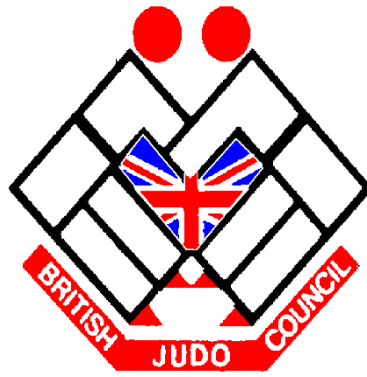




Loss of Conscious Management Policy (Head Injury & Strangulation)

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Appendices

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Introduction

This policy has been adopted from the British Judo Association guidelines.

The British Judo Council takes the health & safety of its members seriously, especially in the case of head injury or of an athlete becoming unconscious due to strangulation (shime-waza), either in the competition or training environment, regardless of the level or age of the competitor. Since the 1970's the medical profession and the scientific community have begun to differentiate sports related concussion and traumatic brain injury from other causes (such as road traffic accidents, etc.). Their management is driven by sporting bodies and the International Olympic Committee, who see the need to have clear and practical guidelines in place for their detection, treatment, and to guide return to play.

Minor head injuries & knocks to the head are common, particularly in children. Following the injury, if the person is conscious (awake) and there is no deep laceration or severe head damage, it is unusual for there to be any underlying damage to the brain. However, sometimes head injuries can be more serious and may result in unconsciousness and / or concussion. Serious brain injury can also occur following the application of shime-waza techniques, during which the blood flow to the brain is temporarily disrupted due to strangulation.

This protocol applies to the following scenarios:

1. Unconsciousness resulting from a direct blow to the head, face, neck or elsewhere on the body where an impulse force is transmitted through to the head and may result in the player being concussed.
2. Concussion may occur without the player being knocked out and losing consciousness – it must always be considered a possibility in any player with a compatible mechanism of injury and must be taken seriously.
3. Unconsciousness resulting from the application of shime-waza (strangulation technique) if the player fails to submit.

THE BRITISH JUDO COUNCIL ENCOURAGES ANYONE WHO HAS CONCERNS FOLLOWING A HEAD INJURY OR STRANGULATION TO THEMSELVES OR TO ANOTHER PERSON, REGARDLESS OF THE INJURY SEVERITY, TO SEEK IMMEDIATE MEDICAL ADVICE.

What is concussion?

Concussion can be defined as a disturbance in brain function caused by a direct or indirect traumatic force to the head, resulting in a variety of non-specific signs & symptoms, which may or may not include unconsciousness. The brain can swell and when its normal function is disrupted, it can affect mental stamina & function, causing the brain to work longer & harder to complete even trivial / every-day tasks. Concussion is a recognised and important injury in sport. It can result from many types of incidents, but issues arise from sports related concussions because rapid decisions need to be made about safe continuation / return to play.

ULTIMATELY, ALL CONCUSSIONS NEED TO BE TAKEN SERIOUSLY BECAUSE THEY ARE A TYPE OF TRAUMATIC BRAIN INJURY!

Second Impact Syndrome

Second impact syndrome is a rare condition in which a second brain insult (concussion or strangulation) occurs before the brain has recovered from the first one, causing rapid and severe brain swelling. It can result from even a very mild concussion or strangulation that occurs days or weeks after the initial injury. Second impact syndrome can cause a severe and catastrophic brain injury, leading to long term symptoms / disability and prolonged time away from sport / employment.

What are the effects of shime-waza?

Strangulation is common in Judo & other combat sports. Strangulation is defined as the application of external pressure to the vasculature (blood vessels) and the airway conducting systems. It can quickly result in the loss of consciousness and carries a risk of associated injuries such as laryngeal (voice box) fracture, airway swelling & blunt cerebrovascular injuries (strokes). As the blood flow to the brain is reduced, loss of consciousness commonly occurs quickly, in 6-15 seconds.

The brain doesn't tolerate lack of oxygen (hypoxia) well, resulting in permanent neurologic injury or death in 3-5 minutes. The quicker brain blood flow and therefore oxygenation can be restored, the lower the chance of temporary or more permanent neurologic compromise, so it is important that coaches / referees are very vigilant and stop play as soon as possible in the event of unconsciousness by strangulation. As well as unconsciousness, athletes may experience brief seizure activity, which appears similar to epileptic seizures, with a gradual return to normal after removal of the strangle force. In otherwise healthy people, the brain function returns to normal following the strangulation episode. However, strangulation does represent a hypoxic brain injury, no matter how brief, and the brain therefore needs time to recover from the injury, in the same way as it does following concussion injuries.

