February/March 2006 · Volume 13/Number 2

ASAP news

Continuing the Little League tradition of making it "safer for the kids."

From Salem, Ore. to Peach Tree, Ga. and the Bronx, N.Y. to Rancho Cordova, Calif., Little League® staff has been covering the country, getting the message out to volunteers on ways to improve their leagues. And one of the messages they've carried is on ASAP.

Jim Gerstenslager, Western regional director, speaks at a Road Show in Oregon, below.

Safety on the Road Show!

In one- and two-day seminars, staff — both Regional and International members — have shared ways to help increase participation and make local programs better for everyone involved. It was all accomplished by passing on knowledge gained from running one of the world's highest quality youth sports programs.

Through all this, Little League has shown its commitment to safety in 2006 by implementing or announcing new rules that increase player safety: Break-away bases will be mandatory by 2008, double first base procedures are now in the rule book and bat performance factors for non-wood baseball bats must meet new restrictions by 2009.

Little League continues to endorse options that leagues can implement immediately to further enhance safety: a new pitch count pilot regulation implemented this year; as well as equipment options such as reduced impact balls, face guards for batting helmets, and batting vests or heart guards to protect batters.

So if you don't have a safety plan, you're continuing to play Russian roulette with players' and volunteers' health and safety. Without a concerted effort to improve safety awareness, leagues without safety plans will eventually experience the same types of injuries Little Leagues had historically seen. It's not a question of if, but when.

Safety Plans Bring Benefits

The message is this: Safety plans improve leagues. The benefits are clear: Having a safety program increases safety awareness. This means more people are watching for concerns and ways to improve everything about a league, the facilities, equipment and activities. And by this awareness, fewer children, volunteers and spectators are being hurt at Little League events.

In 2005, 65% of all leagues submitted a safety plan, which has resulted in an over 77% reduction in injuries annually since before ASAP began in 1995. That has resulted in a savings to Little Leagues nationally that has increased insurance coverages, reduced player insurance premiums and kept Little League affordable despite rising health care costs that have meant the cost per claim Little League has paid has risen 101% since '95.

Other Benefits

- If you carry Little League AIG® Insurance, you will earn a 20% credit on your league's player-accident insurance premium.
- By filling out the annual facility survey, you get a limited edition, 2006 Disney-character pin.

Safety Plan Awards

The leagues whose safety plans are judged first and second place in each region will earn a $500 cash award that may be used for any Little League expense.

Two league officials with the first place safety plan in each region will win a trip to the Little League World Series in August at the home of Little League International, Williamsport, Pa.

The league with the best safety program in the country earns all the equipment necessary to light a 200-foot Little League field. The lighting equipment is the latest from Musco Lighting: Light-Structure Green™, engineered to deliver all the light of Little League's lighting standards on-field using half the energy consumption of their old system, so even less light will be on neighbors.

Want to Reduce Injuries?

Replace standard bases with 'breakaway' style now

New rule appears in Little League 2006 baseball and softball rule books:

Rule 1.06

"… Beginning with the 2008 season, it will become mandatory that all leagues utilize bases that disengage their anchor. Leagues are encouraged to begin the process of implementing these types of base systems during the current season on all their fields so that the process is completed by the 2008 season."

Looks are deceiving. The traditional stationary base resembles a white pillow. In actuality, the base is bolted to a metal post which is then sunk into the ground and fixed in concrete, making it a rigid, unmoving object for the runner to slide into. Since it takes 3,500 foot pounds of force to dislodge a stationary base, a runner who slides into this base the wrong way can do a tremendous amount of damage to him- or herself.

On the other hand, a breakaway base consists of two major parts; a rubber mat, bolted to a pole that is inserted into the ground (usually into an anchor set in concrete) just like a stationary base, except that a separate pillow snaps onto the rubber mat. When a runner slides into a breakaway base, the pillow has the ability to release from its anchor and move with the motion of the runner. But when the breakaway base is stepped on by a player who is not sliding, or by a fielder, it will stay in place.

Players' Age	% of injuries to runners due to sliding	% that resulted in fracture
BASEBALL		
12 & under	48%	44%
13 to 15	60%	51%
16 & older	49%	36%
SOFTBALL		
12 & under	64%	58%
13 to 15	62%	40%
16 & older	63%	33%

A five-year study conducted from 2000 to 2004 showed that 55 percent of injuries to runners occur while sliding into base, and 47 percent of all injuries to runners result in fractures. The chart, at right, sets forth the results of the study as related to sliding injuries in baseball and softball.

