricket); and

b) who receive an impact to the head or neck (either bare, while wearing protective equipment or whiplash type mechanism), whether by ball or otherwise.

2.2 In relation to players representing Australia in international cricket competitions or matches, CA will (where possible within the ICC's rules) adhere to this Policy.

2.3 The governance processes outlined in this Policy apply to all AC staff (employees, contractors etc.) involved in CA sanctioned cricket training and matches / tournaments including High Performance staff, SSSM staff, coaches, selectors etc.

3. PROTECTIVE EQUIPMENT REQUIREMENTS

3.1 The use of helmets and products/attachments properly fitted to helmets that provide additional protection for the vulnerable neck/occipital area of batters (**Neck Guards**) by players as per the CA Playing Conditions and Clothing and Equipment Regulations is mandatory. Helmets are provided by employers and players must receive appropriate educators around their use and storage.

3.2 Helmet use is recommended for umpires.

3.3 Helmets should be replaced immediately in accordance with the manufacturer's recommendations following an impact. Under the Playing Conditions of CA competitions, there is a maximum of 5 minutes delay for a head impact assessment, which includes 1 minute to arrive and 1 minute to leave, meaning that the assessment and helmet replacement is only allocated 3 minutes. In the event of any possible damage where the helmet needs replacing, if a fitted replacement helmet is not immediately available, the umpires and medical staff will advise the player that an off-field head impact assessment (plus assembling of new helmet and stem guard) is required. Employers will provide replacement hemets.

4. HEAD AND NECK TRAUMA MANAGEMENT – CATEGORISING HEAD IMPACTS

Head or neck impacts can be classified as either **'Trivial'** or **'Non-Trivial'** based on how foreseeable it is that the impact force or mechanism could lead to concussion.

4.1 Trivial head impacts:

a) The determination if head or neck impacts are trivial (or not), can only be made by an AC appointed and suitably qualified medical person (**AC Medical Person**). This can be done if the incident is witnessed either live or on reviewing video replay by an AC Medical Person or witnessed by a reliable third party if they can provide an accurate description of the incident to the AC Medical Person.

b) If the incident is not observed directly (by AC Medical Person or reliable third-party) or clear on video then it cannot be classified as trivial.

c) For the purposes of this document an 'AC Medical Person' must be an AC appointed doctor if one is present, or an AC appointed physiotherapist (who has received training in the management of head impacts in cricket) in instances where a doctor is not present. AC Medical Person must have sufficient training and experience in safely conducting concussion assessments.

d) A head or neck impact can be determined as "trivial" if the impact is deemed to have been of such low force that it is reasonable to expect that a concussion could not have occurred. Generally the on-field umpires will assist in the determination of trivial versus non-trivial impacts in that for non-trivial impacts they will call the medical staff on to the field to immediately assess the player. If the umpires are of the belief that the force was so low to have given no risk of a concussion then they will tend to not call the medical staff on.

e) Examples of possible trivial impacts include:

   (I) Ball impacts to the very distal parts of the neck could be deemed trivial from a concussion perspective because of lack of significant indirect force to the head.

   (II) Ball impacts to batters or wicketkeepers that were bowled by spin or slow bowlers and strike the helmet are generally trivial because of the low pace of the ball but may not be non-trivial if the batter or wicketkeeper was not wearing a helmet.

   (III) Impacts to batters off balls bowled by pace (fast) bowlers that result in minimal deflection of the path of ball (glancing impact to helmet) may occasionally be considered trivial (e.g. if the deflection is so small that it can be fielded on the full by wicketkeeper).

f) The documentation of **trivial head** impacts **must** include:

   (I) a medical (or physiotherapy) consultation notes on the AMS, and

   (II) a Head Trauma Report form on the AMS.

Note: a SCAT test or Cognigram testing are not required for trivial head impacts.

g) The AC Medical Person who made the documentation of the incident **must** monitor the Participant (by checking in with them via phone or in person and document this on the AMS via a consultation note) for evolving or delayed signs of concussion or vascular injury, in the next 24 hours, even in cases where the head impact has been deemed trivial.