As strangulation results in compression of vascular structures, there is a potential of secondary injuries in athletes who have other co-existing medical conditions. For example, if an athlete has pre-existing carotid artery disease (narrowing of the arteries in the neck), then less pressure is required to occlude the vessels, and the risk of a stroke is significantly higher.

Recognition of concussion/Head injury

The recognition and evaluation of an athlete with neurologic compromise from either concussion or a strangulation injury in the training or competition environment can be challenging.

Typical Signs	Typical Symptoms
Headache	Loss of / reduced consciousness
Nausea	Fits / seizures
Confusion	Easily distracted / unable to concentrate on tasks
Dizziness	Vomiting
Unsteadiness / loss of balance	Poor co-ordination / balance
Feeling stunned / dazed	Slow to answer questions or follow Instructions.
Double vision	Displaying inappropriate emotions (e.g. laughing, crying)
Seeing stars / lights	Slurred speech
Ringing in the ears	Personality changes
Slurred speech	Decreased fighting ability
Poor concentration	Disorientation
	Amnesia (loss of memory)

If an athlete displays any of the above signs and symptoms, neurologic compromise or a concussion should be considered, and the athlete should be withdrawn from competition or training immediately for further assessment. This point is paramount – any athlete suspected of having a concussion must initially be treated as though they are concussed, withdrawn from competition or training immediately and appropriately referred to either the Emergency services or for assessment by a health care professional (HCP – GP, walk in centre, minor Injury unit, or A&E department)

IF IN DOUBT, SIT THEM OUT!

Adverse (RED FLAG) Signs

Any of the following signs or symptoms are regarded as adverse or red flag signs, which could indicate a more severe underlying brain injury, from either a head injury or strangulation. An athlete either displaying or who develops any of these signs or symptoms must seek immediate help from the Emergency Services by Calling 999:

Adverse signs / Red Flag symptoms may present as follows:

- Increasingly restless, agitated or combative
- Deteriorating conscious state
- Persistent new double vision
- Suspicion of skull fracture
- Neck pain or tenderness
- Seizures or convulsions
- Loss of consciousness for longer than 1 minute
- Children
- Persistent vomiting
- Persistent / worsening headache
- High risk medical problems – e.g. Blood clotting disorders, blood thinning medication
- Altered sensorium due to other reasons – e.g. Drugs, alcohol, epilepsy, learning difficulties, etc.
- Lack of responsible adult to supervise post-injury
- More than 1 other concussion / strangulation injury within 3 months

Immediate mat side treatment



Frequently, head injuries & strangulations will occur in the club environment, where HCPs are not present at the mat side during training or competitions. However, the immediate removal of the judoka from the mat is paramount after a brain injury due to either a head injury or strangulation. The initial suspicion of concussion or strangulation is, therefore, often made by the coach or a fellow athlete. Education on first aid assessment of head injury and strangulation is therefore paramount for all coaches and judoka.

Remember – in the BJC, we've got each other's backs!

We recommend the use of the Concussion Recognition Tool 5 (CRT5) by all non-health care professionals to help identify concussion (or potential brain injury from strangulations) in children, adolescents & adults (see appendix 1).

Maddox Questions

Maddox questions are a basic memory assessment tool which have been validated for the side-line determination of the risk of concussion and are a useful tool for non-health care professionals to confirm that a risk of concussion is present. If an athlete gets 1 question wrong, they must be removed from the field of play immediately.

Maddox Questions:	Suggestions to be more judo-specific:
What venue are we at today?	
Which half is it now?	How far into this fight are we?
Who scored the last in this match?	
What team did you play in the last match / game?	Who did you fight in your last fight / competition?
Did your team win the last game?	Did you win your last fight?

If there is any doubt that an athlete has sustained a concussion or strangulation injury, always err on the side of caution & remove immediately from the field of play for further expert assessment.

