

Digital, Culture, Media and Sport Committee

Oral evidence: Concussion in sport, HC 1177

Tuesday 27 April 2021

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Members present: Julian Knight (Chair); Kevin Brennan; Steve Brine; Alex Davies-Jones; Clive Efford; Julie Elliott; Damian Green; Damian Hinds; John Nicolson; Giles Watling; Mrs Heather Wheeler.

Questions 246 - 363

Witnesses

[I](#): Damian Hopley MBE, Chief Executive, Rugby Players Association; Paul Struthers, Director, Professional Players Federation; and Gordon Taylor OBE, Chief Executive, Professional Footballers Association.

[II](#): Dr John Etherington CBE, Medical Director and Consultant Rheumatologist, Faculty of Sport and Exercise Medicine UK; and Dr Richard Sylvester, Consultant Neurologist, Institute of Sport, Exercise and Health.

Examination of witnesses

Witnesses: Damian Hopley, Paul Struthers and Gordon Taylor.

Chair: This is the Digital, Culture, Media and Sport Select Committee and our latest hearing on concussion in sport. We have two panels today. Our first group of witnesses in panel 1 will be Gordon Taylor OBE from the Professional Footballers Association, Damian Hopley MBE, Rugby Players Association, and Paul Struthers, Professional Players Federation. There will be a short break between the first and second panels. In the second panel we will be joined by Dr John Etherington CBE, Faculty of Sport and Exercise Medicine, and Dr Richard Sylvester, Institute of Sport, Exercise and Health.

Before we start with our first question, which will come from John Nicolson, I want to go around the Committee to see whether any members would like to indicate if they have any interests to declare. No interests to declare, so we will crack on.

Gordon, Damian and Paul, good morning and thank you for joining us. Our first questions come from John Nicolson. Is there an issue with John's—? Okay, a few technical gremlins this morning, so we will go to Heather Wheeler.

Q246 **Mrs Heather Wheeler:** Good morning, gentlemen. It is nice to see you all. My interest in this issue of concussion in sport is very long-standing because I have the Jeff Astle Foundation, the family, based in my constituency. Now this is a wider conversation with everybody. I am interested in whether young sportsmen and women talk about any concerns about later life and the potential for neurological disorders. Is there anybody responsible in your organisations speaking to them as they are growing into the sport? Should there be a standard text in contracts about injuries and playing time and training methods? Gentlemen, if you could give me your views on those two areas, I would much appreciate it.

Gordon Taylor: Thank you. I believe there was some break in the transmission. I don't know whether Heather was addressing me or my colleagues there.

Mrs Heather Wheeler: I am happy for all of you to dig in, but Gordon, please, seeing as you have a microphone that is working, fantastic.

Gordon Taylor: Thank you, Heather. First of all I want to thank the Chairman and the Committee for agreeing to our request to come before you today to let you know what we have been doing on this important issue, what we are doing and what, hopefully, we intend to do. I feel that football is for all, Government is for all, and it is about working together. I feel we showed that—maybe before your time—in so much as when we had the terrible problems of the 1980s, football worked with Government and we managed to get through the terrible tragedies of the 1980s. We had the Taylor report. It then evolved into the Premier League, but that



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was a major area to get through, where we worked with Government, the Football Trust and Football Foundation on safety in our major sport.

It is not just our major sport; it is the world's most popular participant and spectator sport and it is very much part of our thread. We have seen that during this particular pandemic, where I have been very proud of our members, who have managed to keep going, with the help of the Football League with protocols and testing. I think they have done the country proud, particularly with our community programme, nowhere better epitomised than by Marcus Rushford.

Chair: Excuse me, Gordon, thank you very much. The Committee is well aware of football's approach during the pandemic. It is very kind of you to outline it once again, but we are always limited for time. If you could be very kind and just answer the question that Heather put about concussion in sport. Thank you.

Gordon Taylor: Thank you. This is a particular area we have been concerned with throughout my time at the PFA. Of course when there was the coroner's report on Jeff Astle at the turn of the century, this was something we were very keen to get involved with. That is when we wrote to the commission for industrial injuries. We are hoping to have some success with that. We are mindful as well that dementia is not being treated in the same way as cancer, for example, is treated. It is almost a means testing, so many families are quite concerned that with it being that way, their legacy will be adversely affected.

I am looking at ways where we can work with Government to make sure that this disease, as there are so many examples of dementia, Alzheimer's and neurodegenerative diseases, is dealt with not just by the particular participants—and we represent the members, of course—but the game has a duty of care to them, the same as we have done research and screen testing for sudden death syndrome.

Also, we wanted to look at the effects of repetitive heading and concussion. We can change and have changed regulations, but it is almost a parallel process of looking after our members with grants, changes to their homes, adaptations and home care, as well as the need to go into care when the dementia has become very serious.

It is also about research to try to establish a causal link. We did that following the sad demise of Jeff Astle and we were advised that longitudinal studies were the best form of research. That took place. It wasn't conclusive, it took too long and there was a fallout between the medical experts, even though at the time the head of that research was a neurosurgeon, and also there was a clinical neuropsychologist, Steven Kemp, and Leeds Hospital.

While that was going on, we were also involved with the game to make sure that all physiotherapists and doctors present were specially qualified. We were looking at the effects of concussion. In the first decade of this



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century there was Petr Čech. It was about access to grounds, immediate treatment, and taking control from the managers and coaches and putting it in the hands of medical people. That progressed later on. Hugo Lloris was another example. We had the example of Fabrice Muamba, who collapsed on the pitch. Many of the regulations that we brought in helped in that matter.

As we have continued to where we are today, I feel it needs a joint approach, the joint approach I talked about at the start of the meeting. I thank you for having us here today. It is not just football, rugby and horse racing—this is a worldwide issue.

Chair: Thank you. On that point, Mr Paul Struthers has indicated that he wants to contribute.

Paul Struthers: Thank you. I heard only the first part of the question, I am afraid, because there was an interruption in the internet connection, but when it comes to young sportsmen and women coming into professional sport, all of the player associations are at the forefront of education and training for concussion.

I am also the chief executive of the Professional Jockeys Association, and I know that in racing the issue of concussion is a pivotal one. We have seminars for all the professional jockeys every two years, where they have education sessions on concussion and lots of other issues. The seminar in 2010 was when they were first informed that there may be some longer-term impacts from repeated concussions or concussions. That was the first time they were informed of that.

More generically, while our role is there to protect and represent all our members, if I am being honest it is not a particular concern for young athletes at the start of their career. That is why the onus is on us to make sure that they are aware of the risks and the protocols, and are aware that, while they might want to cover concussions and try to pretend they don't have them, adhering to the protocols is very important.

It is a horrible phrase and one I don't like—and it is one that my members, the associations and other members really dislike because it sounds condescending, but it is not meant that way—but at some times it is about protecting them from themselves. There is something that made them professionally the athletes in the first place and that is a very key important element for the player associations.

Q247 **Mrs Heather Wheeler:** Thank you very much. We have heard from football and the jockey side. On the rugby side, could the rugby chap tell us about this issue of standard text in contracts?

Damian Hopley: Thank you, Heather. I would like to echo our thanks for the opportunity to come before the Committee today. In rugby we have an induction day where we bring in all the first-year contracted players together to talk about the highs and indeed the lows of where rugby is at.



I think the point that has been made by my colleagues is around education and how we ensure that players are made fully aware of the huge benefits that playing elite sport can bring but also the downsides.

Since 2014 we have worked with the governing bodies, Premiership Rugby and the RFU, to create mandatory annual education around brain health, as we call it, for all of our players, and listening to the previous sessions of this group and my former playing colleague and good friend, Kyran Bracken, talking so eloquently about the role of former players to come back and explain.

We had the very tragic news pre-Christmas of players presenting with early onset dementia in their early 40s. I think the question is how we use the experience of those players who have retired from the game to come back and talk about brain health and the impact it can have. As both Paul and Gordon have mentioned, there is very much that bullet-proof attitude as a young man or woman coming into a professional sport that you can run through brick walls and that anything is possible. I think it is up to us, as a duty of care, not only as the player associations but the sport as a whole, that we are providing that information.

If you look at the excellent work that Professor Willie Stewart, Craig Ritchie and various others have done in this area, it is ensuring that the research and indeed the demands made on our players marry up, so that they can go into sport with their eyes wide open as to the benefits, but also the potential pitfalls going forward.

Q248 John Nicolson: Thank you, gentlemen, for joining us. I am quite struck that both Mr Struthers and Mr Hopley talked about protecting young athletes from themselves. This really goes counter to a lot of the evidence that we have heard from other witnesses, who have said that when they were young, they found themselves pressurised by their coaches and others into not taking care of themselves. When they had concussion, they were not told to leave the pitch, the rink or whatever, but were encouraged to get back on and continue. Which is it? Is it young athletes being cavalier or is it older coaches and others not having the duty of care that they should perhaps have? Can I start with you, Mr Hopley?

Damian Hopley: Certainly, and thank you for the question. From our perspective, if we look back at the historical issues in rugby, in 2013 a gentleman called Chris Nowinski from the Sports Legacy Institute came from North America to present to our players' board, which is made up of the representatives from each of the clubs. It was really his direct input that led to the concussion forum that happened later that year. I think coach education has become an integral part of how we can better protect our players.

I come back to mandatory education for all players, coaches and staff, which happens annually. Also, because concussion is a hidden illness, you can't see the injury. You can see—as I know, to my detriment—a knee



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that is not working particularly well or an ankle or a wrist, but you cannot detect head injuries, so it is about withdrawing those players as swiftly as possible. I think the coach education that has followed, and indeed the greater awareness around this area now, has made a significant difference.

Looking at the two testaments from Monica and Eleanor in the first session that you had about coaches trying to keep them on the pitch, I think that has changed dramatically now. I think particularly within elite, professional sport—

- Q249 **John Nicolson:** It is interesting, because there must be a huge temptation if you have a star player not to pull him or her off the pitch. In a way, that would only be human because sport is so often about risk taking. I imagine coaching is also about risk taking, to a degree.

Damian Hopley: I take the point, but I also think there is an absolute, intrinsic explicit duty of care. If you have a star player who will not be selected for months afterwards because he or she has gone back on with an injury and it has exacerbated the situation, I think there is a much more holistic view now than there probably was some years ago.

- Q250 **John Nicolson:** How significant is personal injury provision as part of the contracts that you negotiate?

Damian Hopley: We have one of the best standard contracts in rugby for injury provisions. Our players have effectively nine months on full pay once they get an injury and then a further three months on half-pay, so effectively 10 and a half months, which I guess doesn't sound that significant in global sporting terms but if you think of—

- Q251 **John Nicolson:** It doesn't. It sounds terrible. If you could just clarify, if you get some traumatic injury, are you saying that the total amount of compensation you get is 12 months for a percentage of your pay?

Damian Hopley: No. Just to be clear, the injury clause within the contracts means that you have 10 and a half months effectively on full pay to recover, but if you look at where the game has gone now, very few contracts—and certainly in our domain in the English game—have been terminated based on long-term injury, because of the way that the game has gone.

If you look at some of the star players—I am thinking about Mike Brown, who was the Six Nations player of the tournament in 2014, who suffered a horrific collision playing in Italy and was out for a number of months afterwards. He cited in all the press that he did subsequent to that that without all the education, he probably would have tried to get back sooner because he didn't want to let his teammates down. I think it was a very good example of the education protocols serving the player and the clubs to say, "We are not going to rush our star player back because we need to make sure that he is right for the World Cup".



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Q252 **John Nicolson:** Okay, but in the worst-case scenario, if someone tragically has early onset dementia in their 40s and it is attributable to their playing career, what kind of compensation are they going to get? They are going to have to stop working in whatever new career they have.

Damian Hopley: That is a—*[Inaudible.]*

Chair: Sorry, we seem to have another technical issue.

Damian Hopley: We talk about millions. Football talk about billions in their television deals, but certainly one area that we are very keen to progress and get an outcome for is a long-term support function for those players when they leave the game. The RFU, World Rugby and WRU are in the midst of a compensation legal claim against them by former players, but we are looking for the opportunity for the game to contribute to an ongoing fund to look after players once they have retired, not only in the short term but in the longer term, because anecdotally we feel this will be a big issue going forward for the game, so by—

Q253 **John Nicolson:** Sorry, Mr Hopley, you probably did not realise there, but sadly there was a dropout in your connection. I think I can surmise from the second half of your answer, which we heard, that at the moment, if you find yourself, tragically, to be the victim of early onset dementia attributable to your playing career and you are in your 40s, you don't get the level of compensation that would allow you to live with a degree of comfort as you tackle that dementia going on for the subsequent decades after the early onset. Is that correct?

Damian Hopley: The only fund that is available to support those players going forward is from the players' association, from Restart. We have supported a number of players in just getting neurological help, but there is no fund at the moment that supports players long term. It is something that we want to address as soon as we can.