In his book, *The Awakening Surgeon*, Dr. David Janda discusses a two-year study he conducted comparing injuries sustained on fields using stationary bases versus fields with breakaway bases. In the study, 637 games were played on the breakaway-base field and 635 on the stationary-base field. By the end of the study, 45 players sustained injuries on the stationary-base field while only two were injured on the fields with breakaway-bases. The study concluded that, although the breakaway-bases did not prevent *all* sliding injuries, it is "safe" to say they can reduce the number of these injuries.

Installing breakaway-bases on your league's field is a great way to help make Little League Baseball and Softball safer for the children who participate.

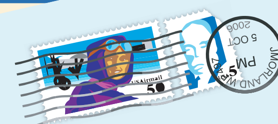
For information on manufacturers of breakaway bases, please visit Little League's website, or go directly to: ***www.littleleague.org/common/equipment/view.asp?cid=5&id=25***

How to Qualify Your Safety Plan

Little League staff made sure everyone at the "Road Shows" knows the 13 minimum requirements have not changed from 2005. ALL leagues must conduct a check of their state's Sex Offender Registry for all volunteers with repetitive contact to the league's players, under the requirements of the Child Protection Program. If leagues want to do a more complete check, Little League has a partnership with https://littleleague.rapsheets.com to offer a nationwide background check for just $1.50 per name checked.

Deadlines

- April 1st – District Incentive deadline: You must have your plan in and approved by April 1. Districts with 60-79% of its leagues' plans approved by April 1 earn $150, while districts with 80-100% will earn $350.
- May 1st – League final deadline: All safety plans must be **postmarked** by May 1 to be eligible for judging in the awards contest and earn the 20% AIG player accident insurance premium.



What,where to send it

Complete the 2006 Qualified Safety Plan Registration Form, the 2006 Little League National Facility Survey and put them with your league's completed safety plan (including the Coaches Manual, concession manual or any other specific supporting documents). Make COPIES for use and future reference. Plans must be approved by the local board and re-submitted annually to re-qualify.

Then send to: **Little League International**
539 US Route 15 Hwy.
PO Box 3485
Williamsport, PA 17701

To check your submitted plan's status, simply go to: ***http://www.littleleague.org/programs/asap/plans.asp?cid=5***
You can see when it's received, under review, and approved. If it isn't approved, the web page will give you the specific requirements for which supporting materials are still needed. You can send these in to Little League International as needed to qualify your plan.

CPR Guideline Changes

AHA tells CPR guideline changes

*For leagues who have CPR-trained volunteers, the American Heart Association has announced important updates to its guidelines for CPR, for both professional and lay rescuer CPR. The following excerpts are taken from **Currents**, Winter, 2005-2006. (Full text can be found at:http://circ.ahajournals.org/content/vol112/24_suppl/)*

Major Changes Affecting All Rescuers

The five major changes in the 2005 guidelines are:

- Emphasis on, and recommendations to improve, delivery of effective chest compressions.
- A single compression-to-ventilation ratio for all single rescuers for all victims (except newborns).
- Recommendation that each rescue breath be given over 1 second and should produce visible chest rise.
- A new recommendation that single shocks, followed by immediate CPR, be used to attempt defibrillation for VF cardiac arrest. Rhythm checks should be performed every 2 minutes.
- Endorsement of the 2003 ILCOR recommendation for use of AEDs in children 1 to 8 years old (and older); use a child dose-reduction system if available.

What did NOT change for lay rescuers:

- Checking for response
- Location for hand placement for chest compressions in adults
- Compression rate
- Compression depth for adults, infants or children (although compression depth for infants and children is no longer listed in inches; it is described only as ⅓ to ½ the depth of the chest)
- Ages used for infant, child and adult CPR recommendations
- Key steps for relief of foreign-body airway obstruction (choking) for infants, children or adults
- First aid recommendations (minor rewording about stabilization of the head and neck for injured victims)

Currents in Emergency Cardiovascular Care is an official publication of the American Heart Association and the Citizen CPR Foundation.

League's past president saved by CPR, AED

Having an AED at your ball field can not only save your players, but fans as well. Lawrence Township Junior Little League in New Jersey can testify to this.