4.2 Non-trivial head impacts:

a) Most cricket related head and neck impacts are **non-trivial**, that is, the impact (direct or indirect) is sufficient enough that there is a possibility of concussion

b) It is recognized that there is an inherent conflict for a single senior medical staff member at matches between prompt on-field assessment after a head impact and prompt review of video signs, which are both equally important. In order to resolve this conflict it is suggested that:

(I) At domestic level matches, a single doctor should prioritise prompt on-field attendance. If a replay is immediately available the doctor can watch a replay for 5-10 seconds before running out on to the field, but should run on to field immediately if a replay is not immediately available. As a trial from July 2026 onwards, on-field umpires have been instructed to give the match day doctor a lay summary of observable signs they saw at the time of impact. If a video umpire is also available, the on-field umpires will ask the video umpire to review slow-motion footage of the impact and again will pass on a lay summary of observable signs to the match day doctor. In particular, the signs which are most pertinent are whether the player was knocked to the ground after impact, how quickly and steadily the player returned to standing if knocked to the ground, and whether the player may have stumbled or lost balance at any stage. If the lay description is of signs likely to constitute a Category 1 or 2 impact, the doctor should err on the side of insisting on an off-field assessment for the player, where the doctor will have the opportunity to review the footage before deciding whether the player is fit to resume. The role of the umpire is limited to assisting in being an extra set of eyes for the doctor who probably will not have had a good view of the impact. The umpire is not required at any stage to make a concussion diagnosis.

(II) At international level, the (Australian) team doctor and team physiotherapist (with the assistance of team analyst) are encouraged to split the duties of video review and on-field attendance as they would prefer. That is, either doctor or physio runs on immediately and prioritses rapid on-field response. The other medical team member priortises trying to review video footage and then running on to field after 1-2 minutes to pass on the video findings. Whilst international umpires could be asked questions they are not currently expected by the ICC to assist in describing what they saw.

c) Non-trivial head impacts can be categorised as either **Category 1**, **Category 2** or **Category 3**:

(I) **Category 1** signs and symptoms.

Observed signs:

(i) loss of consciousness for any time;

(ii) clearly dazed or disoriented;

(iii) definite inability to keep balance;

(iv) vomiting not explained by another cause (such as known gastroenteritis); or

(v) tonic posturing or fitting.

Clinical signs & symptoms:

(vi) visual field defects or oculomotor signs (e.g. nystagmus),

(vii) amnesia – inability to remember recent details,

(viii) definite confusion,

(ix) definite behavioural changes,

(x) other signs of brain ischaemia, or

(xi) clear symptoms of concussion that allow an immediate diagnosis to be made.

Any of these presentations are considered diagnostic of concussion and immediate removal from play is required. Further testing on the day of play is not required to establish the diagnosis.

(II) **Category 2** signs and symptoms.

(i) possible behavioural changes,

(ii) possible confusion,

(iii) possible balance disturbance

(iv) possible loss of consciousness (e.g., slow to rise from a fall), or

(v) any clinical suspicion not otherwise captured which may include mild or transient symptoms that do not meet the threshold for category 1 criteria.

These presentations require immediate removal from play for an off-field assessment. If Category 1 or 2 signs are only revealed after delayed-viewing of a video replay that was not available prior to on-field assessment, the medical officer must return to the field of play or training environment as soon as possible and advise that a player needs to be removed once becoming aware of the video signs.

(III) **Category 3** signs and symptoms include:

(i) any non-trivial head impact without Category 1 or 2 criteria; or

(ii) any head impact with force that could have feasibly caused a concussion, but no Category 1 or 2 signs and no concussion related symptoms (after on-field check).

These presentations require ongoing monitoring during that day and an off-field assessment at the next appropriate opportunity.

5. HEAD AND NECK TRAUMA MANAGEMENT: ASSESSMENT & DOCUMENTATION

5.1 There are three key components to the initial assessment after a head impact.

a) Witness the head impact (directly or through third party)

b) On-field Assessment

c) Off-field assessment

Table 1 summarises the assessment tests and documentation required for trivial and non-trivial head impacts.

5.2 **Witnessing the head impact**. When a head impact occurs, the AC Medical Person responsible must try to obtain as much information about the incident as possible by either:

a) observing the incident live, and/or

b) reviewing a video replay, and/or

c) obtaining a reliable third-party observer account.