Q254 **John Nicolson:** That is terrible. What are you doing with current contracts? As you pointed out, we know a lot more about this than we used to. It sounds like the folk who have played in the past are not being well looked after, but for young people joining the sport today, given what we know, are you writing into their contracts protection should the worst happen and they find themselves in this situation? Will they get lifetime protection and insurance payments through the current contracts that you are negotiating?

Damian Hopley: Currently that isn't the case, but certainly I think—

John Nicolson: Why not?

Damian Hopley: The question is whether we can get that sort of insurance cover. I am not sure that would be possible, so you are looking at setting up a separate fund within the sport to help those players in the longer term.



Q255 John Nicolson: Can I ask the same question of you, Mr Struthers? For folk who have found themselves tragically suffering from long-term injuries, is there compensation available if those long-term injuries only become apparent a decade or so after they stop playing?

Paul Struthers: Damian is better placed, but I echo his comments. As it currently stands, I am not aware of any UK-based sport where that would be the case. In my sport, our members don't work in a team environment. They are all self-employed individual athletes and we are a fully self-funded player association. We get no central funds from anyone in racing at all. Our funding is from the jockeys themselves and from commercial income.

They don't even have a sport-funded injury policy outside of their temporary disablement, which is called the Professional Riders Insurance Scheme. We fund their career-ending insurance scheme, which is for any career-ending injury, but that has been tied in with a commercial agreement. We have funded that to the tune of £400,000 to £500,000 out of our reserves for the last two years.

In racing, we work very closely with ICHIRF, the International Concussion and Head Injury Research Foundation. Dr Turner, who ran that, used to be the chief medical adviser at the governing body in racing. Fortunately in racing, because we have had a robust integrated protocol in place since 2004, Dr Turner's view is that there is no evidence that there is any jockey suffering from a neurological deficit or neurological neurodegenerative condition. However, like rugby, we have the Injured Jockeys Fund, which is our benevolent arm in racing. We are split into three kind of support networks. Any funding is purely charitable at this stage in our sport.

Q256 John Nicolson: That sounds entirely unsatisfactory. The Committee is going to be writing a report on this and issuing recommendations. Does it seem to you that something that we should be recommending is an insistence that when contracts are written, given what we now know about head injuries, they should involve a far greater degree of protection for athletes, whether in your sport or those of the other witnesses that we have interviewed?

Paul Struthers: I will let Damian and Gordon speak for their sports, because there are no contracts in racing with them being self-employed. From this inquiry, any recommendations that strengthen the fact that sport governing bodies have to step up to the plate for protection while playing and protection and compensation post-playing would be very welcome indeed. While we all work closely with the governing bodies, I think it would be fair to say that at times governing bodies have been slow to react in this area.

Gordon Taylor: On the particular point that John raised, in the past I played before there were any substitutes and he is quite right that players were asked to stay on the field and make a nuisance of



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themselves and that could cause long-term injury. It is interesting that the number of substitutes has gradually increased, to the extent that when we wanted more substitutes during this pandemic, that was seen as a worry by possibly not the richest clubs in the Premier League, whereas we were looking to say that there should be at least temporary concussion substitutes. That is a big thing that we feel strongly about and continue to lobby the authorities on.

With regard to insurance and the contract, all our players are protected for the term of the contract. If there is an ongoing medical condition that stops a player and forces a player to retire, he does have insurance. He is also encouraged to take out personal insurance, but the club is obliged to look after him. But whether it can be shown clearly that it is the result of repetitive heading or concussion and a link to his playing career, that is an area that we are discussing today to try to put in place protection for those people, compared with what they can get from the state and from national health.

Q257 Chair: To drill down into those particular points before I move on to another couple of questions I have for you, does the PFA therefore offer any sort of access to remedial care for those who have suffered concussion and may be a means by which to stop them from having long-term brain injury as a result, or is that just simply left up to the clubs?

Gordon Taylor: No, it is not left to clubs. It is the PFA primarily. We have lobbied on clubs' duty of care. Part of our agreements with the Premier League, the Football League and the Football Association is about a duty of care, research into conditions, health and safety, very much so, but with our reserves policy quite a majority of our expenditure is to do with our charity and looking after such people irrespective of their condition. There will be cases where they need new knees, new hips and so on. It may be financial help, but there may be cases—this is what we are talking about today—where they have a neurodegenerative disease problem and then we would try to look after respite care, house alterations and so on.

Q258 Chair: Yes, I understand that is a fund that is paid out for those who are in need post-career. What I am specifically talking about is the need for immediate or relatively immediate treatment after concussion. We heard in an earlier session of a young athlete, not in football, who had to retire at 25, I think, and she retired due to successive concussions. She has been told that if she receives treatment in a relatively timely fashion, as in just post-career, there is the possibility that some of the damage that may have happened could be reversed. I personally have not heard a great deal about this, but I think it is a very interesting area to explore.

You have outlined what you do long term post-career and then we know that the clubs will look after—well, they say they will look after concussion during career. What about those who may have to retire due to concussive injuries and the need for that remedial treatment? Where do they go for that help?



Gordon Taylor: At the moment they would come to the PFA and we would look to do whatever was required. There is a much greater focus on concussion and possible brain injuries in later life and you will have seen that the Premier League are already beginning to test, talking about having mouth guards and talking about recording data. We are very much concerned that clubs record all the data—in spite of the data protection, but mindful of that—in helping the ongoing research, together with the necessary treatment for those participants.

Q259 **Chair:** Again, we are aware of that, but that has been the remedial help. What you are saying is that basically they would have to come to the PFA and apply if they were looking for that. With your resources, in the richest game in the country, particularly at the top level, is there any way in which you would consider having effectively a channel for the individuals who suffer concussion, therefore have to retire and then have that immediate or relatively immediate remedial treatment that can stop or has the potential to stop dementia down the line?

Gordon Taylor: Yes, there is. The game can afford that and that could be provided, definitely, once we start to get back from the medical evidence and the specialists the type of treatment that can prevent that from worsening.

Q260 **Chair:** Chris Sutton said he headed the ball 72,000 times during his professional career. Do you think that heading the ball leads to a higher risk of developing dementia—yes or no?

Gordon Taylor: That is why we are looking to get research and get the medical evidence, because we are not specialists.

Q261 **Chair:** With respect, Jeff Astle died in 2002. It is 19 years ago. You mentioned research and I understand this is not wholly your responsibility.

Gordon Taylor: I have also mentioned the coroner's report. We felt that highlighted it and that is why we went to the industrial injuries commission because we felt that was sufficient evidence. They said, "No, it is not. You need to establish a much greater causal link". At the moment we are still in that process because of the research.

Q262 **Chair:** You can't answer this Committee when we ask you whether or not you think that heading the ball 72,000 times in a career leads to a higher risk of dementia? You can't say that here?

Gordon Taylor: The latest research shows that there is a much greater risk with repetitive heading and concussion. That is why we are addressing this issue even more strongly than we have in the past, because the evidence is starting to emerge, even to the extent that people are suggesting whether any heading should be allowed at all. But certainly it should be controlled in training and the game should begin to start thinking about changing its rules.



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When they had the problem with the American gridiron game, when they crash heads together with helmets and so on, the people who look after soccer or youngsters in the USA banned heading under the age of 11. We have been a bit more cautious in this country on that, but there is a strong feeling that particularly for youngsters repetitive heading in training should be very much controlled and even to consider seriously whether it should be allowed at a younger age at all.

Q263 **Chair:** Mr Taylor, you played professional football for well over a decade. I think Bolton Wanderers was one of your clubs you played for.

Gordon Taylor: I played for two decades.

Chair: Two decades. I was being careful with “well over”—it was about 18, 19 years.

Gordon Taylor: Many of my contemporaries have suffered from this, and the majority of the PFA staff come from the professional game and are very mindful. Touch wood, nobody has suffered with a neurodegenerative disease among my staff, but certainly their families have because this is a problem that affects both men and women and it affects a lot of people who have never even played the game, of course.

Q264 **Chair:** Yes, of course. That was the point of my question. I wanted to ask you whether or not any of your contemporaries or friends had at the time suffered long-term injury due to—

Gordon Taylor: Lots of my contemporaries and people I have played with and people I have played against. I am very mindful of this. Particularly you will be aware of those members who won the World Cup. We have been able to help them and many others as well, who have been grateful for our help, but it still needs to be addressed because this is now bigger. As people are living longer, it is probably resulting in more deaths than cancer does.

Q265 **Chair:** How much has the PFA spent in the last five years on research into the link between head injuries, concussion and dementia in your sport?

Gordon Taylor: In the last few years, I think the commitment has been over £1.5 million. We have also committed £600,000 to research. We also have a welfare benefits adviser who can look at what is available from the state. Also, at the moment we have a taskforce dealing with this and it has recruited families and also people very much affected. There is a network now being established to deal with this, because we have found that regular contact and helping them work their way through what is a maze of benefits and what they are entitled to and what it will cost is an absolute problem. We have also developed a supporting—

Chair: As Members of Parliament, we all know the labyrinth behind the workings of the benefit system.



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Gordon Taylor: Exactly. That is why I think it needs to be done between us. This is a serious issue for society as a whole and it is not just this country; it is a worldwide problem.

Q266 **Chair:** To drill down, you have spent £600,000 on research and £1.5 million in total, including what you have helped individuals with who are suffering from this. Is that right?

Gordon Taylor: It is ongoing and it has particularly increased in the last few years. In 2021 I think we are well over: £100,000 field study; £125,000 field extension study; £43,000 research; ICHIRF research £200,000; Nottingham focus study £98,000; new research with the FA £150,000. As I say, we have spent £1.6 million to help 186 families.

Q267 **Chair:** Why is it that Mr Sutton, when he came in front of us, said that you have blood on your hands, Mr Taylor?

Gordon Taylor: It is a very emotive subject. In my own family, my mother—God bless her—had dementia, my father had a tumour of the brain and my uncle had Parkinson's, so it is a very emotive subject. Chris Sutton is someone I speak to in a civilised manner and I try to explain. He was offered help for his father, who was a contemporary when I was playing, and he has also been offered to come in and see what we are doing, what we have done and what we plan to do in the future, and the same with other families who are suffering, because it is a very emotive subject.

In this last week I attended Frank Worthington's funeral—another great player and great character—and the family put into their brochure for his funeral their grateful thanks for the PFA for all the help they had received. We get so much thanks from so many other people in the game, but our help has to be confidential unless they give that approval because it is a very sensitive and personal thing.

As head of the PFA, I am pleased you accepted our invitation to be here today and I am always prepared to put my head above the parapet, because what we do needs to be transparent and needs to be out there. I am more than prepared to do that with anybody.

Q268 **Chair:** Basically what you are saying is that Chris Sutton is carried away by the emotion of the issue, rather than feeling, as many people do around—

Gordon Taylor: I didn't say he was carried away by the emotion. I just said I have spoken to him on a number of occasions.

Chair: You said it was an emotive issue, therefore that is a link between what he said—

Gordon Taylor: Of course it is. If it involves an illness within your family, I don't know how it can get more emotive than that.

Q269 **Chair:** Yes, but it is specific to the charge that he had, that you have



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blood on your hands. Those were the exact words he said, which are incredibly strong words and, as you say, very emotive. Is that because there are many within the game who feel as if the PFA has focused on many of the things in the game but perhaps has been asleep at the wheel as far as this goes? It is 19 years since the inquest into Jeff Astle.

Gordon Taylor: I can do a timetable of all that has happened. We have never been asleep on it. We were frustrated by the initial research. The data was not there in our national health service and that is a factor for you to consider. When we found out that the data was available in Scotland, the field study was able to go back in time rather than going forward in time, which we were told was the best. That is why we have come up with probably the best evidence in the world, which was in the hands of Willie Stewart from Glasgow University.

Q270 **Chair:** Yes, but talking about Professor Stewart, 19 years on since the inquest into Jeff Astle he described football's protocols for concussive head injury in the sport as "a shambles". You are partly responsible for having brought that shambles about.

Gordon Taylor: Yes, I saw that. We have spoken with Willie Stewart. He is also a member of the committee that has been appointed by football. The chairman of that committee is involved in neurodegenerative diseases, and Willie Stewart of course is involved in pathology and he is very much part of that process. He is in there and he will speak his corner, as he has done. At the moment we are in a world where it is free speech so he can give an opinion, but what I would say back to that is it is far—

Chair: Yes, but the point is you are the head of the union—

Gordon Taylor: Sorry, I was only going to say I would not agree that it is a shambles.

Chair: Okay, so you don't agree it is a shambles because if a—

Gordon Taylor: That is a ridiculous thing to say, because this is a serious subject that we are giving serious attention to.

Q271 **Chair:** Okay, thank you. The Committee appreciates your appearance today and also what you have to offer. You are, of course, the head of the union. Does it not concern you that the professor, who is acknowledged as the country's leading expert in this area, refers to the protocols for your members, which are inflicted on your members, as a shambles? Does that not deeply concern you and mean that those protocols need to be not only revisited, but majorly overhauled imminently?