On the field of play, the first aid principles of Danger, Response, Airway, Breathing, Circulation should be followed. For non-HCP's, do not attempt to move the injured athlete (except for urgent airway management) unless you are trained to do so. Both head injuries and strangulation injuries present a significant risk for the athlete having a concomitant neck or spinal cord injury, so assessment for these must be done on the field of play before they are moved.

Signs and symptoms of a brain injury evolve over time (in both concussion & strangulation). It is therefore important that any athlete suspected of or who has had a head or strangulation injury is supervised by a responsible adult who can be alert to the development of deteriorating or red flag symptoms. If they do, the athlete should be taken immediately to the nearest Accident & Emergency Department.

An athlete **must not** return to play that day, but must be assessed by an HCP & complete the graduated return to play protocol prior to any further Judo training / competitions if:

- They are under 19 years old
- They have been unconscious for any length of time

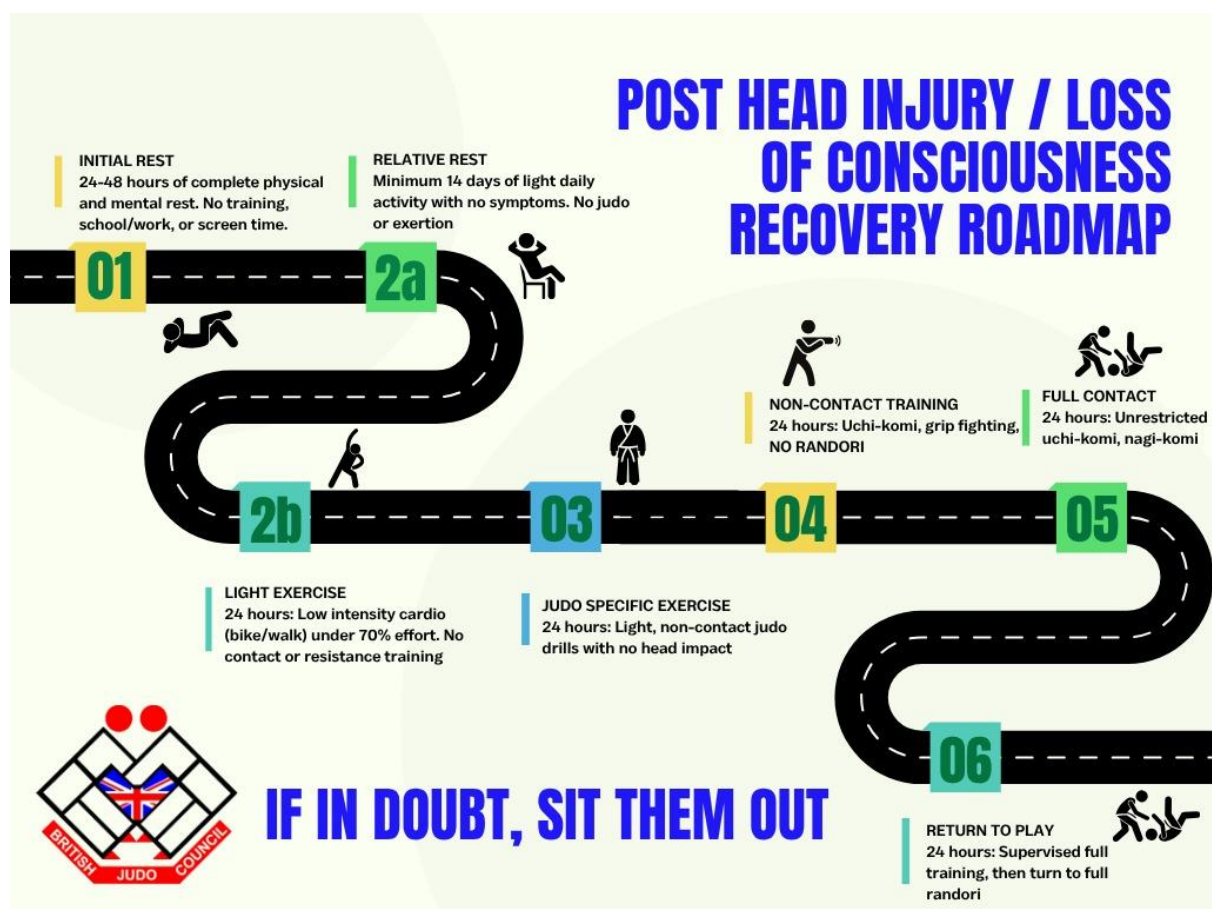
- They have had any seizure activity or twitching
- They have any adverse / red flag signs
- Their mechanism of injury is compatible with a significant head or strangulation injury
- Their CRT5 assessment suggests a concussion / brain injury has been sustained
- They have not been assessed by an HCP
- They have had a previous or suspected head injury / strangulation in the preceding 3 months.