5.3 On-field assessment.

a) An on-field assessment must take place for every head impact, either immediately (non-trivial) or at the next or most appropriate break in play (trivial). The timing or urgency of the on-field assessment will be determined by the AC Medical Person, and to a lesser extent the umpires, depending on their evaluation of the incident.

b) An on-field assessment must involve:

(I) Asking the participant if they have any new symptoms after the head impact, and specifically asking for the presence of common concussion symptoms.

(II) Performing modified (cricket specific) **Maddocks questions**.

(i) What venue are we at today? [compulsory question]

(ii) What bowler has been bowling this last over? (or similar)

(iii) How was the last batsman dismissed? (or similar)

(iv) Who did you play against in your most recent match before this? (or similar)

(III) Asking the participant for a description of the event (and if this description does not sound accurate, checking with the umpires if the AC medical person did not witness the event clearly).

The above on-field assessment must allow for the assessment of disorientation, behavioural change, amnesia, confusion or other signs of brain ischemia.

c) If the on-field assessment was unsatisfactory (concussion possible), the participant must be immediately removed from play.

d) If **Category 1** observed signs are evident the diagnosis of concussion is established.

e) If **Category 2** observed signs are evident or if the on-field assessment is unsatisfactory for any other reason (e.g., uncertainty exists over the presence of new symptoms), the participant must immediately be removed for an off-field assessment (SCAT and Cognigram).

f) If **Category 3** status is confirmed (a **non-trivial** head impact without Category 1 or 2 criteria has occurred and the initial on-field assessment was satisfactory), an off-field assessment should be completed at the first available time (e.g. next innings break).

g) If the incident is determined to be a **trivial** head impact (see section 5.1), the participant must be monitored and assessed again at the completion of the session (match or training) or post-match or training.

h) Medical notes of these assessments must be documented on the AMS.

5.4 Off field assessment.

a) The off-field assessment should ideally be performed by a doctor where possible. Alternatively, a suitably qualified and trained AC Medical Person (physiotherapist) can perform the assessments required and report to the team doctor.

b) An off-field assessment must include;

(I) a SCAT test (on the AMS) for non-trivial head impacts. Note that the on-field and optional sections of the SCAT are not required, and whatever version of the SCAT is on AMS is adequate at the relevant time. A brief version of the SCAT which focuses on symptom evaluation, immediate memory, concentration, balance and delayed recall is adequate for a Category 3 head impact which is asymptomatic.

(II) a Cognigram test:

(i) when Category 2 signs or symptoms are evident or

(ii) where there are any concussion related symptoms post-head impact.

A SCAT or Cognigram test is not required if the diagnosis of concussion has already been established (e.g., due to ***Category 1*** criteria).

c) If the outcome of the off-field assessment was satisfactory (i.e., a diagnosis of concussion has not been established or possible) then the player may return to play that day, but delayed symptoms of concussion must be monitored for.

d) Repeat off field assessment for head impacts with ***Category*** 2 criteria, if the outcome of the initial off-field assessment was satisfactory a repeat off-field assessment must be performed either prior to the next match day or training session, or at 48 hours post impact, whichever is soonest. This must include;

(I) a clinical assessment,

(II) a SCAT test (on AMS), and

(III) a Cognigram test.

e) Repeat off field assessment for head impacts with ***Category 3*** criteria, if the outcome of the initial off-field assessment was satisfactory a clinical assessment should be performed either prior to the next match day or training session of at 48 hours, whichever is soonest.

5.5 Definitive concussion diagnosis and 'high risk' head impacts for concussion.

a) **Definitive concussion diagnosis**.

At any point during the various stages of assessment, the diagnosis of concussion is established if ***Category 1*** video or observed signs are present, or the outcome of an off-field assessment is unsatisfactory.
In these instances, the participant must immediately be removed from play (or not

allowed to return to the field) and they must enter the Graduated Return to Play (**GRTP**) process (*Appendix 2*).

b) **High risk head impacts.**
Based on CA led research there are mechanisms and presentations known to present a higher risk of concussion in cricket, these include (but are not limited to);

(I) a batter being hit by a ball bowled by a pace bowler which both impacts on the back/side of the head/helmet/neck **and** deflects greater than 90 degrees from its path after impact,

(II) an impact of ball or bat to unprotected head.

Whilst the mechanisms outlined above do not warrant mandatory removal for assessment after head impact, medical personnel are encouraged to err on the side of caution in terms of removal of the player for further assessment if this mechanism occurs.