Gordon Taylor: With regard to that—*[Inaudible.]* Sorry, did you miss that?

Chair: Yes, you broke up. Please continue.



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Gordon Taylor: Of course any criticism has to concern you. From that point of view, that is why we are continuing to lobby, not just our own association, the FA, but FIFA and UEFA, to give a lot more care and attention to this particular issue.

Q272 **Chair:** There is a lot of lobbying that goes on over 19 years, considering the power that you have within the game, the power that your members have.

Gordon Taylor: It is not just lobbying. Well, of course the union is about lobbying, but we have been successful with much of our lobbying. We are successful in that now we are discussing this issue at this level. I can go through a long list of changes to regulations for the health and safety of our members. I already touched on the heart screening and every opportunity to prevent problems for our members, not just for safety of crowds, which we saw in the 1980s with Hillsborough and Heysel and so on, but for the safety of the members.

Q273 **Chair:** There is nothing at all you would have done differently over the last 19 years and you have done now for concussion in your sport? Do you think—

Gordon Taylor: I wish we had managed to unlock the key. When you say there is nothing at all we would have done differently, we are doing our best, along with every other issue in the game: pensions, contracts—contracts have been talked about—and freedom of movement.

Q274 **Chair:** So you were not too slow to act?

Gordon Taylor: There is a whole host of issues, but this was never, ever off our agenda.

Chair: You have not been too slow to act, Mr Taylor? You resist that claim and you resist the claims of Mr Sutton—and others, I have to say—that effectively the PFA has not stepped up as far as this goes? You have not been too slow to act?

Gordon Taylor: I think it is an unfair criticism because I know what we do. I am perfectly happy to show anybody what we have done, what we are doing and what we intend to do, but as the problem is with us and there is more evidence of that problem, it needs more than just the PFA to be involved in this. It needs Government as well to realise the seriousness of dementia, how it is affecting more people, irrespective of whether they have played football.

Q275 **Steve Brine:** This question is for Damian and Paul about the Health and Safety Executive, which issued a statement to us that literally just came to us during the session today. I have not had a chance to review it in any detail, nor have other Members, but there are lots of references in it to the balance of risk versus benefit of sport, how at the elite level the governing bodies are the gamekeepers and have set the rules and laws of playing and participating. It is the governing bodies and the rules of the



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sport that dictate how the sport is played, so on first glance there is lots of, "It is them, not us." Damian, in your experience with the Health and Safety Executive, has it been a feature on training grounds?

Damian Hopley: No, it has not been a feature. At one point—and I can't quite place the date in the early noughties—we had a situation where one in four players would be out injured at any one time. There was a comment made that if the Health and Safety Executive got hold of rugby it would probably look at whether it is fit for purpose. But at the moment, I do not believe the clubs report into the Health and Safety Executive because of the definition of workplace injuries. We have great confidence in the clubs' reporting lines, the RFU's reporting lines, but I don't believe there is a crossover with the Health and Safety Executive as such.

Q276 **Steve Brine:** But its purpose is to prevent work-related death, injury and ill health, so if it is not a feature on the training ground—and I am guessing, therefore, it is not a feature in treatment rooms, for instance—should it be?

Damian Hopley: I guess it comes down to the definition of the workplace injuries, because it is probably a given that in rugby—I will take my sport—injuries are part and parcel of the game. I am talking broader now than concussions and sub-concussive episodes and brain health. It probably comes down to—dare I say it?—the legal definition of what workplace injuries are and how that applies within that health and safety remit.

Steve Brine: Paul, I know you don't have a training ground, but you have something else. Go ahead.

Paul Struthers: Injury surveillance and injury reporting is all under the administration of the governing bodies, so the British Horseracing Authority. The racecourses—the theatre where racing happens—adhere to health and safety legislation and they have to risk assess everything they do and all their set-ups there. In turn, for the health and safety requirements at a racecourse, the British Horseracing Authority has general instructions dictating the standards. We have very robust standards of medical care and lots of other things and I know the BHA has made a submission to this inquiry on those injury statistics. If the inquiry wants more detailed figures, we can definitely provide those.

Again, I do not want to sound complacent, but the BHA medical department has very robust injury reporting mechanisms. We are fortunate in racing, in a sport where injury risk is significant. Last week we had the tragic news that we had lost one of our jockeys, Lorna Brooke, to injuries suffered on the racecourse a week previously. It is a dangerous sport. Health and safety is a massive priority and one of our biggest priorities, for obvious reasons.

Q277 **Steve Brine:** I hear what you say about the BHA and that makes sense, but the question I want to go on to is: is it marking its own homework? Baroness Grey-Thompson did her independent report on duty of care in



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sport and that recommended a sports ombudsman that would hold national governing bodies to account for the duty of care they provide to their athletes, their coaching staff and the support staff. Do you have any truck with that? Do you think that would be a good idea?

Paul Struthers: It would be hard to speak for all sports. I can see some merit in that. I think it would be fair to say that every player association has its issues with the governing body. Those issues will vary across the different sports. One of ours, for example, would be the welfare of jockeys and more their mental welfare, being self-employed athletes in a sport where there are no seasonal breaks and we race 362 days a year.

I can see some benefit to it. When it comes to injuries for jockeys, because the BHA is independent of jockeys, it would not be a concern of mine specifically at the PJA that I think the BHA isn't doing a good enough job with injury at all. I think that would be an unfair criticism for me to level at the BHA. As I say, it is for Damian and Gordon to speak about the other sports. I certainly see some value in that overarching role, because you are right: the sports governing bodies are left to their own devices and mark their own homework.

When I look at this topic on concussion protocols and I look at the protocols we have had in place in racing since 2004, we are fortunate that we have a clear mechanism of injury, because a jockey falls off a horse and therefore there is a clear identifiable risk of concussion that can be assessed. I look back on a 17-year protocol that has been strengthened during that time. While I think the other sports have caught up with the BHA and our sport, despite pressure from player associations, I think it did take a little bit of time to catch up. I know that may be complicated by international governing bodies, which racing doesn't have either, so the BHA is in full control of its rules and regulations.

Q278 **Steve Brine:** Yes, got you. Finally, Damian, Paul said everybody has issues with their governing body. What are yours?

Damian Hopley: To backtrack slightly on the injury surveillance, in 2002 the RFU, in conjunction with Premiership Rugby and ourselves, set up the Professional Rugby Injury Surveillance Project, which is run every year annually out of Bath Uni, and the RFU and is a very thorough and very helpful tool for us.

On our governing bodies, there is probably an interesting piece here with Dame Grey-Thompson's piece about the ombudsman. I certainly feel that, as a sport, sometimes rugby doesn't help itself in its lack of joined-up thinking. I think that some more robust governance would be most welcome across the professional game. Going back to John Nicolson's point, support around how we help longer-term injured players is absolutely crucial going forward.

Specifically for rugby at the moment, we have just put into the paper on this very issue about how we can make the game safer. As Professor



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Stewart mentioned in the first hearing, 19% of our concussion injuries happen during training. Progressive Rugby—who we have spoken to—and ourselves are agreed that we need to look at training in rugby to see whether we can reduce the number of contacts in there and look at having a bit more rigour around how the players are treated in training environments to make the game safer and therefore reduce concussions. That is consistent across a number of stakeholders who have appeared before this Committee.

Gordon Taylor: If I may, following on from Paul and Damian on the question of the Health and Safety Executive, it is a bit like the checks on the education of our apprentices. I would very much be in favour of a greater emphasis on that for making sure that with all the staff at clubs and coaches, it is about checking on full qualifications. Also, we have had the issue of child abuse and that always has to be high on the agenda. Also, medical treatment, in line with regulations, because we find at times that it is very difficult for the leagues to monitor themselves.

From that point of view, as we are discussing this, we are all involved in major public sports and we have a duty of care for our youngsters coming into the game in particular to make sure that they are looked after by proper people, fully qualified people, all the medical equipment that is needed and that if there are some problems it is available. The same with the educational process, because we want to make sure the youngsters who come into the game, if they don't make it in football, will have proper qualifications to use for their futures as well. There is a number of areas where I would be pleased with a greater approach.

Q279 **Chair:** Thank you, Gordon. Before I move on to Clive, I will follow up on one thing. Damian Hopley just said that in 2002, I think it was, they set up a special sports injury unit, a monitoring unit, at Bristol University and they have followed through since then in the last 19 years. Has football done anything similar over such a span of time to monitor injuries?

Gordon Taylor: Football now has a medical sub-committee for our collective bargaining agreement, and that is discussing all such issues regularly. The Football Association has formed its own specialist committee. The PFA has its own devoted taskforce for this particular issue at the moment. I am hoping that what we are doing in England will start to have an effect with FIFA, UEFA and world affairs, because this is a world issue as well.

But if we can set the lead, as we have done in the past on different areas—like the difficult days of the 1980s that I have referred to, what we have done with the pandemic and keeping going, protecting the best sporting interests, working together against the European Super League—I think this is something we can do.

Q280 **Chair:** To drill down, this isn't specific to your organisation; this is football itself. We just heard that rugby set up this institution in 2002 through Bristol University to monitor injuries. Presumably that would



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involve all forms of injuries, but in this case head injuries. Does football have a similar medical institution with academic support in this country for head injuries or for any other form of injury?

Gordon Taylor: It does, and it has for some time now, yes.

Q281 **Chair:** When you say "some time", when?

Gordon Taylor: We have the FA research taskforce in place and the results of the field study that has been done. Medical matters used to be and have always been handled by an FA medical committee. That needed to be kept as fresh as possible. I don't want to be firing arrows at the FA, but there was a different approach when it was talking about looking at selling Wembley and so on. I said at the FA Council its business should be about a duty of care to all the youngsters coming into the game at grassroots and professional levels. With the publicity received of late, that has certainly happened now, but of course it could have happened earlier.

Chair: It has to be shamed into it, to a certain extent. Don't worry about casting arrows at the FA. Everyone else does, so you might as well join the party.

Q282 **Clive Efford:** Welcome, Gordon, Paul and Damian. We have evidence from the PFA and we heard Gordon refer to Jeff Astle's coroner's verdict, which was sent to the Industrial Injuries Advisory Council, and it did not accept that as being sufficiently robust enough to have acquired brain injury recorded as an industrial injury. But Paul and Damian, what has been your experience of trying to have acquired brain injury listed as an industrial injury?

Paul Struthers: It has very much been a campaign led by football, for obvious reasons, given what has happened in football. I know the Scottish Professional Footballers Association is involved, even though it become a devolved issue, but it has been very much led by football, I have to be honest, unless Damian and rugby have been involved as well.

Damian Hopley: I agree with that, Paul. From our perspective, with the former player who very sadly presented with early onset dementia pre-Christmas, while we know there have been some links, I guess we are understanding more and more in this space. You will have seen yesterday, Clive, the news about the Alzheimer's Society setting up the PREVENT:RFC programme up in Scotland where it is going to study the brains of 50 former elite players, including Ben Kay and Shane Williams. Richard Oakley, who presented at this Committee before, will be leading that. It is a very important step forward for Sport United Against Dementia.

Q283 **Clive Efford:** Are there barriers to sportspeople receiving compensation for concussion injuries that they have acquired during their sporting career?



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Damian Hopley: Again, I will probably be led by Gordon on this one, because football has led the way on it. Gordon, you may have a better input.

Gordon Taylor: *[Inaudible.]*

Clive Efford: Gordon. You are frozen, sorry.

Gordon Taylor: Yes, I am sorry, the line broke up. If you can hear me, that is why we are wanting clubs to keep records, because if there are records of concussion, that can be referred to. But as a general understanding at the moment, dementia is not classed as that, but it could be a particular injury that a former player could report on and get a benefit.

I was also asked about the expert panel on head injuries and concussion. That wasn't formed recently—it was formed in 2015, so that has been in existence for six years.

Q284 **Clive Efford:** But on progress on this since Jeff Astle in 2002, it went to the Industrial Injuries Advisory Council in 2003 and was rejected, and we seem to be going at a snail's pace. Can I go back to Paul and Damian and ask what discussions you have with employers within sport to provide support and to recognise that with acquired brain injury they should provide support to people who suffer that during their careers?

Damian Hopley: From a rugby perspective, Clive, this is a relatively recent development. As I mentioned earlier with John on his question, I think this is more about what sport can do to help players when they retire, in both the short term and long term. We have a pathway for a number of former players, providing ongoing referral to confidential counselling and potential neurological support. Dr Richard Sylvester is on this hearing later. We use him a lot to help those players, but it is probably more about when players are leaving clubs now there is almost an MOT done to make sure they are in sufficient health to start their next career, and if not, what can the sport do under the duty of care to help those players out in the longer term.