On June 28, 2004, past president Patrick Cox was speaking with Ed Miller by a batting cage. Suddenly Cox fell to the ground, stopped breathing and went into cardiac arrest. The Little League President, Tony Muzi, called to the coaches on the fields for help. Ken Kiernan, a former EMT who was helping coach, ran over. He saw that Cox was not breathing and didn't have a pulse.

He began CPR as Miller ran for an AED. Keirnan administered an electrical shock to Cox's heart and continued CPR. After a moment Cox's heart began to beat and he started to breath. When the paramedics found Cox alive, he was rushed to the hospital and underwent heart bypass surgery.

If Kiernan had not acted quickly and decisively to administer CPR and the AED, Cox would not be alive today. Interestingly enough, it was Cox who pressed to purchase the AED machine when he was the president the year before; little did he know it would be used to save his own life.

Changes for Lay Rescuer CPR

The major changes in the 2005 guidelines recommendations for lay rescuer CPR are the following:

1. If alone with an unresponsive infant or child, give about 5 cycles of compressions and ventilations (about 2 minutes) before leaving the child to phone 9-1-1.
2. Do not try to open the airway using a jaw thrust for injured victims—use the head tilt–chin lift for all victims.
3. Take 5 to 10 seconds (no more than 10 seconds) to check for normal breathing in an unresponsive adult or for presence or absence of breathing in the unresponsive infant or child.
4. Take a normal (not a deep) breath before giving a rescue breath to a victim.
5. Give each breath over 1 second. Each breath should make the chest rise.
6. If the victim's chest does not rise when the first rescue breath is delivered, perform the head tilt–chin lift again before giving the second breath.
7. Do not check for signs of circulation. After delivery of 2 rescue breaths, immediately begin chest compressions (and cycles of compressions and rescue breaths).
8. No teaching of rescue breathing without chest compressions (exception: rescue breathing is taught in the Heartsaver Pediatric First Aid Course).
9. Use the same 30:2 compression-to-ventilation ratio for all victims.
10. For children, use 1 or 2 hands to perform chest compressions and compress at the nipple line; for infants, compress with 2 fingers on the breastbone just below the nipple line.
11. When you use an AED, you will give 1 shock followed by immediate CPR, beginning with chest compressions. Rhythm checks will be performed every 2 minutes.
12. Actions for relief of choking (severe airway obstruction) have been simplified.
13. New first aid recommendations have been developed with more information included about stabilization of the head and neck in injured victims.

Heart Injury Battled

Commotio Cordis

Make your league's players and fans safer

Commotio, what?! You may not be aware of the fatal syndrome called commotio cordis that, according to the American Medical Association, has claimed the lives of 128 people in the past four years. In all cases, commotio cordis is unforeseen and often fatal.

Commotio Cordis seems like a heart attack, but is not. It occurs when a person's chest receives a direct, low-speed impact during an incredibly short, 20-millisecond window of the heartbeat. The heart begins to beat wildly and develops deadly arrhythmias (non-synchronized heart beats) called ventricular fibrillation.

During ventricular fibrillation, the heart's beating is uncoordinated and it becomes an ineffective quivering muscle, pumping little blood to the lungs or the body. When vital organs do not receive a sufficient blood supply, the individual dies quickly.

Majority of cases strike boys

The Cardiac Arrhythmia Service in the New England Medical Center reports more than 75% of commotio cordis cases occur in males ages 4 through 18. Sporting events are the normal scene for commotio cordis and more than half of the sporting events are a baseball or softball game. While commotio cordis has been found to happen in ordinary occurrences like running into another person's chest or being struck by a bat, 81% occur by projectiles such as balls, according to the American Medical Association in the *Journal of the American Medical Association, (JAMA) 2002.*

Chest protectors and safety balls do not eliminate the problem and can create a false sense of safety. Yet, studies show that safety equipment does reduce risk. The May 2003 *PEDIATRICS* publication stated the softest ball triggered ventricular fibrillation in 11% of their tests compared to 69% with a standard baseball. The best preventative measure is coaching your players to move away from close pitches and to not creep closer to the batter when fielding, giving them more reaction time to stop a ball with their glove, not their chest.

Since the timing of the chest blow is so crucial to commotio cordis occurring, the typical way to survive commotio cordis is not by preventing it, but treating it. If cardiopulmary resuscitation (CPR) and an Automatic Electric Defibrillator (AED) are used immediately, survival rates have reached as high as 74%, according to the President of Medtronic Physio-Control, an AED manufacturer.