5.6 Documentation of the off-field assessments.
The following minimum documentation is required after a head impact and/or concussion:

a) **AMS consultation notes are required** for:

(I) All head impacts (***trivial or non-trivial***) must have an appropriately coded ***initial AMS consultation*** by the AC Medical Person who conducted the assessment or witnessed the incident.

(II) At a minimum, a **subsequent *AMS consultation*** must be recorded just prior to a Participant returning to play after concussion (irrespective of completion of a GRTP template in the participant's AMS medical or physiotherapy module).

(III) When the 'availability' status changes in any direction (available ←→ modified ←→ unavailable).

(IV) Justifying the clinical reasoning if the SCAT assessment or Cognigram were considered inconclusive.

(V) Where any clinical judgement overrides the SCAT assessment or Cognigram results.

For all consultations on the AMS, the 'availability status' must be selected (available, modified or unavailable). Participants injury status must not be changed to available until a consult note is made and the GRTP template is changed to reflect that they have completed the GRTP process (*Appendix 2*).

b) **Head Impact Assessment (HIA) form**.

For all head impacts (*trivial or non-trivial*) a HIA form must be completed on AMS (or GER AMS App). A HIA must be completed to include:

(I) the outcome of the on-field assessment (initial assessment),

(II) off field assessment (subsequent assessment of the incident on the same day as the incident),

(III) same day review (check in later in the day, post-match or next morning) and,

(IV) 48 hours post head impact, or pre the next cricket training or match session review (whichever comes first).

c) **SCAT assessment**.

A SCAT assessment should be completed using the SCAT form on AMS (or GER AMS App). The SCAT6 versions of the assessment test can be utilised. It is advisable to use the version that is populated in the AMS and GER AMS App.

d) **Cognigram assessment.**

When a post-head impact Cognigram test (either to confirm / exclude the diagnosis of concussion or as part of the RTP process) is required (see section 6.4), the test result must

be exported from the Cognigram portal and added to the player consultation note on the AMS for that injury.

e) **GRTP Template.**

When a diagnosis of concussion is established the GRTP template must be completed on the AMS medical module.

Table 1. Assessment Tests and Documentation Required for Trivial and non-Trivial Head/Neck Impacts

	Video Review	**Clinical Assessment & AMS Notes (initial, next day check in and/or 48 hour check in)**	**HIA (Day 0 & 48 hour review)**	**SCAT (on AMS)**	**Cognigram (uploaded to AMS)**
Type of impact	**Non-Trivial Head / Neck Impacts**				
Category 1	Required	Required	Required	Not required (concussion established)	Not required (concussion established)
Category 2	Required	Required	Required	Required	Required
Category 3 - possible concussion symptoms	Required	Required	Required	Required	Required
Category 3 - no concussion symptoms	Required	Required	Required	Required, but can be brief version	If SCAT test inconclusive / unavailable
	Trivial Head / Neck Impacts				
Trivial	Required	Required	Day 0 only	Not required	Not required

6. HEAD AND NECK TRAUMA MANAGEMENT: GRADUATED RETURN TO PLAY

6.1 When a diagnosis of concussion has been established, the final determination on whether a participant may return to training and play, can only be made by an AC doctor. If a player is returning from concussion at an away game and the doctor clears prior to departure "subject to no symptoms developing at the final training session", the physio and doctor in conjunction should make a note after this session that the player was checked and determined to be asymptomatic.

6.2 GRTP Essentials. A participant must not be allowed to return to play or made available to play until they have satisfied all of the following criteria:

a) Fully completed the GRTP requirements documented in the RTP Template on the AMS for that concussion. Each step of the GRTP must be clearly documented as completed,

b) At a minimum, completed all stages of the GRTP process outlined in *Appendix 2*, with the minimum defined number of days between each stage (minimum twelve (12) days* from head impact to return to playing),

c) Has an AMS consultation note by the AC Doctor stating the GRTP process has been completed and documenting the clinical status of the Participant,

d) Has completed a satisfactory Cognigram test (relative to their baseline) in the final 48 hours of the GRTP process, and the Cognigram result uploaded onto the AMS, and

e) The participant remains free of concussion related symptoms.