IF IN DOUBT, SIT THEM OUT!

The BJC concussion and strangulation advice sheet can be given to the responsible adult supervising the injured judoka (see appendix 2).

Graduated return to play (RTP)

We recommend that all members follow the Judo Specific Graduated Return to Play Protocol after any suspected brain injury from either a head injury or strangulation injury. The BJC recommends that the following protocols are also implemented by the club coaches and officials. In consultation with a GP or other registered HCP



Stage	Aim	Details / Activities
1	Initial rest (mind & body)	24-48 hrs Complete physical & cognitive rest (no exercise, minimize screen time on electronics, time off work / study) Review by HCP
2a	Relative rest	14 days Return to normal daily activities that don't provoke symptoms Must be symptom free at end of this stage before continuing
2b	Light aerobic exercise (add in Judo movements)	5 x 4mins on / 4 mins off session (total of 20 mins work in a 40 min session) Work to <70% maximum heart rate Light bike / jogging / walk / swim. No resistance training
3	Judo specific exercise (add in Judo movements)	Total session time <45 mins, regular 3-4 min rest intervals to ensure no symptoms Work <80% maximum heart rate No head impact. Banded Uchikomi (no Uke), ladder drills, Ashi-waza with cones
4	Non-contact technical training (increase exercise, co-ordination & cognitive load)	Must return to work / education before returning to judo S&C: Progressive loadings 50-75% & start resistance training Total session time Work to <90% maximum heart rate No head impact. Stand grip fighting, Uchikomi with Uke. No Nagekomi, Ne-waza, Tachi-waza Must have clearance from HCP / GP before progressing to next stage.
5	Full-contact technical training (increase Judo confidence & assess functional skills)	S&C: progressive loadings 75% - normal pre-injury activity Full unrestricted Uchikomi & Nagekomi, open play Ne-waza & Tachi-waza Regular 3-4 min rest intervals to ensure no symptoms

		Must be supervised by Judo coach to assess if back to normal self
6	Return to play	Return to open play Randori

The content of the graduated return to play is the same for all age groups and all skill levels, but the duration of each stage is dependent on age and level.

Minimal time for Graduated Return to Play in Under 19

The impact of a brain injury from either a concussion or strangulation can be more profound in children & young people, whose brains are still developing. They behave differently to adults and more damage can occur silently without subjective symptoms being evident.

Please follow the UK Concussion Guidelines for Non-Elite Sport.

Minimal time for Graduated Return to Play in Age 19 & over

Minimum timings:

- 24-48 hours for stage 1, or until symptom free
- 14 days for stage 2a (relative rest)
- 24 hours at stages 2b-6

Athletes must be symptom free before starting or progressing to the next stage.

If symptoms develop, the athlete should have full rest for a minimum of 24 hours, or until symptom free, then resume the graduated RTP at the level below.

Athletes with other medical problems which places them at higher risk, veteran athletes, or those with a history of previous brain injury in the preceding 6 months should consider the slower RTP schedule as followed by under 19's.

Education

Education on the first aid assessment of head injury and strangulation is paramount for all coaches and Judoka at all levels in order to reduce the impact of these injuries. There are several excellent e-learning modules available online, including:

HEADCASE, England rugby

(<https://www.englandrugby.com/participation/playing/headcase>)

ConcussEd

(<https://www.concussioneducation.co.uk>)

NHS Head injury & Concussion

(<https://www.nhs.uk/conditions/head-injury-and-concussion/>)

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CONCUSSION RECOGNITION TOOL 5[®]

To help identify concussion in children, adolescents and adults



FIFA[®]

Supported by



RECOGNISE & REMOVE

Head impacts can be associated with serious and potentially fatal brain injuries. The Concussion Recognition Tool 5 (CRT5) is to be used for the identification of suspected concussion. It is not designed to diagnose concussion.