However, survival rates have been shown to decrease 10% for every minute before a defibrillator is used. Also, studies have found survival rates for any out-of-hospital sudden cardiac arrest worldwide is low, averaging 6% or less.

Family Escapes Co

Although rare, the DeWine family's experience demonstrates how shocking and life-changing commotio cordis can be.

On May 8, 2004, a crowd had gathered to watch a Little League Minor's game in Fairborn, Ohio. Tyler DeWine, age 9, was up to bat. After turning from an inside pitch on the new pitcher's first delivery, he regained his stance but again had a second inside pitch. Tyler dodged away and stepped out of the box, thinking he had heard the ball hit the catcher's glove.

In fact, the sound he heard was the ball hitting his chest. A minute later he lost consciousness. Help rushed over and 9-1-1 was immediately called. His heart rate was erratic and no one first on the scene was trained in first aid or CPR. When Tyler's mom, Kelle, reached him, she saw

by Education, AED's

with Automated External Difibrillator (AED)

What is an AED?

AEDs are portable automatic devises used to restore normal heart rhythms to patients. They are lighter than a laptop (about seven lbs.) and consist of a small 3-buttoned computer, electrodes, and electrical circuitry. When the AED is applied to the outside of the body, it automatically analyzes the patient's heart rhythm and advises the rescuer whether or not a shock is needed. The shock is delivered through adhesive electrode pads, through the chest wall, and into the heart. The shock stuns the heart momentarily, and gives the heart a chance to restart normal activity.

With proper training, AEDs are easy to use. They provide voice and text messages prompting you through the CPR and defibrillator process. Most require you to initiate the delivery of the shock and will not shock unless the person is in cardiac arrest. Once the victim's heart resumes a normal beat, it has been defibrillated.

Steps for treating commotio cordis

1. Purchasing an AED should be done with the help of your local physician. This ensures quality control and proper maintenance of your AED. The price ranges from $1,500 to $3,000. A physician can administer classes and make sure that all designated responders are properly trained. In addition, they can help develop an emergency response plan.
2. Training in CPR and AED usage is needed to provide assistance. A typical class is about 4 hours long. Early CRP is an integral part of providing life saving aid because it helps circulate oxygen-rich blood to the brain. After CPR, knowing how to run an AED effectively is crucial. You will learn to perform under pressure and know the steps to increase the chance of survival.
3. You should contact you local EMS so they will know where the AEDs are located. This will enable your dispatcher to notify the EMS system if an AED is on the premises.

The chance that commotio cordis or a standard heart attack will happen on your ball field seems low. However, if it does, isn't the preparation and price worth keeping one of your players or fans coming back to more games?

mmotio Cordis Tragedy

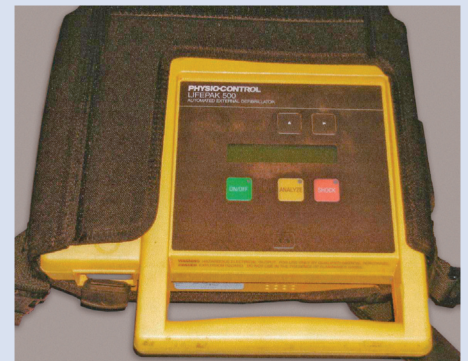
his eyes roll back and he had no pulse. Tyler's body began shaking as if from a seizure and his face was gray. Suddenly, his heart resumed normal beating.

Only one person present, an off-duty medic, suspected commotio cordis, but was unable to do anything since there was not a defibrillator at the ball field. The EMTs arrived after 10 minutes and rushed Tyler to the hospital.

Initial examination showed stitch marks on his chest from the ball's impact, but the ER doctors weren't overly concerned. The cardiologist there gave him an MRI and confined Tyler to bed in the Intensive Care Unit for two days. Tests later showed that Tyler had contusions on his heart. The cardiologist told the family turning your back to the ball may not protect a player, as the chest and back bones and muscles are not thick at early ages.

At his six-month checkup, Tyler told the Doctor, "I made a decision. I decided not to play baseball. I died, but I got a second chance. I'm not going to play." His mom commented, "He had a big thing taken away from him." He still has an interest in baseball and his mom, Kelle, is now the safety officer for their Little League and AEDs were put at all the fields.

However, "the awareness is just not there," Kelle explained about commotio cordis nationally. This was an emotional experience for Tyler and his family, but they are thankful he is alive. He is the only survivor without being defibrillated they know of. It is believed that the shaking of his body was enough to restart his heart.