*NB: Twelve (12) days is generally the minimum number of days that a participant may return to playing, but it is expected that some participants will require longer return to play times and more extensive rehabilitation.

6.3 Expedited RTP in Occasional Circumstances.

In occasional circumstances, a participant may be permitted to return to match play, in less than the minimum 12 days set out in section 7.2(b) of this Policy if the AC Doctor managing the GRTP determines that it is safe for the participant to progress through each GRTP stages in an accelerated fashion. In these circumstances, the AC doctor must apply to the AC Concussion RTP Advisory Panel for approval of an Expediated RTP.

The AC Doctor can only apply for the Expediated RTP if the player has satisfied all of the following:

a) there were no Category 1 or 2 signs at the initial presentation (head impact),

b) they are able to maintain a minimum gap of 24 hours between each GRTP stage, minimum of six (6) days from head / neck impact to RTP,

c) the participant has not experienced any other concussions in the previous 12 months,

d) Cognigram result returned to baseline level,

e) is symptom free for a continuous six (6) day period before the proposed RTP date,

f) no substantial concussion history (i.e. fewer than 5 lifetime concussions); and

g) the participant is 19 years or older.

6.4 There are key GRTP processes that **must be followed** when managing a Participant who has been diagnosed with concussion.

a) The GRTP process can only commence after diagnosis of concussion as per *Appendix 2*.

b) The Participant must not return to playing in the same match if the diagnosis of concussion is established.

c) Regular medical reviews by an AC Medical Person (ideally the AC Doctor) are required (e.g. daily or every second day) that should include:

(I) a medical assessment including a symptom check, how they are coping with daily activities or any rehabilitation / training activities and a neurological examination if required;

(II) determination of the clinical status of the Participant including whether there has been improvement or deterioration since the time of injury; and

(III) determination of the need for emergent neuroimaging to exclude a more severe brain injury or of referral to a neurology specialist (e.g., for multiple concussions or those not resolving within an expected time period).

d) Return to physical activity must not occur for at least 24 hours after a concussion diagnosis. After the initial 24 hours, the Participant may commence the GRTP process (outlined in *Appendix 2*), including some restricted physical activity once they are able to complete their usual daily activities without concussion related symptoms.

e) Staged physical activity should be upgraded on a graduated basis with progression through stages and Participant's must return to a previous stage if symptoms worsen. See *Appendix 2* for recommended GRTP progressions.

f) The staged activity for return to training and playing must be documented on the AMS through the GRTP template with each stage of the GRTP clearly documented.

g) A Participant diagnosed with concussion must be instructed by the AC Medical Person making the diagnosis that they must not be performing activities that may put themselves and others at risk such driving a motor vehicle, climbing ladders, riding a bike etc. until medically cleared to do so.

7. HEAD AND NECK TRAUMA MANAGEMENT: GOVERNANCE

7.1 Recording and reporting interference or breach of this policy.

All Consultation notes should record any difficulties in diagnosis, including:

a) whether the Participant complied with the requirements of this Policy to leave the field or training area for assessment where required; or

b) whether any influence or obstruction or interference was attempted by the Participant, or any other person involved in the match or training session.

Where any case notes are recorded in relation to 7.1 (a) or (b), a separate notification containing these notes and any other relevant details must also be sent (email) to the CA Chief Medical Officer (CMO) and the CA Head of Performance Services as soon as possible. In addition to this pathway, the on-field umpires are also able to report players and/or staff under the Code of Conduct if they feel that any person is unduly interfering with the medical assessment.

7.2 Managing head impacts in the absence of a qualified AC Medical Person.

a) In instances where an AC Medical Person is not present or available at the time of the head impact; a paramedic, sports trainer or first aider may make the initial determination of whether a player should be immediately removed from play within their scope of practice, level of concussion training, experience and qualifications. CA supports a conservative approach to removing participants after a head impact, particularly when there is no AC Medical Person available. If this does occur, the qualified medical person allocated to the match/training or the AC Medical Person responsible for the team or match should be notified of the incident in order to direct any further immediate actions that may be required. When no AC medical person is allocated to the team or match, the relevant SMO should be contacted.

b) In instances where an AC medical person is not present or available and a participant is removed from play, an off-field assessment should be completed by an AC medical person as soon as practical, participants should not be allowed to return to play until this is completed.

c) A Cognigram test completed remotely may be a useful aid for assessment in circumstances where the player has a non-trivial head impact that does not require presentation to hospital and an AC medical person or other qualified medical person is unavailable in person on the day. If a player is remote and an off-field assessment by an AC medical person cannot be performed in a timely manner, aspects of the off-field assessment including SCAT 6 symptom check may be performed by Telehealth, when deemed appropriate by the AC doctor responsible for the participant.