Q285 **Clive Efford:** Can I come to you, Paul? It strikes me that when a serious injury occurs in horseracing, it is quite obvious that somebody has a major injury that has been caused by being trampled by a horse or falling during a race, for instance. But what we are talking about here in football or rugby and also in horseracing is that people acquire these injuries over a multiple number of smaller traumas, lower-level traumas, though they are important none the less. Is there a difference between the way in which industrial injury is recognised when it is a serious injury such as someone being trampled by a horse and getting a head injury and this sort of acquired brain injury that we are talking about today in the way that people are treated in racing?

Paul Struthers: I am in danger here of getting involved in an area where I am underqualified to talk. When it comes to industrial injuries, I



know one of the challenges that footballers had with the IIAC is the barrier that it set that any research has to be independent, yet because sport is funding the research itself, it is therefore not independent and it is any support that this inquiry can give to that. This is no criticism of this inquiry at all. Sport seems to be criticised on the one hand for not funding enough research, but then the IIAC is criticising sport for funding that research, which makes it not independent, so I think it is important.

Obviously there is developing research that these repetitive impacts, these sub-concussive impacts, have a long-term impact. As I say, it is why the research project that racing has particularly got behind is ICHIRF, the International Concussion and Head Injury Research Foundation, which I understand should be producing an interim report or some finding this year, albeit it is long term. It is because despite all of the other research and developing evidence and hard evidence, again we are led by the experts across sport, aren't we? As we know, the experts aren't always in agreement—they are often conflicting, which is a challenge for us to get our heads around.

It is to fully understand why in horseracing, for example, we have no evidence of that being an issue, yet our athletes suffer concussions regularly. Even though they might not have the same number of head impacts that heading the ball, particularly in training, would give you, they still suffer falls at home and elsewhere and have a number of sub-concussive impacts, so why is it that our population doesn't appear to suffer the same issues that other sports do? It is a real challenge, but it is a hugely important one.

Q286 Clive Efford: Thanks. Gordon, if I can turn back to you, we are the Digital, Culture, Media and Sport Committee, and one of the biggest issues we have been talking about recently is the European Super League. I know football fans would be disappointed if we did not give you an opportunity to comment on that. Was it a surprise to you when the European Super League was announced a couple of weeks back?

Gordon Taylor: I shouldn't say it is an old chestnut, but we had similar points of view put at the formation of the Premier League. All I know is that we do our deals with the Premier League. The Premier League was very concerned about it. I think there had been some double-talking because you saw how upset UEFA was, but I just felt the reaction coming from our members was brilliant, coming from managers, Government, Prince William and so on. The reaction was good and I think we need to be mindful of that.

Q287 Clive Efford: Can I ask you, Gordon, whether you had no discussions within the PFA or no inkling at all that this was coming?

Gordon Taylor: No, none whatsoever. What we have been worried about is increasing the number with the European Championship coming up and also of course with what we have in place with the Champions League. They have been trying to extend it. They keep going to the well for more



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and more games and looking at quantity rather than quality. Bearing in mind during this pandemic the intensity of games coming one after the other, there has been a real demand on players.

Much as a closed league is ridiculous, it is not in our culture, but we do need to be mindful of the health and safety of our players. Even though we have had massive improvements in medicine and science and sports science, it is still only an average eight-year career because of the intensity of the competition.

Q288 Clive Efford: What was the reaction of your players to the idea of a European Super League? Was it unanimously opposed? Were they concerned about the fact that they may not be able to play international football if they were dragged off into this European Super League? What was the reaction that you got from your members?

Gordon Taylor: It was the same as we saw with the managers of the biggest clubs coming out and speaking against it. I thought there was a great solidarity. The players of the Premier League have shown great solidarity in getting us through this pandemic as well, from facing early criticism, as you know, from the Home Secretary and Matt Hancock. They got themselves together and said how much tax they pay and also contributed to NHS charities together, which the PFA and myself personally did as well, in addition to all the community work.

I felt there was a real feeling of what sport was about, about its uncertainty and about its magic and about the ability to have dreams and achieve them. If we lose that, we are not being respectful to our heritage, because this small island has more full-time clubs, more full-time players and the highest aggregate number of crowds in the whole world when things are normal, so I felt it was a great response.

Q289 Clive Efford: If a European Super League happened in the way that was planned, what are the implications for the PFA? Do the players who go off to play for those clubs stay in the PFA or do they have to join FIFPro or a European players' federation?

Gordon Taylor: FIFPro is worldwide, but there is no way those players were going to do that. When they signed their contracts, they were quite mindful that those were contracts to play under the current circumstances and that their conditions would not be changed without themselves or their union being a part of that process. That has been a problem in looking at the pandemic. Also, when the Football League was looking to have a hard salary cap without consultation, that is when people and unions get tested. But the solidarity of our players has not been in doubt and I have been very proud of them.

Q290 Clive Efford: That is an interesting point. They were changing terms of contracts without any negotiation whatsoever by forming that league.

Gordon Taylor: Exactly, and above all I felt they showed how much they care about supporters, remembering they have played for 12 months



without fans. It is like having a meal without salt and pepper; it is just not the same. It has shown how crucial the fans are and I felt our players were at one with the fans and at one with their communities with the work they did for their communities.

Q291 Alex Davies-Jones: Gentlemen, we have talked a lot this morning already about what compensation support packages there should be for players and what support there should be after they stop playing, but I do want to touch back on this for one question. My grandfather and my father were both miners. My grandfather died in his early 60s of black lung disease, pneumoconiosis. My father suffers from vibration white finger. The UK Government have now taken responsibility for these and they have set up compensation schemes, but both conditions were not diagnosed until years, decades, after they stopped mining and the pits were closed down.

Damian, what responsibility should there be to address welfare issues from injuries that may not become apparent for decades after players stop playing?

Damian Hopley: I go back to this point, Alex, about the duty of care on the game. The next World Cup, which will take place in France in 2023, will be the most commercially successful World Cup there has ever been. In talking with Kyran and various other former players, there is definitely a sense that the governing bodies need to ring-fence some money going forward to look after those players. It might be an industrial injury through playing, it might be a head injury that is determined later on in their lives, but certainly the sport needs to look after its own. There are certain ways that we, as the game in England, are trying to do that and that is talking about reducing the amount of contact in training, so there are some key things that we can do as a national and international sport.

An example is that Kyran Bracken played 51 times for his country and was captain three times. He is now suffering some significant brain health issues. He presented to this group fantastically well, but Kyran has to come to the players' association and our charity, Restart, to get support. This is a guy who has lifted the Webb Ellis trophy for England and has made an extraordinary impact on the sport, but he is not going to the governing body, he is coming to the players' association. For the record, we are not particularly well resourced in what we can and can't do. Like all sport, we have been decimated throughout the pandemic.

I think that it really is about this duty of care and I would appreciate and applaud support from this Committee to look at having something like that instilled and drummed into the sports going forward so that players have somewhere to go and they know they have that support. As Kyran says, I do not want to be waking up in 10 years' time wondering who is going to look after me. Here is a man who has dedicated his life to rugby. He is now dedicating his life to this cause of brain health and progressive rugby. That is where there is a real step change required.



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Rugby has been very good in how it supports catastrophically injured players, and we have seen a number of players over the years who have benefited from that. As a game, we are very good at rallying around and supporting charitable causes. Restart, our own charity, has spent over £400,000 on mental health challenges, but—

Q292 Alex Davies-Jones: Sorry to cut you off there, Damian. That is wonderful and I applaud that. It is great that you support these charities, but one of the big concerns that I have is that all of this funding and future funding that you are putting in place is for professional players, whereas amateur players are going to fall through the net. I represent a seat in the south Wales valleys where we have fantastic rugby teams and rugby culture. Men and women play the game passionately and have done for decades, and long may it continue. I am worried that they are suffering from these injuries now and we are seeing some increasing mental health issues and increasing dementia. I am not saying that is all related to this, but there must be a link. What support is there for the players who are at an amateur level? My concern is that the children coming through are going to fall through the net here.

Damian Hopley: I agree. Alzheimer's Society and Dementia Connect are running the 24/7 hotline to try to help people. I think that it is around NHS pathways now. We have talked about Government and sport working together on this. We look through a lens of elite sport because as player associations we look after professional players, but I think that Heather mentioned this in one of the previous Committees. The link between what happens in elite sport and community sport is absolutely there and it is making sure that there is a culture within the game that we look after our own. It is not just relying on charities to do that; it is a broader piece for the sport as a whole.

Q293 Alex Davies-Jones: That takes me perfectly on to my next question. You mentioned the PREVENT:RFC project that the Alzheimer's Society has just announced in the past few days, with Shane Williams and Ben Kay joining Alan Shearer in the fight against dementia. Should it be up to charities to lead the way in research in this area or do you think that there should be more Government support?

Damian Hopley: Again, it is combining the two. This Committee has brought the likes of Richard Oakley and Professor Stewart and Professor Ritchie together, so I think that there is a fundamental role for Government to play here. Dementia is the biggest killer in our country, so we need to make sure that there is as much information as possible. In many ways, we need more data but we need that yesterday. That is the challenge we have, so I think that the role of Government here is absolutely fundamental.

Q294 Alex Davies-Jones: What is your opinion on documentaries or the increasing media presence around these issues? For example, how well received internally was the BBC documentary, Alan Shearer's "Dementia, Football and Me"? Gordon, I will ask you that question after Damian.



Damian Hopley: The one mantra we use a lot in our world is, “Players listen to players”. When the Premier League’s highest goal scorer goes and talks about this—and we have had a number of very public discussions, whether it is Kyran, Steve Thompson or Alix Popham, talking about their struggles with early onset dementia—it goes to the heart of what this is all about. These are in many ways outstanding role models who have done extraordinary things for their sport and now they are lifting the lid on the issues that players face once they finish playing.

Alex Davies-Jones: Gordon, do you have anything to add on that?

Gordon Taylor: Yes. I agree with Damian. It is a matter of education for our members, Alex, as you say. It is a matter of education for our youngsters at grassroots level. We should be proud of our pyramid. That was the problem with the ESL. It was the peak of the pyramid going their own way and everybody left to battle for themselves. It is all together.

I feel that with the particular issues you are talking about, it is an education factor, a research factor and a treatment factor. It needs the personalities like Alan Shearer who are prepared to be tested. As I mentioned before, my staff, many of whom are former footballers, have all been willing to be checked and tested. We need to do that for all our former players, if they wish to do so and feel comfortable with their mental health as well and, of course, with their fitness and health.

This is an issue we can focus on all day long and keep improving, I am very much aware of that, but now that it has been so illuminated I feel that it has been a really good exercise today for you to hopefully find out and us to find out what you can be prepared to do in Government as well. The one thing I worry about is that there are so many people dealing with these issues that we get some complication and duplication. I am hoping that we can get some clarity.

Alex Davies-Jones: Yes, I agree: clarity and some leadership is what we need on this. Thank you.

Chair: On the point of Alan Shearer, I have to say that I have never heard “Alan Shearer” and “personality” used in the same sentence. Mr Shearer did, of course, refuse to appear when asked before this Committee, so I think that that says a lot in that respect.

Q295 **Julie Elliott:** Good morning, gentlemen. We are coming towards the end of this part of the Committee, but a lot of things have been raised. I am particularly interested in the impact on grassroots and how grassroots sports are looked after and those sports that are not rugby and football, in spite of the knock-on effect of the pandemic. We heard in a previous session some evidence from Eleanor Furneaux, who was an elite athlete but had to repair her own helmet, basically, because she was not given a new one. Paul, many sports do not have the financial resources of football and rugby, so who should be responsible for ensuring the welfare of those elite athletes in the sports?



Paul Struthers: It is the governing bodies. As you say, what I would call the big three player associations—and two of them are not that much bigger than us—get some central funding for the professional cricketers, footballers and rugby players. Like you, I was shocked at some of the evidence of the last session. I coach at grassroots level. I used to coach a bit of rugby and now coach a little bit of football, so I am aware of the level of training that goes on now of coaches at that children's level. For example, we have no heading at all at the age group I coach. We do not even allow it at all in training and in the matches.

I think that it is important that protocols are sport specific. Equally, what it appears to be, unless something has changed in the last few years, is we still have too many sports where protocols do not exist, barely exist or are inadequate, or they exist and are simply not enforced by those who are looking after the athletes. If as a result of this inquiry we could see an absolute minimum standard that all sports should adhere to, all the way from elite level down to grassroots, I think that would be a significant step forward.

Q296 **Julie Elliott:** You said in the first part of your answer that governing bodies are responsible for the welfare of elite athletes in the less-funded sports. Do you think they are doing their job? Do you think they are looking after them properly or do you think there is room for improvement?

Paul Struthers: When I talk about governing bodies, it is about the welfare standards, so there is probably slight confusion there. In the absence of player associations—and we have seen it through Dame Grey-Thompson's report—there is a lack of support.