STEP 1: RED FLAGS – CALL AN AMBULANCE

If there is concern after an injury including whether ANY of the following signs are observed or complaints are reported then the player should be safely and immediately removed from play/game/activity. If no licensed healthcare professional is available, call an ambulance for urgent medical assessment:

- Neck pain or tenderness
- Double vision
- Weakness or tingling/burning in arms or legs
- Severe or increasing headache
- Seizure or convulsion
- Loss of consciousness
- Deteriorating conscious state
- Vomiting
- Increasingly restless, agitated or combative

Remember:

- In all cases, the basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.
- Assessment for a spinal cord injury is critical.
- Do not attempt to move the player (other than required for airway support) unless trained to do so.
- Do not remove a helmet or any other equipment unless trained to do so safely.

If there are no Red Flags, identification of possible concussion should proceed to the following steps:

STEP 2: OBSERVABLE SIGNS

Visual clues that suggest possible concussion include:

- Lying motionless on the playing surface
- Slow to get up after a direct or indirect hit to the head
- Disorientation or confusion, or an inability to respond appropriately to questions
- Blank or vacant look
- Balance, gait difficulties, motor incoordination, stumbling, slow laboured movements
- Facial injury after head trauma

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STEP 3: SYMPTOMS

- Headache
- "Pressure in head"
- Balance problems
- Nausea or vomiting
- Drowsiness
- Dizziness
- Blurred vision
- Sensitivity to light
- Sensitivity to noise
- Fatigue or low energy
- "Don't feel right"
- More emotional
- More irritable
- Sadness
- Nervous or anxious
- Neck Pain
- Difficulty concentrating
- Difficulty remembering
- Feeling slowed down
- Feeling like "in a fog"

STEP 4: MEMORY ASSESSMENT

(IN ATHLETES OLDER THAN 12 YEARS)

Failure to answer any of these questions (modified appropriately for each sport) correctly may suggest a concussion:

- "What venue are we at today?"
- "Which half is it now?"
- "Who scored last in this game?"
- "What team did you play last week/game?"
- "Did your team win the last game?"

Athletes with suspected concussion should:

- Not be left alone initially (at least for the first 1-2 hours).
- Not drink alcohol.
- Not use recreational/ prescription drugs.
- Not be sent home by themselves. They need to be with a responsible adult.
- Not drive a motor vehicle until cleared to do so by a healthcare professional.

The CRT5 may be freely copied in its current form for distribution to individuals, teams, groups and organisations. Any revision and any reproduction in a digital form requires approval by the Concussion in Sport Group. It should not be altered in any way, rebranded or sold for commercial gain.

ANY ATHLETE WITH A SUSPECTED CONCUSSION SHOULD BE IMMEDIATELY REMOVED FROM PRACTICE OR PLAY AND SHOULD NOT RETURN TO ACTIVITY UNTIL ASSESSED MEDICALLY, EVEN IF THE SYMPTOMS RESOLVE

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Technical Notice 127B

Guidelines for Unconsciousness due to Strangulation in Judo Practice and Contest

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In response to questions by Robin Otani – President.

Unconsciousness from strangulation

- 1) Whilst a person is visually conscious there is no danger threat.
- 2) At the point of becoming unconscious, the eyes-lids will flutter, the body and face will become limp and totally inactive. Contestants however will normally continue breathing.

Those in supervision must be careful. There are several factors to look for to ensure an opponent is fully conscious. Consciousness is a neurological observation. Perhaps it is easier to define what is unconscious.

In the unconscious state, there is no response to stimulation or pain, there is a lack of what is perceived as normal muscle movement (a person having an epileptic fit are moving their muscles but not in a normal way). There is an absence of normal speech and the eyes are closed and not responsive. The person is still breathing and they will still have a circulation however. Should those in supervision wait for this, the opponent is significantly unconscious and could be in significant danger.