7.3 Emergencies and neck injuries.

For a clearly serious head or neck injury, a qualified medical person should immediately enter the field of play as part of an emergency response without waiting to access a replay. If video was unable to be checked prior to the on field assessment it should be checked as soon as possible afterwards. Umpires or other witnesses may be used to provide additional descriptions of head impacts and subsequent participant responses that weren't initially observed by the qualified medical person.

More serious co-existing diagnoses (e.g., fractured skull, neck injury, vascular injury) should be managed as an emergency priority and once these are excluded then diagnosis of concussion can be considered. Vascular injury (such as vertebral artery dissection, carotid artery dissection, subarachnoid haemorrhage etc.) should be suspected if a player, after neck or base of skull impact, experiences transient or enduring neck pain, pain around the eye, headache, signs of brain ischemia (e.g., vertigo, ataxia, visual deficits, brainstem syndromes). Medical personnel should be vigilant to the evolution of signs and symptoms over subsequent days and have a low threshold for seeking investigative imaging if indicated.

7.4 Good medical practice.

All concussion assessments should be conducted in a standardised fashion. The minimum requirements for conducting off-field assessments are as follows:

a) Adequate time should be allowed to conduct the appropriate medical assessment, including the SCAT 6 and/or Cognigram. For example, a concussion diagnosis cannot be excluded in less than 10 minutes if there were sufficient grounds to remove a player from the field; and

b) Adequate facilities should be provided for the appropriate medical assessment. At a minimum, off-field assessments should be performed in a distraction-free environment (e.g., locker room, medical room) rather than on the sideline.

c) No staff other than medical staff should be present while the assessment is being undertaken, unless permitted by the medical staff or expressly requested by the participant.

d) *[Subject to new Playing Condition change]* If a batter has been removed for a head impact assessment during a last wicket partnership, the umpires at their discretion may offer the batting team 10 minutes grace before their innings is declared closed. In this time, the doctor should endeavor to make a diagnosis of concussion, possible concussion or that the player can return to bat. In this 10 minute period the match referee should attempt to pre-approve a concussion replacement who should pad up and be available to bat if the doctor determines it is not safe for the original player to continue.

In the absence of a Category 1 symptom or sign establishing a concussion, the diagnosis of a concussion (and/or fitness to train and play) is a clinical judgment, made by a medical professional. Neither the SCAT nor the Cognigram should be used by itself (or together) to make, or exclude, the diagnosis of concussion. Nevertheless, an AC MO can use their clinical judgement to override the SCAT assessment or Cognigram results when inconclusive and the AC MO must keep detailed clinical notes regarding this.

The diagnosis of concussion cannot be 100% excluded until a minimum of 48 hours after a non-trivial head or neck impact to account for the possibility of a delayed concussion presentation. If a concussion remains highly unlikely, due to a lack of video signs or any symptoms, a player is permitted to continue to play, but on the proviso that they will be monitored for the emergence of any delayed symptoms, as per the Flowchart in Appendix 1.

8. CONCUSSION SUBSTITUTE

8.1 A Concussion Substitute is available as per the applicable ICC and CA Playing Conditions.

8.2 For use of Concussion Substitute, the AC medical person on duty must comply with the procedure outlined in the ICC or CA Playing Conditions when completing steps relating to the activation of the Concussion Substitute. Importantly, this includes:

a) formally notifying (initially verbally and followed as soon as possible in writing) the match referee (or the highest-qualified match official at the match if there is no match referee) of any concussion diagnosis that he/she has made in relation to a Participant during a particular match; and

b) the AC medical person must not be the person required to make the decision to activate the use of a Concussion Substitute. His/her involvement in the process should be limited to providing the medical advice associated with the management and/or diagnosis of a concussion;

9. PATHWAY (UNDERAGE) PLAYERS

9.1 Managing concussion in pathway (underage) players requires a more conservative approach compared to adult players as per the AIS guidelines and Amsterdam concussion statement. The AIS guidelines define a youth (underage) player as being under the age of 19, and Australian cricket follows this age definition with respect to concussion.