I think that the variation between governing bodies seems to be quite stark in how they look after their athletes. It is fair to say that it is a concern in the professional sports that are members of the PPF and the amateur sports, the Olympic sports, that there is not enough emphasis by governing bodies on welfare generally. As I say, in racing, which is my area of expertise running the jockeys association, apart from one insurance scheme that is funded by racehorse owners as a supplement on their entry fees and jockeys' riding fees, we are entirely self-funded. All of the jockey support is funded either by ourselves or one of two charities, the Jockeys Education and Training Scheme and the Injured Jockeys Fund. The Irish authorities, for example, have just announced an extended break for jump jockeys of 24 days. We have a 12-day break in this country and it is virtually impossible to get it longer.

Any lead that can come from Government—and it comes back to one of the earlier questions about this ombudsman idea. I think that sport and governing bodies are getting better, but I have long held the belief that unfortunately welfare often seems to come second place to profit and money.

Q297 **Julie Elliott:** Thank you. Damian, where do you see necessary changes



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for the non-elite athletes in rugby, who face the same future risks as their elite colleagues who are well paid, not well paid relative to football but well paid counterparts? Where do you see that? Gordon, I will be asking you the same question.

Damian Hopley: From our perspective, there has probably been quite a significant culture shift where rugby has come from and to. We alluded earlier to getting the player back on the pitch: it doesn't matter, it is a hidden injury, you cannot see it. Even over the last few years in the refereeing standards, in the last Six Nations there were more red cards than we have seen probably ever in the competition, with five. I think that culture shift of understanding more about brain health is starting to distil down into the grassroots, ensuring that there is a duty of care but also that people are better informed about brain health and getting removed from the game.

The RFU has its Headcase e-learning resource, which has worked very well and had some great pick-up across the sport. We come back to that education piece. I used the example of Mike Brown earlier. If Mike Brown is sitting out a number of games because of a serious concussion, hopefully that is setting an example to younger players that they have to look after their brain. Hearing some of the horrible stories from the previous session, certainly from Eleanor and Monica, you just want to make sure that the people around the game, the volunteers, are fully up to speed and have enough education around what a sensible protocol is to impact positively on the sport.

Q298 **Julie Elliott:** Can I follow that up by asking whether you think it is the same in the women's side of rugby?

Damian Hopley: It is a very good point. The women's game is now exploding and we have just seen the English women lift the Six Nations trophy for the third time in a row, which is fantastic. We are all excited for the World Cup, which has been postponed for a year. I guess that there is not enough data and longitudinal studies in the women's game at the moment, but that has to be a key consideration because all the evidence is that women are probably more susceptible to head injury and concussion.

For the game generally, how do we amend the rules? Do we look at something as significant not just for the women's game but across the whole piece? Obviously, the growth in the women's sport, one of the fastest growing sports in the world now, means that we are going to have to start to look at far more data and research in that context.

Q299 **Julie Elliott:** Thank you. Gordon, can I put the same question to you?

Gordon Taylor: Yes, it is a really good question. It is crucial that the governing body gets involved with the grassroots, but it is also important for the professional game. I have seen at first hand how when we have done our agreements with the Premier League and the Football League we allocate millions to the grassroots level and communities, but I feel



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that Government again have a real part to play in that. There is also money from the Football Foundation and there need to be rules and guidelines with grants that are made to grassroots clubs and teams that they have to be mindful of policies put through coming from the top and coming from the FA, if that makes sense. That is part of the responsibility of receiving moneys and help that comes from Government as well as from football. From that point of view, everybody needs to be singing from the same hymn book, if you get what I am saying, Julie.

Q300 Julie Elliott: Do you think that there is enough in grassroots football? Every primary school I visit, when you talk to young people and ask, "What do you want to do when you grow up?" a majority of boys always say they want to be a professional footballer. Do you think that there is enough education at grassroots football level to make sure that those young people are not trying to do some of the things that they see their heroes on the pitch doing? *[Interruption.]* You have frozen, Gordon. Sorry, no further questions. Oh, he is back.

Gordon Taylor: Youngsters as young as five, six and seven have their link-ups now. It used to be 16 years old before anybody thought of joining a full-time club, but now they have their own academies. They invite the very best of these youngsters, so the professional clubs for the very best of those youngsters have an even bigger responsibility. They do not want them to devote full-time to football. It has to be mindful that it is only an average eight-year career. There is such a fallout rate. We lose five out of—

Q301 Julie Elliott: If I can just interrupt you there, could you comment on the women's game as well? Are the same provisions there in the women's game for youngsters?

Gordon Taylor: —six who join—*[Inaudible.]*

Chair: I don't think we are going to get anywhere in that respect. The answer is that the provisions are not the same in the women's game, at the very top of the game anyway. I think that that is an issue that needs to be addressed as a matter of urgency. Our final question comes from Kevin Brennan.

Q302 Kevin Brennan: Paul, could I ask you for a very short answer? Were you invited along to the roundtable on concussion in sport that was held recently by the Government?

Paul Struthers: No. I understand we might have been invited subsequently to—

Q303 Kevin Brennan: Yes, I will follow up in a second if you would let me just pursue this, Paul. Damian, was your organisation invited? A one-word answer will do.

Damian Hopley: No.

Q304 Kevin Brennan: Gordon, even a shake of the head will do. I think that is



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a “no” from you as well. I will come back to you, Paul, since you have an umbrella role here in a way. Isn’t it staggering that the Government would hold a roundtable on concussion in sport and not invite along the organisations whose duty it is to represent the welfare of the players themselves? Paul, could I ask you to comment on that?

Paul Struthers: It was disappointing and we were reaching out to officials to try to be involved in a subsequent roundtable to the initial one. I think that I was informed last week that we have now been invited to one. I have not seen the invite personally.

Q305 **Kevin Brennan:** Did you hear about the first one before it happened and did you try to get a seat at that table?

Paul Struthers: I would have to go back through my correspondence and check whether we knew, and I would be happy to inform the panel subsequently when I have done so.

Q306 **Kevin Brennan:** That would be very helpful. On that last question, Damian, were you aware of it and did you try to get a seat at the table?

Damian Hopley: I was contacted, Kevin, but just to provide phone numbers for other people to appear. I was aware of it and, as Paul said, disappointed that, given the scope of what we do, we were not part of that.

Q307 **Kevin Brennan:** They were not interested in you as the head of the professional rugby players’ union in England; they were just interested in your address book. Is that correct?

Damian Hopley: That would be a fair summation, yes.

Q308 **Kevin Brennan:** Gordon, did you try to get a seat at that table prior to the roundtable?

Gordon Taylor: I felt that it was disrespectful of the player organisations not to invite us, and that is why I am very pleased that when we requested a meeting with you, you have granted it. From the point of view of Government, to ignore the player associations, who I consider have been the leaders in so many areas with what you have seen lately with mental health, racial abuse on social media, women’s football and, of course, with the topic we have been discussing today—you would have thought it was the first call to make rather than the very last.

Q309 **Kevin Brennan:** Thank you, Gordon. Can I ask a couple of questions? I know that we have gone a little bit long this session, so try to keep the answers brief if possible. On concussion substitutions, I think that the PFA has expressed frustration at the position that has been taken. We pressed Dr Cowie from the FA, the medical representative, last time about the position taken in football about having permanent concussion substitutes rather than temporary concussion substitutes. Is there more you could do, Gordon, to stop football going off on its own on these issues and instead to follow practice that is well established in rugby that



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a temporary concussion substitute makes much more sense than a permanent concussion substitute?

Gordon Taylor: Yes, exactly, and that is what we are doing. That is what we are doing with the international board. It knows the strength of our feeling on that, and that has been publicised. We are going to keep going at that because that—

Q310 **Kevin Brennan:** What do the players themselves say to you about it, Gordon?

Gordon Taylor: It has been discussed before that the players themselves, very much on such issues, are focusing on what they are doing with their playing. As has also been mentioned, we have a big fear that players on the pitch know if the manager is saying, "Grit your teeth, can you carry on?" That decision needs to be taken away from players. We have had goalkeepers who have wanted to get back and say they are okay. It is about that duty of care. That needs to be shown clearly by the club as well as by their own players' association but, above all, by the Football Association, the governing body. Surely we should care enough about our sport that the health and safety of the participants has to be the No. 1 priority on the agenda.

Q311 **Kevin Brennan:** Thank you, Gordon. I think that we can all agree on that. Damian, can I ask you about rugby? You mentioned the number of red cards that have been issued during the Six Nations tournament this year, which is a record number of red cards. Do you and the players think that all those red cards were justified?

Damian Hopley: Good question. I think that possibly Zander Fagerson was the one that probably got most airtime on whether it was justified. I think that there has been a pretty clear directive from World Rugby and the referees around tackle height and head on head. We are seeing far more in the Gallagher Premiership this year. The key here is trying to change behaviours to make the game safer. Players are having to adapt pretty quickly or suffer the consequences. One of the discussions around progressive rugby was whether it is the number of substitutes, law interpretation or refereeing. I do not think that there is one quick fix solution for rugby, but certainly by addressing a number of areas we will make our game safer and that is what has to happen.

Q312 **Kevin Brennan:** Do you think that Owen Farrell should get more red cards than he does?

Damian Hopley: I am not going to comment on that.

Q313 **Kevin Brennan:** I am not surprised. Just to finish up, Gordon, on an unrelated subject in a way. Do you have any thoughts on the story at the weekend that Daniel Ek, the chief executive of Spotify—a loss-making company we are told—can afford to buy a Premier League football team, and not only a Premier League football team but one of the six renegade elite ones in the form of Arsenal?



Gordon Taylor: We have thoughts in general about the governance of the game and making sure that the owners of clubs have a fit and proper person test. This is one of the strong issues that we are discussing with the Football League on sustainability. You get the wrong owners or they put in money that is just loans and then suddenly pull those back and the club is struggling. It is a real, proper test and I feel that at the moment it is not a fit and proper person test in the whole meaning of the words for the sport as well as the business. Having said that, that is the way of the world. It is up to football to double check those two parallel lines: the business side of things as well as the sporting heritage.

Q314 **Kevin Brennan:** You may not be aware that the Committee is also conducting an inquiry into the economics of music streaming, and Spotify is a music-streaming platform. As the players' union representative, you might want to talk to colleagues in the Musicians' Union just in case football players end up getting paid as badly as musicians do if Mr Ek does take over at Arsenal, but I will say no more than that and just hand back to the Chair.

Gordon Taylor: I know and I am very much aware of that. We have a link-in as well with the other entertainment unions, including the musicians.

Chair: Thank you for your evidence today, Gordon Taylor, Damian Hopley and Paul Struthers. We are now going to take a very short break as we set up our second panel and put another 10 pence in the meter. We will conclude at that point and then we will be joined by Dr John Etherington and Dr Richard Sylvester.

Examination of witnesses

Witnesses: Dr John Etherington CBE and Dr Richard Sylvester.

Q315 **Chair:** This is the Digital, Culture, Media and Sport Select Committee and this is our second witness panel today in our latest hearing on concussion in sport. We are joined, as I said earlier, by Dr John Etherington CBE, Faculty of Sport and Exercise Medicine, and Dr Richard Sylvester, Institute of Sport, Exercise and Health.

John and Richard, good morning. Thank you very much for joining us. You watched the first panel, the players' representatives. What was your overarching impression? Do these sports grasp the issue? Do they grasp the dangers that are involved? Do you think that in any way they have been slow to act?

Dr Etherington: What we heard from predominantly today was the representatives of the players' unions and clearly they are very concerned about it, and understandably so. In my dealings with some of the sporting governing bodies, I believe that they are grasping that. Certainly, on the medical side, which is where I have most perspective,



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doctors working in professional sport or community sport are concerned about this. I think that they feed that back to the professional governing bodies. Have they been slow in responding? I can see a lot of activity now. It is very difficult for me to comment on previous historical responses. I definitely think that the governing bodies are interested now.

Q316 **Chair:** Is that just due to the fact that there is also the potential for more legal action that has focused minds?

Dr Etherington: I am sure that focuses minds, but I would like to think that members and fellows in my faculty who are trained in sport and exercise medicine are raising this as a particular issue and taking it very seriously.

Q317 **Chair:** Do they have enough sway, though, within those organisations? We had the chief medical officer—I was going to say the head doctor—from the Football Association and she did not know how much the organisation spent, or did not wish to tell the Committee how much it spent, on research every year. It was a very strange meeting indeed. Unlike rugby, in which they had enough support in place for the questions, she was in a hotel room, basically on her own, seemingly without any briefing at all. I was quite struck by that. We have also had other sports in which it has been revealed to us—and I know that this is a question that is going to be answered later—that you have one day a week on one particular sport for doctors and concussion. Do your fellow professionals have enough sway in these organisations?

Dr Etherington: We are quite adamant that our responsibility is to the patient or the player. We have recently taken very strong action on people who have not had that in mind. It is always a challenge if you are working for an organisation speaking truth to power, but it is the doctor's responsibility to do that. I know Charlotte Cowie and I know that she is a person who would do that.