AEDs becoming common equipment at fields

A month after Tyler was injured, his friend was on-field with a heart guard playing baseball when he was hit in the chest. Kelle is proud to report the friend was not injured.

His parents found comfort in talking to other parents affected by commotio cordis, and Kelle now advocates AED use in her home state of Ohio.

ASAP First Aid Outline

FIRST AID

Use this first aid clinic outline to put on a quality coaches

Q *"I am a new Safety Director for South Highline Little League in Washington and I need to organize our annual safety and first aid training meeting. Do you have a list of what topics need to be covered in such a meeting? I want to make sure that what we cover will meet Little League's requirements. Any information you can provide will be of help.*

"Thank you in advance for your assistance."

Chris Sylvester

Safety Director, South Highline Little League in Washington

A The major points would be the minimum knowledge necessary to handle emergency situations: assessing the injury for severity, explaining basic first aid care and what to do if the injury is beyond this care (emergency responders, 9-1-1), and other information pertinent to preventing injuries such as heat illness prevention and care and proper water breaks (with dehydration signs), flexibility drills and warm-ups and cool-downs to help to reduce muscle pulls and strains, and any other prevention ideas your presenter might include.

Use the overview of a first aid training program below to design your first aid clinic, or expand any part that you feel has more need in your area.

Emergency Management

The original program, Emergency Management and Prevention of Injuries in Baseball and Softball contained recommendations that can help you put together a quality first aid training class to meet the requirements of first aid training for your coaches and managers using local resources. You don't have to follow the specifics of any set program, just get the PRICES – **P**rotection, **R**est, **I**ce, **C**ompression, **E**levation and **S**upport (or RICE or PRICE, whatever you use) – idea into participants' heads and talk about the specifics of first aid and injury prevention for specific baseball/softball injuries.

Start with basic terminology (contusion, laceration, etc.), and give the most up-to-date techniques for preventing sports injuries. Help attendees understand and differentiate between mild, moderate and severe injuries and the appropriate actions to take in each category. Teach appropriate first aid techniques for the injuries they will encounter.

Basic baseball/softball issues include:

- Contusions
- Muscle pulls and strains
- Over-use injuries
- Sprains
- Fractures
- Injuries to small joints
- Facial injuries
- Injuries to teeth
- Eye injuries
- Insect bites and stings
- Heat illness
- Triage and Emergency Management

Help design an emergency plan for your league when severe injuries occur, and tell the managers/coaches what their role is in that plan:

- Make sure managers/coaches stop all play to protect the player from further injury, as well as those not being closely monitored due to the focus on the injured player.
- Check player's breathing, pulse and alertness to immediately judge the seriousness of the injury:
  - — If necessary, send someone to call 9-1-1/ambulance/EMS
  - — Call the player's parents
  - — Send someone to nearest intersection to direct emergency services to you
  - — Review Medical Release form for important information/ warnings about medical conditions player has
- Evaluate the injury:
  - — Can player be moved off field?
  - — If not, clear area around player and begin examination
  - — If so, move player to sideline for closer examination
  - — Determine if player can return to play or needs first aid
- Give the appropriate first aid for the injury
- Turn over care to professionals when they arrive and help as directed
- If parents are not available, go with player to treatment center with ambulance; turn over team to authorized coach
- If emergency medical treatment isn't required, urge player and parents to see a doctor for a proper diagnosis and treatment plan
- Record the injury on an injury report.

OUTLINE Eases Coaches Training

training for your league's managers, coaches and volunteers

- Follow up with the player until injury is healed and player can return to play
- Get medical release prior to allowing player to return, if formal treatment was required

You should have medical professionals available either on-site or at most a phone call away — as well as a method to reach them, by cell phone or phone at the field — for severe or life-threatening injuries.

And finally, help the coaches/managers to understand specific techniques to determine whether an injured player is ready to practice and play again; in some cases this may require a doctor's release. The evaluation process involves determining whether injuries are mild, moderate or severe, and should address what to do in each case. The evaluation includes classifying injuries using symptoms and signs, with appropriate looking, listening and careful feeling and, if appropriate, moving of the injured part. In evaluating fresh injuries, remember the *three types of motion*:

- **Active motion** – Player is able to move the part themselves.
- **Active assistive motion** – Player is able to move with a little help from you. Watch for warning signs like the player telling you it hurts to move).
- **Passive motion** – the player's injured part is moved by someone else; be especially cautious with passive motion that you do not make the injury worse.