So, those in supervision are looking for the first signs of 'sliding' down this slope. It is best described as an opponent unable to defend them self. A normal reaction to attack is to defend. This is higher neurological function. The strangle is on, the lock is on, the throw is on, and the opponent is behaving in a normal way to defend. The first sign that all is not well is that the opponent is not responding how those in supervision think they should be responding. The reactions are slower, that normal bright response is lacking something, the vocal noises are not perhaps quite right, the eye lids are perhaps droopy, the muscle tension is reduced. This is all very subtle however the opponent is drifting into a situation where they are struggling "from a conscious level" point of view, to defend them self. So, on the one situation, the choke is on, none of the above features are occurring, the opponent is making a normal conscious response to get out. Those in supervision allow the contest to continue. In contrast, the choke is on, the eye lids are fluttering, the resistance to the choke is a bit weak, the legs are a bit limper than they would like. The normal defence reaction is gone. It is only a matter of time now as they descend the slope into true unconscious. Those in supervision seeing the progressive deterioration must step in and stop the contest for the sake of the opponent. The conclusion to the contest is not in doubt. The opponent cannot defend "normally" any more. The decision of the official is that "if I allow the contest to continue, I believe the opponent is at risk of harm because the opponent is now in a position of not being able to defend them self in a normal conscious way". It is very subtle.

- 3) In a Judo Contest suffocation or blocking of airways is almost impossible and certainly takes a minute (60 sec) or two to be effective.
Blocking the airway prevents oxygen reaching the brain. The best example is holding your breath. You do not immediately pass out when you hold your breath. It takes time. Suffocation or airway blocking is in effect holding your breath. The airway however is protected by the larynx, a cartilage structure at the top of the

throat with rings of cartilage in the wall of the main windpipe or trachea. These structures would in effect need to be crushed requiring some considerable force. For true suffocation to occur however, a relatively long period must pass. Children lack fully formed cartilage rings and their windpipe or trachea is more likely to be damaged, hence the technique of choke in children is not taught as a competition technique.

- 4) Strangulation to unconsciousness mainly comes from restriction of blood to the brain. If the technique is applied correctly this can be effective in seconds.
There are two main arteries in the neck, one each side called the carotid arteries. They lie quite superficial in the neck; indeed, you can feel your own carotid arteries if you press lightly behind your larynx. In contrast to the windpipe or trachea, the wall of the carotid artery is thinner and easily compressed. If compressed, blood flow through the carotid ceases and unconsciousness occurs in a matter of seconds. So why don't you get a stroke? The reason is that there are a couple of arteries that run through the bony cervical spine at the back of the neck called the vertebral arteries supplying blood to the back part of the brain.
So, how can those in supervision spot which is being applied? A "choke" pressing on the carotid artery has its effect in seconds - if correctly applied, the opponent probably will not even have time to put up a resistance and the effect will be profound unconsciousness. The opponent will probably not even have time to submit before they pass out. A "choke" crushing the trachea or larynx needs considerably more pressure and a vigorous defence by the opponent will ensue possibly for a time before the opponent recognises the futility and submits. Those in supervision therefore need to step in early for the former and give time for the opponent to escape in the latter.
- 5) If the strangle is not 'tight' however, a partial restriction of blood will take up to around 20 seconds to be effective. An effective strangle is as effective as turning a tap off. No blood flows. But I am sure we all have taps in our house that drip; water does get thru as does blood. Unconsciousness is not immediate. The opponent will recognise it coming on and resist, the attacker will recognise that the technique is not effective and will change or alter the application to try and gain success. Once again, if this is successful, unconsciousness rapidly follows. A clever opponent recognising what may be happening may insert their hand between their throat and the attacker's attempt at a choke and thereby protect their carotid.
- 6) Screams, gasping noises, red face and normal physical movements and resistance would not normally be a reason for those in supervision to stop the contest. However if those in supervision perceive another reason for this i.e. hand or lapel over the face/chin or pressure being applied to the vertebrae of the neck or back, then the contest should be stopped.
Consciousness versus unconsciousness is described in the first section. Screams can be a normal high level action of consciousness. Gasping may be due to pressure around the neck. Red faces are due to the lack of blood flowing back to the heart in the very weak low pressure veins. Physical resistance is the opponent making a conscious attempt to defend. By themselves, these do not indicate a reason to stop the contest. There are techniques however that are illegal, not because the application of the technique is dangerous, but because the consequence of the action following the technique is dangerous or even life changing. Those in supervision are therefore on the lookout for the application of illegal techniques on an otherwise conscious opponent to prevent the consequences of the technique being applied. This of course applies both ways and a good example of this is the drop seoi nage that children try and copy.
Observation by those in supervision is therefore so important.
- 7) In the event those in supervision cannot see the strangled face then they must look to see if the body becomes limp and inactive.
We are taught at medical school to examine the whole patient. Those in supervision must do the same. They must be aware of every visible clue and to use all their senses. Not hearing the silent opponent is sometimes more worrying than hearing the noisy one. Looking for the limp leg or arm; feeling the limp arm or perhaps that the arm is not as tense as it perhaps should be; recognising that the opponent is perhaps not so actively fighting as there were a second ago but also recognising that the opponent may be summoning up a huge muscular effort to move the attacker. Those in supervision will recognise that a significant strangle may be being applied and that their other observations suggest unconsciousness may be a cause for intervening.
- 8) In the event of uncertainty, those in supervision must stop the contest and make their judgement accordingly. However in the case of judging 'consciousness or unconsciousness', the designated official has the sole responsibility to, act alone and quickly, to make an immediate decision, without consultation with other officials. The prime aim is both for the safety of the opponent and trauma welfare of the attacker. The decision not to allow a situation that is dangerous to continue overrides any criticism, that stopping the contest was premature. However controversial it may be, safety must always come first. There is usually a provision and opportunity for all those in supervision to discuss the situation before declaring the result of the contest..