I spent 35 years in the army. It was a similar situation where, as a medical officer, your responsibility is to speak truth to power and try to influence training or operations in a way that is as safe as possible within the medical guidance. Team doctors have a very similar challenge. They have to speak truth to power. They have to give the medical perspective. Part of it is down to their character and their training, but it is also about professional responsibility.

Q318 **Chair:** Dr Sylvester, what are your thoughts on hearing that first panel? Do you feel as if the representatives of the players in these sports, those unions, have been quick enough to grasp this issue?

Dr Sylvester: Again, it is difficult to look at things historically. It is very different between different sports as well. I advise rugby and football; I am on their expert advisory panels. There are very stark differences in the way their organisations and governing bodies are structured and the influence the medical teams have. Six years ago the RFU and the FA



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approached me to develop a clinical service for the players that would be independent of the clubs and the club doctors, which on reflection was quite good foresight, given what has happened more recently. Have they done everything they should in time? No, I don't think so.

Chair: Why?

Dr Sylvester: Just comparing sports, I think that the management of acute injury in rugby is very different from football. It is the same injury; should it be managed completely differently? No. Are there barriers to implementation of what we know should be done? Yes, and they do vary between sports. That is something for the politics of sport, not the medics. I think that we know what we should be doing. My view is that if there is a standard operating procedure that we know should be followed, if a sport is not following that, that is a big problem for the governing body and the medics involved.

Q319 **Chair:** Do you think there is a balance to be struck between taking part in sport and the dangers of early onset dementia? Should we just accept that if you are going to be in a sport that involves, for example, heading the ball or impact such as in rugby or horse riding, with the potential to injure yourself, that that is just part of it and however much you try to minimise it, there is always going to be a risk?

Dr Sylvester: In everything we do there is a risk. The really difficult thing is twofold. First, there are enormous benefits to sport and participation at an amateur level and a professional level, socially, culturally, economically and physically, that we cannot minimise. They are very important.

The difficult thing that I face daily in discussions with athletes, both grassroots and professional, is trying to look at the risk-benefit analysis for them as individuals. It is easier for somebody if it is their profession. They may be willing to take a greater risk than if their profession requires them to work full-time in another job rather than sport.

Equally, it is very difficult to have these discussions when we do not really understand the risk. The field study has shown an increased risk in dementia in later age in professional footballers. It also showed a decreased risk of cancers and cardiovascular disease. That increased risk of dementia in absolute terms is small, but equally what we really need to know is what risk individuals are taking. I think that in the research aspect we do not understand the individual factors that are clearly at play because not everybody who participates in contact sport goes on to develop dementia. Clearly, the link has been made numerous times and we do not understand the causality or the mechanisms and it is going to take a bit of time to work that out, but we do not even understand the level of risk at the moment properly.

Dr Etherington: I would like to come in there. I agree with that. It is very difficult to quantify that risk. It is impossible at the moment to



quantify that risk to an individual. You can say that the relative risk might well be higher when you are 80 for having dementia if you play professional football compared to if you didn't, but when you are seeing a 15-year-old who is starting hopefully to play professional football, how do you advise that individual what his risk is? If he is 15 or, indeed, 25, having a three times greater, for example, risk of dementia when you are 80, what does that mean to a 20-year-old or a 15-year-old? Are they going to stop playing football because of it? I have had similar conversations with people training physically very hard in the military: what did they perceive the risk to be in 40, 50 or 60 years' time?

Q320 Chair: Should you not as a first instance err on the side of caution when it comes to settling that particular issue?

Dr Etherington: The precautionary principle is generally a good one, but it has drawbacks, doesn't it? Supposing heading a football causes long-term damage and, therefore, it is sensible to prevent long-term damage by stopping heading. But supposing it is not heading that causes long-term damage. We have stopped heading the football, we are quite happy we have intervened, we have produced a precautionary measure, but we are missing—and I do not know what it is—another precautionary measure because we are confident we have it.

As Richard points out, physical activity is very good for you. It is the single most important factor in improving your quality of life but also your longevity. Anything that distracts people from taking physical activity cannot be good. I think that it is easier to say to take a precautionary principle, but we risk having—

Q321 Chair: Would you say that heading the ball 72,000 times in a career is safe? The word "research" is spoken about an awful lot here, but it is whether or not this has been entirely proven, yes or no, and whether or not you could say to most people that heading the ball 72,000 times is not a good idea if you want to avoid these type of injuries long term.

Dr Etherington: I think that you have hit the nail on the head. We have not directly proven that it is bad for you. On the other hand, I don't think that it sounds very good and 72,000 times of repetitive hitting on the head is probably not a good thing, but there is no evidence.

On the earlier debate there was talk about industrial injuries. The level of evidence you are going to need to produce a link between any particular sporting activity and an industrial injuries benefit is just not available at the moment. In most of the industrial injuries you talk about—and a good example is mesothelioma from asbestos exposure—there is a 30 to 40-year lag time between exposure and developing the cancer; hence it has taken us a long time to determine that link. That is the risk with concussion, brain injury, heading a football or anything. Are we prepared to wait 30 to 40 years to prove that link?

Q322 Chair: Dr Sylvester, what do you think of the current protocols for



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dealing with concussion across the main UK sports, the ones that we have focused on quite a bit, so football, rugby and horse racing?

Dr Sylvester: My speciality really is not the acute management of concussion; it is more the chronic issues, either people who do not recover or, in many ways more relevant, the long-term effects. That is what neurologists do. I have ended up becoming a bit more of an expert in the acute management of injuries because of my work in this.

We know that people who have had a significant head injury to the point where their brains are not functioning very well are a danger to themselves and a danger to others if they carry on playing. I think that we desperately need to be able to measure recovery objectively. This is not a fault of protocols, we just do not know when people's brains have recovered. We go on the basis of, "Do you feel better? Can you run a bit? Can you do whatever sport you do?" and some pretty poor cognitive testing, to be honest.

There is a danger, though, with becoming absolutely obsessed with the protocols. That to me is what has happened to a large extent in NFL and American football. They have multiple doctors in the stadium. They have spotters in the stadium. They have angles of video and they are obsessed with spotting concussions, and that is good. We need to get people off. If they have had a brain injury, they need to be off the pitch: they need to be safe. My concern is the emphasis on that. If we are then saying they can go back to play one or two weeks later and have more injuries that have a long-term effect, we are almost sweeping that under the carpet.

Q323 **Chair:** What you are saying is that there is perhaps an overfocus in observers' minds, such as ourselves for instance, on the immediate point of contact that someone has suffered. We are struck as a Committee by the fact that one of the athletes who appeared before us, who was in the skeleton bobsleigh, had been put on a flight, despite the fact that she did not know basically where she was or almost who she was for three weeks following the injury.

Dr Sylvester: I think this is not just a sports issue but the management of acute brain injury. My background is not just sports injuries but all brain injury and I see that happening time and time again. People are discharged from hospital, from A&E, completely confused for weeks. It is difficult to manage acute brain injury. Sports have a specific setting. They often have witnessed injuries and I think there need to be very carefully thought out protocols that are followed very rigidly. I would not bother with head injury assessments. If there are any concerns, people are off. One of the issues in football is that the assessment is done very quickly on the pitch, and we know from evidence that the longer you assess someone after a head injury, the much more likely you are to say they should not go back to play. A quick pitch assessment is not fit for purpose in my view.

Q324 **Chair:** Remedial treatment has been mentioned a few times. You have



touched on the fact that you think there may be an overemphasis in the minds of observers on just protocols—"job done" effectively. We had the PFA before talking about the very long-term stuff, the way they have helped adapt people's homes who have unfortunately and tragically suffered from dementia down the line. Is there any possibility that sport could bring together a programme to help those who may have suffered concussive injury over the medium term, so they can potentially stop or at least mitigate any long-term effects? Is that something sport should look at?

Dr Sylvester: I think you have to be very careful with definitions here. Forgive me if I go too sciency but I think the whole area is a bit fraught so I do not know what concussion means. I think it means a brain injury but it also means lots of other symptoms that you get from injuries around the head and neck. On a very simplistic level, if I have a head injury, I might get damage to my neck muscles that may cause neck pain and headaches, which is nothing to do with the brain. A lot of the chronic symptoms I see after head injury in sports or concussions are not related to brain injury and they can be managed by people like me and by sports medicine doctors and GPs and we get the vast majority of people better.

If you are talking about the link between repetitive brain injury and neurodegeneration, can that link be broken early on? I do not think there is any evidence that we can at the moment. I think brain injury is one of many risk factors for dementia. Some are modifiable and some are not modifiable. Our genetic risk is not modifiable, obviously. For an athlete, their previous head injury risk is not modifiable once they have had it. But there are many modifiable risk factors for neurodegeneration that we can affect, so cardiovascular fitness, cholesterol levels, depression, social isolation, diet.

There are all these things. In clinic when I assess a recently retired athlete or an athlete with concerns about their cognition, we concentrate a little bit on their concussion history and their impact history but we concentrate a lot on what we can modify. Are they drinking too much? These things we know affect our risk of neurodegeneration down the line. In the future I hope there will be specific treatments that can maybe damp down inflammation caused by brain injury that we think is the link between the injury acutely and neurodegeneration later on, but there is no evidence that works at the moment.

Dr Etherington: Can I come in here? I absolutely agree with what Richard says and I think part of my concern about all this debate is the disconnect between what is considered to be sport concussion and the risks of dementia and what we know about brain injury generally, as if it is a separate condition.

One of my specialities is rehabilitation medicine and I have spent a long time treating people with complex injuries but also brain injury and severe, traumatic brain injury, anything from road traffic collisions, to gunshot wounds to the head and things like that. We have approached



that, particularly in military rehabilitation, which is better resourced than the NHS, with a very active rehabilitation programme for decades. My experience of treating people with severe, mild or moderate brain injury is that they all benefit from a rehabilitation programme.

I do not know whether or not that alters the course of the disease in the sense of stopping neurodegeneration. Does it improve symptomatic control? Yes, it does. Does it improve outcome measures in occupational outcomes, mental health, social interaction and self-management? Yes, it does. What concerns me about the present cohort of patients that have been identified is that we label them with dementia in the context of dementia being a progressive disease, yet we do not offer them any standard rehabilitation that we would use for any other form of traumatic brain injury.

In the context of war, fighting in Iraq and Afghanistan, there is a big concern about so-called mild traumatic brain injury in those people who were not severely injured as a result of open or closed head injuries but had major exposure to repetitive blasts. The Americans were particularly concerned about this and we looked into it from a British point of view.

These are effectively post-concussion syndromes that require a rehabilitation approach that would include talking about the health risk factors that Richard mentioned, but also giving people cognitive strategies, education about what a brain injury is, and giving them a programme that gives them hope. At the moment I see that we are labelling people with dementia and waving them goodbye and saying, "It's tough, isn't it?" That to me is the nub of the problem at the moment for these chronic neurodegenerative or neurological symptoms.

Q325 Steve Brine: What is the state of the science at the moment? You will remember when you had your spat with Stirling University you said their study was not very well designed. I do not know if they have forgiven you yet and given you an honorary doctorate at Stirling or something, but what is the state of the science at the moment?

Dr Sylvester: The bottom line is that there is progress being made as a signal of neurodegeneration relating to repetitive brain injury, possibly to sub-concussive events. I do not think we have established causality. I do not think we have established individual risk factors and there are many more questions than answers.

One of the problems is that there are many small studies done by individual groups or by small collaborations with small numbers and differing methods, making it difficult to compare across studies. Much larger multicentre, international collaborations would provide much clearer answers. In the US, the college athletic community, which is essentially very well-resourced, with massive members of essentially professionals in their level of play, is allowing that sort of research to be done.



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There is much more that we do not know. There are many more gaps in the science than there are answers in this field. I come from a neuroscience background, a traumatic brain injury background. I was shocked when I started in the sports concussion world that so many things we use routinely in neuroscience and neurology had not been applied to this field, partly because of the lack of involvement and interest of me and my colleagues. Traumatic brain injury has never been particularly popular with neuroscience. It is becoming much more so, and sports concussion is driving that to an extent. When I see a 25-year-old athlete with multiple concussions, the fact that I cannot give them any useful information about risk suggests to me that scientifically we have an awfully long way to go.

Q326 Steve Brine: Dr Etherington, what do you think the state of play is at the moment in the science? We have seen in the last 12 months that there is debate among scientists, and that is healthy. What do you think the state of the science is in this area at the moment? A lot of work is being done and a lot of concern is being raised around the scientific proposition. Do you concur?

Dr Etherington: I think Dr Sylvester is quite right. There is quite a lot of work out there but it is fairly piecemeal and it needs to be larger and probably international and cross-disciplinary. We talked about funding research. That is because the funding comes from governing bodies or groups with an interest but by definition there are only going to be relatively small funds and they risk at least the concept of conflict of interest. If you want larger studies, we need to go to larger funding bodies such as MRC, NIHR, Wellcome Trust or something like that.