9.2 Assessment: For players aged 13 years or older, the assessment process outlined for adult players in section 6 of this Policy apply including SCAT / Cognigram tests can be used.

9.3 Concussion Management in pathway players:

a) Rehabilitation of adolescents is slower, and initial attention should be to remove the adolescent from school and monitor symptoms related to schoolwork and then exercise and sport. Rehabilitation of adolescents is slower, and initial attention should be to remove the adolescent from school and monitor symptoms related to schoolwork and then exercise and sport.

b) It is recognised that education of adolescent players and parents, guardians and coaches is an important part of managing the concussion in adolescent participants. The medical staff working with pathway teams in CA sanctioned tournaments, should endeavour to educate pathway players on concussion management and the application of this policy.

c) RTP Essentials for **Pathway players**. Any participant who is under 19 years of age on the day they are diagnosed with concussion **must not RTP** (or be cleared as available to play on the AMS injury status) until they have satisfied all of the following criteria:

(I) have a fully completed RTP template on the AMS for that concussion episode that clearly documents that they have completed all stages of the RTP processes;

(II) at a minimum, completed all six (six) stages of the Pathway RTP process outlined in *Appendix 3* over a minimum of fourteen (14) days;

(III) remained asymptomatic for 12 consecutive days leading into the RTP date. The temporary exacerbation of mild symptoms with exercise is acceptable, as long as the symptoms quickly resolve at the completion of exercise, and as long as the exercise-related symptoms have completely resolved before resumption of cricket specific training;

(IV) has an AMS Consultation note for the initial assessment by an AC Medical Person and another at the end stage of the GRTP process by an AC Doctor stating the GRTP process has been completed and documenting the clinical status of the participant;

(V) has completed a satisfactory Cognigram test (relative to their baseline if there is one available) in the final 48 hours of the GRTP process, and the Cognigram result uploaded onto the AMS; and

(VI) the participant remains free of concussion related symptoms.

d) Key RTP processes **that must be followed** when managing a Pathway (under 19 years of age) participant who has been diagnosed with concussion.

(I) The GRTP process can only commence in line with the criteria outlined by the Concussion Protocol in *Appendix 2.*

(II) After the initial 24 hours, the Participant may commence the GRTP process (outlined in *Appendix 3*), including some restricted physical activity once they are able to complete their usual daily activities without concussion related symptoms.

(III) Staged physical activity should be upgraded on a graduated basis with progression through stages and Participants must return to a previous stage if symptoms worsen. See *Appendix 3* for recommended Pathway RTP progressions.

(IV) The staged activity for return to training and playing must be documented on the AMS through the RTP template with each stage of the RTP clearing documented.

(V) If any participant sustains a second concussion in the same cricket season (July 1 to June 30), they must not RTP in the same season unless they have been cleared to do so by the AC Concussion Advisory Panel (see *Appendix 5*).

(VI) A Participant diagnosed with concussion must be instructed by the medical person making the diagnosis that they should not be performing activities that may put themselves and others at risk such driving a motor vehicle, climbing ladders, riding a bike etc. until medically cleared to do so.

10. BASELINE CONCUSSION TESTING

In respect of each Australian domestic cricket season, each AC MO must ensure the following:

a) For all Participants (players only) taking part in international and domestic competitions, a baseline Cognigram test (within the two previous years) should be completed before commencement of the cricket season;

b) A baseline SCAT6 Test also may be useful (at the team doctor's discretion); and

c) For all pathway players participating in the U16 and U19s Female; and U17 and U19s Male National Championships, a baseline Cognigram test (within the two previous years) is conducted before commencement of the National Championship.

11. MANAGEMENT OF PLAYERS WITH MULTIPLE, COMPLEX OR PROLONGED CONCUSSIONS

11.1 Role of the AC Expert Concussion Panel (**Expert Panel***).*

Players with multiple or complex concussions should be managed conservatively. These players often require multiple medical opinions from a variety of specialists.

An Expert Panel can be established to streamline the diverse management of difficult concussion cases by establishing a panel of experts who jointly assess each case and, if possible, produce a consensus opinion.