- 9) If a person goes unconscious for a few seconds this will not cause damage in a healthy person. The risk to a healthy person for a few seconds is minimal. The emphasis is on healthy. Children are at risk, and perhaps the older person is potentially at risk. What is the older person? It is very clear that people can develop atheromatous (or cholesterol) plaques in their carotid arteries leading to either transient strokes (TIA or Transient ischemic attack) or a stroke itself. How much of this is at risk I am not sure however I have never heard of any such event occurring indeed from my understanding, the Kodokan equally hold this view.
- 10) However total restriction of blood to the brain for 10 or more seconds will result in some brain cell damage and longer periods could result in death or other life changing event. Those in supervision must act and step in soon. Those in supervision should develop in their minds the features of normal conscious behaviour and abnormal behaviour. In this way those in supervision will recognise, as obvious, an opponent who is unconscious and at risk of serious harm. The attacker will often continue unless they are stopped by those in supervision. If those in supervision are worried, then the competition should be stopped.

Airway obstruction (the choke)

Slow, struggling, will fight to get out, require a great deal of pressure, visually looking to see where the lock is being applied (front of the throat), going blue is a late feature but to start with is the appearance of a struggle to breathe, red in the face, bulging eyes. An appearance of panic and desperation as airway obstruction comes on. This must be seen as a legitimate technique as it leads to submission or time out as the opponent cannot escape the hold. The most important observation those in supervision need to make is to ensure that the windpipe is not being physically crushed as this requires POINT contact, direct pressure to the front of the throat, literally in the middle requiring a large amount of frontal force. The use of the flat of the forearm or gi across the throat is unlikely to crush the trachea snapping its cartilaginous rings but if held long enough will produce slow unconsciousness.

Arterial obstruction (the strangle)

Rapid onset, like a tap being turned off. The body goes limp, there is no struggle, there is no attempt at defence. The referee must recognise that there may be no airway obstruction, the lack of struggle to get out. Instead it is virtually instantaneous - unconsciousness. This is all to do with arterial compression. This then leads to the problem needing immediate action. Because there is no defence, the contest is over and continuation of the strangulation technique will lead to frontal brain damage. Those in supervision must be aware of these differences;

- a) allowing the restriction of air entry to control their opponent in the struggle to escape.
- and
- b) that of the arterial tap being turned off (the lack of response, the sudden onset limp body over a couple of seconds).

Those in supervision must recognise these differences and intervene where necessary. However as soon as the arterial tap is turned off, once released, the arterial tap is turned on again, consciousness returns. For the opponent, nothing may have appeared to have happened. There was no struggle and the opponent may argue that there was never any danger, that they were in control all the time whereas to the outside observer, unconsciousness intervened. This limpness can be subtle and this is where it can be difficult to be certain. Is it that the opponent is relaxing to create an explosive manoeuvre to get out or is it not. The answer lies in the presence or absence of muscle tone. The lack of muscle tone from strangulation leads to a total flaccidity of all muscle groups. Those in supervision must therefore look for the response of the opponent to the strangulation. Is what is seen a build-up response to try to escape from the strangle, or is it NO response at all?

The bottom line is safety and if the those in supervision believe danger is involved, then they must intervene.

Approved by: The National Technical Committee (NTC)

Authorised by: Robin Otani – President

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