Q327 Steve Brine: Without that we will continue with a situation where we have a conversation about the problem, people say the problem has not been established with a causal link—and Dr Sylvester expressed his view on the Stirling work that did not have a control group, for instance—and we do not move forward, do we? What is the biggest hurdle in making sense of the science? What you are saying to us in evidence is that there are not big enough studies to be statistically significant.

Dr Sylvester: I do not think it is just size. I think it is methodology as well. There are many ways to crack a nut but we need to use state of the art, well-validated methods that have been used in similar situations. There needs to be much more large-scale funding. The governing bodies provide some money for research, which is just the tip of the iceberg.

The field study was a very cheap study because it was epidemiology. It was just looking at data that already existed. To follow up a large group of retired athletes over time—for example, looking at their brain function in detail, trying to tease out why they have symptoms: is it related to brain injury; is it related to mental health issues; is it related to other factors?—is painstaking work that on a large scale is expensive and needs to be done properly by people who know how to do it.



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Q328 **Steve Brine:** Who is asleep at the wheel, because the PFA said they were not? What would you put as your number one recommendation if you were writing our report?

Dr Sylvester: My view is that in the larger scale thing this is a public health issue and an NHS issue as well. I am exceptionally concerned, more concerned about grassroots than in the professional game. I think they now, belatedly, get relatively good medical care and access to specialists who know what they are doing. I see adolescents who cannot do their A-levels because of a head injury playing rugby at school. I uniformly do not see people being managed well after head injury still in the NHS. I think the governing bodies clearly have a responsibility, they have a duty of care. The clubs and the PFA do. This is a wider public health issue and in Scotland there has been involvement from public health but in England there has been a silence from that.

Steve Brine: I think that says a lot.

Q329 **Julie Elliott:** In a previous session Professor Stewart gave evidence that rates of concussion in women in football are twice those of men in football. I go to Dr Etherington first, then Dr Sylvester. Do you think women suffer concussive injury at a higher rate than men?

Dr Etherington: As you say, there is some prima facie evidence that is the case, but quite why is open to debate.

Q330 **Julie Elliott:** Do you think that is the case?

Dr Etherington: There are some studies that have shown that, but there are not hundreds of studies that have shown that.

Q331 **Julie Elliott:** Are there any studies that have shown the opposite?

Dr Etherington: There are some studies that have shown no difference in the rate as well.

Q332 **Julie Elliott:** Are there any that have shown that men have more concussive injury than women?

Dr Etherington: Not that I am aware of.

Q333 **Julie Elliott:** Dr Sylvester, do you believe that women suffer concussive injury at a higher rate than men?

Dr Sylvester: I am not sure the evidence is convincing at the moment. I certainly see more and more women with sports-related concussion injuries coming to my clinic, whether that reflects the increased rate of participation in these sports or not. I think there is some evidence that women take longer to recover from concussions. There are clearly some physiological differences. They are basically playing the same game with the same rules, as far as I can see. I do not know of any sport where there are major different rules. Far be it for me to say there should be, but from a medical point of view there could be good arguments why there should be.



There is stuff about reporting. I have had experience of one member of a female team reporting symptoms and then multiple other members of the team reporting symptoms as well. Whether that is an education issue—I think in general, and I have to tread carefully here, women are often better at reporting symptoms, are more self-aware than men in health in general. That is a positive thing in many respects. I have had many cases of male athletes minimising their symptoms after a concussion, denying symptoms and then only really presenting to their doctors when things are much worse after maybe another injury or something else has happened. I think that should be encouraged. I do not want to sound like a broken record but more research is needed.

Q334 Julie Elliott: If we move on to children, first, is there any age threshold in this area of work that we would define what a child is, and secondly, do you think concussive injury in children should be a greater concern?

Dr Sylvester: There is even less evidence around the long-term consequences of concussion in children, but there are theoretical reasons and practical reasons why it should be more of a concern.

Q335 Julie Elliott: Is there an age threshold? Is there any definition of what age it is?

Dr Sylvester: We do not fully develop our brains until after the age of 21, so our frontal lobe, which is the bit that controls our behaviour, the handbrake of the brain, does not come online before that age, which may explain some behaviour in universities, for example.

Julie Elliott: And many things.

Dr Sylvester: Exactly, and in some people it never seems to develop particularly well, but there you go. What we see in more severe traumatic brain injury—say, a road traffic accident causing a severe traumatic brain injury in a younger age group—is that you get a double whammy. You get the effect of the brain injury on the brain and you also get the profound lack of development of normal brain function. You get a halting of development due to the injury, so people often stall and do not mature as they would normally. That is my concern in this situation.

The other thing is obviously all times of life are important, but I see it time and time again where someone has a head injury three weeks before their GCSEs or their A-levels and they either do very badly or they have to take years off. I have had people who have gone from a position of strength to a position of weakness with far-reaching consequences.

Q336 Julie Elliott: Dr Etherington, can I ask you the question about children's age threshold, whether we should be more concerned with children?

Dr Etherington: As Richard says, the brain is developing during that period, so that is a particular concern. It often occurs at periods when there are critical life events like national examinations and so on. Having seen children who have been managed in school settings, if there is not



an awareness by staff and coaching staff of this, it can be mismanaged and people pushed forward a bit too quickly.

The other point Richard touched on is that if you have what is maybe a relatively transient concussive episode but it is in the middle of your GCSEs and you have to drop out for a year, there will be significant psychological and mental health consequences to that. One of the big challenges in managing people with brain injury is sometimes unravelling the mental health consequence of the experience from the organic consequence on the brain itself. It is very difficult to separate it and personally I think one has to treat the person symptomatically, whatever they are presenting with. Clearly, and it is true of professional sportsmen, the physical consequence of the brain injury and the concussion has a mental health consequence that may be more severe and impactful than even the injury itself.

Q337 Julie Elliott: Earlier in this session you were asked a little bit about the precautionary approach to head injuries and concussive injuries. You said the drawbacks of physical activity are good for you to having a precautionary approach. Is there any evidence that banging your head with a ball repeatedly is good for you, which is physical activity in many ways?

Dr Etherington: No. I am not sure I would look for the funding to do that study. No, there is not, but running around a pitch is good for you. But one of the consequences of running around a pitch at whatever age is that you get other injuries and some people advocate that we should stop running around a pitch because of various other injuries. A brain injury is often more serious and has longer consequences. We would say as a faculty that we need to keep people physically active and we need to encourage activity and sport is one of those activities.

Q338 Julie Elliott: Would you encourage banging your head with a ball?

Dr Etherington: No, I would not.

Q339 Julie Elliott: Ethically, do you think we should approach age and gender with a precautionary approach until the signs are different?

Dr Etherington: I am not sure it is an ethical question. I think it is more of a practical question. Using a precautionary approach is reasonable in certain circumstances where you have evidence that precaution is likely to benefit. All I am saying is it is very simple to say that heading a football is bad for you, so if you stop it we have removed the risk of concussion from children or others playing sport and, therefore, we do not need to worry about longer-term consequences. It might not be the factor or all the factors that are contributing to that, and that is all I am saying. It is very easy to think it is common sense to do something but we do not have the evidence that will have an effect. Maybe we will not have the evidence for that for many years.

Q340 Julie Elliott: That concerns me because you mentioned earlier the



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situation with industrial disease vis-à-vis the condition I had a lot to do with when I was a trade union official. I saw many people die of the condition from being exposed to asbestos. As you say, it has a 30 or 40-year incubation period and we are around the peak of that now. Asbestos was banned in the 1980s in this country because we knew there was a link. We did not know the extent of the problem at that point but it could be argued we knew many years before and nothing was done. Should we not learn from that, that the suggestion and the evidence appeared to be there but was not totally conclusive when it was banned? If we had acted years before, many more people would have been protected, would they not?

Dr Etherington: Yes, absolutely, and if you want to use that argument, the argument is whether there is any benefit at all to inhaling asbestos, so do not inhale asbestos. We should have been preventing inhaling asbestos long before the proven principle, which, if you look at other industrial injuries, is that precautionary principle. Is there any benefit to inhaling ethyl chloride or whatever? No, so we will stop doing it.

I do not think that repetitively heading a football 72,000 times is likely to be a beneficial thing. I was surprised at that figure, that professional footballers would be training to that intensity. To me it would seem sensible that you reduce that intensity, although we have no real evidence.

Q341 **Julie Elliott:** What I am trying to get at is the approach we take to young people and different genders, particularly women, because although there does not seem to be evidence, from what everybody is saying there is clearly some anecdotal evidence at the very least that they are more impacted. A professional footballer probably knows how many times he has headed a ball. There is no recording of a child in the playground doing headers and keepie-uppies, as they were called when I was a kid, and yet the damage will be happening. Should we look at a precautionary approach to that type of behaviour in children and young people particularly?

Dr Etherington: The guidance from the FA is that they should, and they should reduce heading in training or exclude it completely in certain age groups, and reduce it up until professional level. You can certainly argue you should reduce it in the professional level. I am not disputing there should not be a precautionary principle applied to something like heading a football.

What concerns me is that we think that is the job done: "We have stopped heading footballs so we do not have a problem." We will not know if that is the case, if there is a 30 to 40-year latency, until 40 years down the line. You see it in all branches of medicine: "We have solved this problem because we have reduced this risk factor," but we have not because we do not know what other risk factors are involved or what other medication is needed or what other conditions can occur as a consequence of the treatment we are doing.



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Q342 **Julie Elliott:** I will move to Dr Sylvester and ask him the same question about whether ethically we should approach ageing and gender with a precautionary approach until the science is more definite. What is your view on that question?

Dr Sylvester: With those specific age and gender groups, if there is a suggestion that we need to be more careful, we should aim for the more precautionary side. I do not think it is just heading of the ball. It is impacting rugby, which is the analogy.

Julie Elliott: And boxing, of course.

Dr Sylvester: Yes. Don't get me started on boxing.

Julie Elliott: We have already had evidence in this Committee that boxing should be banned.

Dr Sylvester: Yes. The concern is that it is not the concussions that are necessarily damaging, although they are, but they are not the only factor. It seems that the length of career and position is really important, certainly in rugby. We need to have a sensible approach to this and deal with things that are easy to deal with. There are three things you could do. You could do nothing and say, "We don't have the evidence, we don't have causality, and we are not going to do anything". The other extreme is to say, "We are going to ban all contact, we are going to ban heading, and we are going to ban tackling," which would fundamentally change the nature of these sports, and I would say would be an existential crisis for these sports. I do not think people would watch touch rugby. I do not know what that says about society, but there you go. Somewhere in the middle, which I think is sensible at this stage, is to say, "What can we do to minimise exposure without fundamentally changing the character of the sport?"

I see footballers who tell me about training sessions they did in the 1980s where they stood on the halfway line, the ball was kicked as high as possible, and they headed it, and that happened for an hour. If you look at the amount of heading and the number of tackles that players make in the game, there are not that many. There is a lot to be done in reducing exposure without fundamentally changing the nature of the game. We fundamentally change the nature of the game to try to preclude severe injuries, laws about high tackles, and so on. I am not a rugby player or a footballer. I do not really understand the sports' intricacies, but that can be done, and that has been done in American football very successfully. I think we are at the stage where we need to think carefully about the things we can do that are sensible and that minimise risk, and in particular groups it is probably more relevant than others.

Q343 **Alex Davies-Jones:** I have a few quick follow-ups for the witnesses on women and the impact concussion can have on them. Dr Sylvester, you mentioned that the research on this topic was fairly limited and there needs to be more investment and more attention given to the impact on women. What steps do you think the Government can take to progress



this further?

Dr Sylvester: Fund lots of research. Do research calls, something like NIHR or MRC. These funding bodies have not funded good studies in this area so far, for whatever reasons; I do not want to speculate. I think some pressure from above would be helpful. You mentioned in the last session a number of times how hundreds of thousands of people participate in these sports week in and week out. This is a big public health issue. The professional element is the tip of the iceberg. We need simple, safe protocol and instructions that can be followed by non-specialists, coaches, players and GPs, week in and week out. That is a public health issue as well. We are very good at public health. Some of the things that have happened in the UK around covid have been remarkable. The structures are there and a lot of people participate in these sports.

Q344 **Alex Davies-Jones:** I agree. Dr Etherington, I will come to you as well, please, on women in sport and the attention they are given from medics and the medical profession as a whole, as well as on concussion injuries. We have heard a lot lately from women athletes. Dame Jessica Ennis-Hill, for example, has spoken out about how when she was on her period she was forced to push through that, and period pain, to compete. We have heard sportswomen such as GB athletes talk about the dangers of contraception they were taking at the time when they were forced to compete. Do you think women's health is given the adequate attention and focus that it should have from sports doctors and team doctors as a whole?

Dr Etherington: The faculties responsible for the training or setting standards for the training of people in high professional training and sports and exercise medicine now spend a lot of time on the issues around women's health and women's health in sport. For doctors I speak to working in professional sport, and perhaps semi-professional sport, this is a very big part of what they are dealing with. It is great that there is increasing participation of females in all branches of sport. From a specialist's point of view, there is a real understanding of it. It could get better, and as you say, there is always an opportunity for more research in these areas.