11.2 Panel Members

When a player has sustained a concussion that is complex, the player or treating doctor may request that the case is reviewed by the ***Expert Panel***.

The CA CMO and the player's treating doctor will jointly determine suitable concussion experts and submit them to the player for approval.

At a minimum the Expert Panel should consist of the following members:

a) Chair (the CA CMO or delegate);

b) the SMO;

c) any treating doctor;

d) external health practitioner experts (up to 5 people); and

e) CA Head of Performance Services or delegate (to act as a scribe, coordinate meeting agenda and guide on processes post meeting).

11.3 Referral to the Expert Panel

A referral to the Expert Panel can only be made with the player's informed consent. It is the responsibility of the treating doctor to educate the player on the process and ensure they have a clear understanding of what will be required of them, and the purpose of engaging with the panel. The player will be provided also with an information sheet (*Appendix 4*).

Referrals, including a summary of the case, shall be written to the panel members by the treating doctor. See *Appendix 4* for an example of the player information and referral letter template. Examples of the rationale where an Expert Panel may be required are:

a) Participants with prolonged (> one month) symptoms not resolving.

b) Multiple concussions with increasing symptom duration or symptom severity.

c) Concussions occurring with diminishing impact force.

d) Where there are conflicting management proposals that are difficult to resolve.

e) Players considering retirement due to concussion.

f) Where the player or practitioners involved in care have significant concerns regarding the long-term sequelae of the specific case.

11.4 Expert Panel meetings

Where possible Expert Panel meetings will be held in person, although online meetings are also acceptable.

The Expert Panel members will receive relevant information at least 7 days before the meeting (with the player's consent), including:

a) Copies /access to all relevant medical history notes;

b) Copies / access to all relevant medical imaging;

c) copies / access to all neuropsychological results;

d) copies / access to all relevant video footage of concussion injuries;

e) copies /access to any other relevant information;

f) list of all practitioners involved in the patient's management; and

g) a consent form signed by the patient, consenting to participate in the process.

11.5 Expert Panel report

The Expert Panel recommendations should be summarised by the meeting scribe and approved Chair and panel members. The meeting notes are to be recorded in the player's AMS medical file. Each individual panel member should provide their own written report where appropriate.

DOCUMENT REVISIONS

Date	By
25 September 2017	CA SSSM Manager, CA Chief Medical Officer, Queensland Cricket SMO, AFL CMO, Hawthorn Football Club Medical Officer
30 June 2018	CA SSSM Manager, CA Chief Medical Officer, CA Men's Team Doctor, Queensland Cricket SMO, AFL CMO
23 May 2019	CA SSSM Manager, CA Chief Medical Officer, CA Men's Team Doctor, Queensland Cricket SMO, AFL CMO
31 July 2020	CA SSSM Manager, CA Chief Medical Officer, CA Deputy CMO, Australian Cricket State Medical Officers

30 June 2021	CA SSSM Manager, CA Chief Medical Officer, CA Deputy CMO, CA Men's Team Doctor, Australian Cricket State Medical Officers
16 May 2022	CA SSSM Manager, CA Chief Medical Officer, CA Deputy CMO, CA Men's Team Doctor, Australian Cricket State Medical Officers
22 & 23 May 2023	CA Concussion Forum: CA SSSM Manager, CA Chief Medical Officer, CA Men's Team Doctor, Australian Cricket State Medical Officers
29 April 2024	CA Concussion Forum: CA SSSM Manager, CA Chief Medical Officer, CA Deputy CMO, CA Men's Team Doctor, Australian Cricket State Medical Officers
30 June 2025	CA Head of SSSM, CA Chief Medical Officer
30 June 2026	CA Head of Performance Services, CA Chief Medical Officer, CA Deputy CMO, CA Men's Team Doctor, CA Head of Scheduling, Operations & Domestic Cricket, CA Match Officials Manager

APPENDIX LIST

ITEM	LINK TO DOCUMENT
Appendix 1	*Head Impact Assessment Flowchart*
Appendix 2	*Graded Return to Play Procedure*
Appendix 3	*Return to Play for Pathways Players*
Appendix 4	*Expert Concussion Panel Documents* (cover letter, player information sheet, consent form)
Appendix 5	*Concussion Return to Play Advisory Panel*