This touches on the brain injury side of things. Much of it is around the culture of the sport or the sport environment or the national governing body or the coaching staff around how they support their athletes, be they female or child athletes. If we come back to concussion, for example, it is less about educating GPs, because lots of people never go and see their GP about their concussion. A big part of it is about educating coaches, school teachers and parents about what to do about this. If I go 400 yards to the right there, on a Saturday morning there may be 50 teams playing sport. None of them has a doctor near them and none of them has a professional coach.



It is about awareness and education about all injury, but in this context concussion. It is about modelling behaviour and the coaches and parents modelling good behaviour so that you take a person off the pitch because they have had a suspected head injury, not try to make them play on. That modelling encourages presentation. It may be, "I do not want to play in the football team this weekend because I have period pains." That needs to be modelled as a good behaviour. Also, what to do if it is not getting better, or how to seek resources.

Richard makes the point that this is a public health issue. I agree, it is a public health issue. I think it is interesting that Public Health England did not feel it had anything to contribute to the debate today. That is because, as far as I am aware, there is no concussion protocol or concussion group looking at managing brain injury in presenting to A&E or in the sporting environment, and there probably should be. For the vast majority of people, it is going to be transient and can be managed quite simply, but we need to pick up those people in which it is recurrent or who have serious consequences.

Q345 Alex Davies-Jones: I agree. There is a lot of focus now, which is very welcome, on men's professional sports and this issue. Like you, I share concerns that the women's professional sports and the grassroots level, amateur teams and other sports that do not have the funding are slipping through the net here and are not being given adequate attention. I share that concern.

Dr Etherington: The guidance can be quite straightforward. The Scottish guidance on concussion is pretty straightforward. It is good. BMJ published guidance that came from Simon Kemp a year or two ago. It is pretty straightforward. We need to have that awareness at every little game of football and rugby in the parks that I see every day, and not have parents or parent coaches pushing people back on to the pitch when there is a potential brain injury. I do not think it is that complicated to do this and it is a public health issue.

Dr Sylvester: Also, kids do not just play one sport. They play rugby, they play football, they play basketball, and they play cricket. I have loads of kids who had a concussion playing rugby but then are in the basketball game three days later, because it is a different coach and there are no guidelines on concussion in basketball. I am not sure if there are or not. This transcends individual sports as well.

Alex Davies-Jones: There is a lot for us to think about.

Q346 Clive Efford: There is a lot that we do know about acquired brain injury and head injury in general and what it can cause. Do health professionals engage with the research that is out there and the facts and statistics that are around to provide the best support, healthcare and interventions? Do we make the best of what we do know?

Dr Sylvester: Absolutely not, is my answer from my experience. I think that the management of acquired brain injury is very patchy in the UK. If



you are lucky enough to be referred to a multidisciplinary team that has good experience with managing both mild and more severe brain injury, that is one thing, but it is a bit of a postcode lottery. The management of the chronic symptoms after concussion, in my experience, is really poor. As John was saying earlier, it is not that complicated. You manage symptoms. It seems straightforward to me. If I have a patient in front of me, why do they have symptoms? What can I do to help them? There are all sorts of things. We manage people's low mood and anxiety, their dizziness and balance problems, their migraine headaches and their musculoskeletal problems, all of which contribute to the long-term effects of head and neck injury not just brain injury. I do not quite understand why it is not done properly. It is a question that has vexed me for a long time.

Dr Etherington: In the broader sense—Richard is really referring to this as well—the person who gets a bang on the head at work, or someone who gets a more serious injury, is assaulted, which is a very common cause of brain injury, is not managed well in the average A&E department. More severe brain injury, if you want to get me ranting, is pretty poor.

Dr Sylvester: The levels of traumatic brain injury in the prison population is remarkable. I think the problem is that people look okay. They look and sound like they are fine, but it is a really major, hidden disability and unless you really screen for it very carefully you miss it.

Dr Etherington: This is a condition that has major societal consequences. As Richard said, there have been studies that suggest that something like 60% of the prison population have a recorded significant history of brain injury. Is that a factor that contributes to their behaviour? We do not know. If you look at very severe brain injury and the services commissioned by NHS England, there are 950 beds commissioned for the whole of England, and of those just under 200 are probably used for trauma. Neurological rehabilitation for trauma is about 200 beds in England, but in context I used to have that many beds with complex trauma in the military in one site, Headley Court, in England.

That is the most severe end of the spectrum, where people are dependent on others for their care, but there is a whole spectrum of poor management of brain injury in the population, which has consequences for the Ministry of Justice, the Department for Education and the Department for Work and Pensions, because they are going to be paying for them. I had a period of time as a national clinical director for NHS England in rehabilitation. What we were trying to do was say this was a societal consequence, it is not just an NHS responsibility. It is important to look into it.

Q347 **Clive Efford:** Is there an argument here that early intervention prevents those longer-term problems, and do we know how to determine what early intervention is required in each set of circumstances? Do we know



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enough to be able to say, "This person needs this sort of intervention, and this person needs this"?

Dr Sylvester: Yes, I think that is what I do every day.

Q348 **Clive Efford:** But are there enough of you?

Dr Sylvester: No. There are very few. Very, very few.

Q349 **Clive Efford:** The frontline is GPs. If I am feeling groggy and some time after I have had a head injury I go to see my GP. Do they know enough about the symptoms to be able to identify the potential for me to have some sort of head injury?

Dr Sylvester: I think they often know there has been a head injury. The big problem is it gets labelled as post-concussion syndrome, which is like chronic fatigue syndrome and long-covid syndrome; it is a collection of symptoms that has had a trigger. The management of post-concussion syndrome in most non-specialists' minds is: it will get better over time or it will not. It is clinical nihilism. The approach that needs to be taken is that 85% to 90% of people with a concussion will be absolutely back to normal in three or four weeks—why is this person not back to normal? What are the factors? Are they treatable? In almost all cases, yes, they are.

Q350 **Clive Efford:** Is there advice that should be given to sportspeople in particular so that if you hit your head, you have an injury, these are things you should look out for and these are precautions you should take immediately?

Dr Sylvester: There are the very acute things. When you go to A&E you will be given a head injury advice sheet, "Do not be on your own for the next 24 hours", or, "If you have severe headaches you need to come back to A&E." The sports, football and rugby for instance, have what is called a graduated return to play protocol, which is a rehabilitation protocol. All of them say that if you are struggling and you cannot get to the end of that protocol, which is return to sport, return to academic activities, return to work, you need to seek medical advice, probably from the GP in the first book, or a specialist in the management of chronic symptoms of concussion.

The trouble is, if you go to see a GP who is not used to managing these problems, which is the vast majority, it does not move on from there. If there are not commissioned services that manage this very large number of people, they do not get the timely and correct intervention. I can say one thing for sure is that if you do not intervene early on, these issues become embedded and chronic and then they are untreatable.

Dr Etherington: I would say that a lot of GPs will pick this up but they do not have any resources to refer to, and it is not something they will necessarily be experts in managing themselves or can do inside their



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practice. I have sympathy with general practitioners. They are presented with all sorts of conditions.

- Q351 **Clive Efford:** I will move on to sport governing bodies. Outside of the big, rich sports like football, many Olympic sports employ a medical officer for only about half a day a week. Is that enough or should they be doing more?

Dr Etherington: In an ideal world, yes, but that money comes from the national governing body funding, and if they do not have the money to pay for it, they can't.

- Q352 **Clive Efford:** In your professional opinion, should they be required to have a full-time medical officer?

Dr Etherington: Clearly it would benefit my fellow members, because there would be a lot more jobs out there. I do not think it is feasible. Also, you have some groups, like skeleton bobs, which has a significant risk attached to it, but there is a relatively small number of athletes and you will not have a full-time doctor for that role. In that context it is about having access to medical services, which a lot of the professional and national governing bodies now have, which they did not have, access to a doctor who knows what they are doing. That is part of our responsibility, to make sure that doctors have a qualification level where they know what they are doing. It comes back to that awareness from the coaches, the playing staff and modelling good behaviour.

- Q353 **Clive Efford:** I will press you a little bit more. Surely the sports governing bodies have a duty of care to their athletes. Should they be doing more to monitor what is happening around head injuries?

Dr Etherington: Yes, I think they should. There needs to be better epidemiology of the sport's injuries, in particular concussion. Yes, that will give us some data with which to work. Having said that, there is a lot of good examples of that in different sports. It is piecemeal. Rugby, for example, is doing that across the board. I am not sure football is.

- Q354 **Kevin Brennan:** Thank you to the witnesses for giving evidence today. A few brief answers on these will do. Have the Government been proactively engaging your organisations in developing policy? I suppose we are talking in the context of the Faculty of Sport and Exercise Medicine and the Institute of Sport, Exercise and Health.

Dr Sylvester: No.

Dr Etherington: No.

- Q355 **Kevin Brennan:** No, okay. Clearly that is a gap that perhaps the Committee could look further into. Do you think it would be valuable for there to be national guidance on this subject for sports, Dr Sylvester?



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Dr Sylvester: Yes, absolutely. I think there are many sports that are too small to do the job on their own. There are many levels of sport, and the guidance can be developed, something like in Scotland.

Q356 **Kevin Brennan:** Do you agree with that, Dr Etherington, just to put it on the record?

Dr Etherington: Yes.

Q357 **Kevin Brennan:** Yes. Your suggestion is that a similar approach should be taken as in Scotland, in how that guidance is made and how it is spread among sports? Is that what you are suggesting, Dr Sylvester?

Dr Sylvester: Yes.

Q358 **Kevin Brennan:** I will ask you about something that has interested me in what we were talking about earlier on whether or not heading the ball is a problem in football. Following our last session, we received a letter in evidence as a Committee from Professor Nick Webborn OBE, a clinical professor in sport and exercise medicine at the University of Brighton. He said, and I quote from his written evidence to the Committee: "from a scientific perspective the committee seems to be falsely assuming that it is repeated contact with the ball that is the issue rather the impact collision of the head by various parts (head/elbow etc) of the opponent which causes more trauma to the brain." He goes on to say: "It may be the element of heading within the game is, of itself a risk, but not the impact of the ball, but this is as yet unknown." In previous sessions it seemed there was quite strong opinion that heading the ball, particularly the number of times that we heard that the ball does get headed in training and so on, was a problem. What is your response to what Professor Webborn said to us in that written submission, Dr Sylvester?

Dr Sylvester: I think he makes a very valid point. One of the issues is that you cannot disassociate other head injuries from heading the ball. The people who head the ball a lot are the people that get other impacts to their head, because that is when it happens; it is when you go up for a header, for example. It is still an open question. The two may be so closely correlated that it may be difficult to disentangle them. I do not know.

Q359 **Kevin Brennan:** Dr Etherington, do you broadly agree with that, or do you have a different view?

Dr Etherington: I agree with Dr Sylvester. The data is not there, but it seems sensible to avoid 72,000 headers of a ball.

Q360 **Kevin Brennan:** I will ask about CISG, the Concussion in Sport Group, which is an international body that comes to a consensus about this subject. Have either of you had any involvement with CISG? Dr Sylvester, you are nodding your head.



Dr Sylvester: Yes. I have been to the consensus meetings. The last one was in Berlin and the most recent one was meant to be in Paris, but it has been delayed. I found it a rather unsatisfactory event.

Q361 **Kevin Brennan:** That is interesting, because there has been some criticism from people who have health issues following playing professional sport, and also in the media, about CISG. The criticism essentially comes down to the 2016 meeting, which you went to, I presume, in Berlin. They found 3,819 relevant studies on the subject but only 47 of those studies were accepted as meeting the bar to be considered evidence that the group could take into account. Is that correct? Is that criticism justified or, if not, what was the element of it that you found unsatisfactory?

Dr Sylvester: I was not involved in the analysis of the scientific papers, but I agree. My experience is that a huge number of published papers in this field are not fit for purpose and should not be included. One of the problems with these sorts of analyses is that you can only fit together studies that are comparable. There is an issue that if somebody does something completely different, it may be quite interesting and valid, but you cannot necessarily put much weight on it. I found that transparency in the whole process was lacking. I found that there was a very North American bias, so people that had a view had made their minds up before looking at the evidence, to some extent.

Q362 **Kevin Brennan:** Do you think they had made their minds up too much—in which direction had they made their mind up?

Dr Sylvester: There were various factions. I just found it was an unusual meeting. Other consensus meetings that I have been involved with have been more productive, let's say.

Q363 **Kevin Brennan:** Final question: do you think CISG has too much influence over the narrative on this debate?

Dr Sylvester: I certainly think that certain voices within it do, yes.

Chair: Thank you. That brings our session to an end. I wish to thank Dr John Etherington and Dr Richard Sylvester for their evidence today. It has been most illuminating. Thank you very much.