Look for **disability** (the player can't use injured part); this is the most serious injury. If a player sprains his ankle, but can still limp around, it may be **mild** or **moderate**; if he can't get up, it is probably **severe**. Look for **swelling**, the more immediate and large the swelling, the more serious the injury, because swelling on outside means bleeding on inside. Also, a noticeable **deformity** means a serious injury. If the body part doesn't look the way it did before the accident, something's wrong. Consider **unconsciousness** or any **eye injury** as a serious situation, in the category of **severe** injuries, until you are assured otherwise by a medical professional.

Use the **PRICES** guide to treat injuries:

P – Protection
R – Rest
I – Ice
C – Compression
E – Elevation
S – Support

In conclusion, ask for managers/coaches to consider how to prevent injuries:

- Pre-participation health screenings (at least through a health questionnaire/ medical release form asking for health concerns and medications)
- Proper maintenance of playing site (examine game and practice facilities prior to use)
- Pay close attention to playing conditions (heat and humidity as well as severe weather)
- Make sure players know basics of good nutrition (especially water replacement on hot days)
- Proper athletic conditioning (stretching, strengthening and endurance, as well as agility and coordination drills)
- Avoid over-use (pay special attention to activities outside of Little League, to allow rest to avoid over-use injuries
- Consistent and proper use of all protective equipment
- Close coach supervision and organization of warm-ups, practices and games
- Careful compliance with all Little League rules having to do with safety

This is a brief summary. You will want to elaborate on proper techniques for different injury types, how to treat them effectively and what NOT to do in any given circumstance. If anyone is ever in doubt of the nature or seriousness of an injury, they should NOT attempt treatment; a health care professional should be consulted immediately.

Finally, remind all managers and coaches to carefully evaluate ***all*** injuries to ensure a child does not require professional care. It's not worth risking a child's health just to continue a game.

CPSC recommends safety equipment

The U.S. Consumer Product Safety Commission (CPSC) supports safety equipment in your league. Fact Sheet #329 states: "softer-than standard baseballs, safety release bases and batting helmets with face guards could significantly reduce the amount and severity of 58,000 (or almost 36 percent) of baseball-related injuries to children each year...." Baseball and softball in the U.S. have an estimated 6 million children, ages 5 to 14, participating in leagues and 13 million children in non-league play. "In (one year) hospital emergency rooms treated an estimated 162,100 children for baseball-related injuries," it states.

Their review of injury data and causes found "protective equipment currently on the market may prevent, reduce, or lessen the severity of more than 58,000 injuries occurring to children each year."

Soft Core Balls: "Softer-than-standard balls may prevent, reduce or lessen the severity of the 47,900 ball impact injuries to the head and neck."

Helmet with Face Guard: "Batting helmets with face guards may prevent, reduce, or lessen the severity of about 3,900 facial injuries occurring to batters..."

Release Base: "Safety release bases that leave no holes in the ground or parts of the base sticking up from the ground when the base is released may prevent, reduce, or lessen the severity of the 6,600 base-contact sliding injuries occurring in organized play."

Are You Improving on

Minimum requirements for safety plans mostly

The following 13 requirements are also on your 2006 Qualified Safety Program Registration Form, distributed to all safety officers earlier this year. The only change from 2005 is an allowance for people with a medical license not to attend your league's first aid clinic. However, one representative from each team is still required to attend the clinic for your plan to be qualified.

If you are not sure how to develop any of the minimum requirements, please visit Little League's website for some great ideas on ways to develop a qualified safety plan and improve safety in your league. Go to: http://www.littleleague.org/programs/asap/requirements.asp

Here are the 13 requirements:

1. Have an active safety officer on file with Little League

2. PUBLISH and distribute a safety manual to coaches/managers

- The intent is to print and hand out the safety plan (or relevant sections) to all staff: Concession manual to concession workers, equipment policies to facilities crew, first aid to managers and coaches, etc. Keep copies in common areas for all volunteers.
- Samples can be found in the example safety manuals on the CD or LLBS website.
- Include all relevant material for coaches, including these minimum standards.
- Keep a copy for your league. Send a copy to your DA or District Safety Officer. Little League International does not keep copies for leagues' future use.

3. Post and distribute emergency and key officials' phone numbers

- Include emergency procedures for handling injuries and who to contact to track/report them (see requirement 10).
- Include emergency phone numbers for ambulance, police, fire department, etc.
- Include league president and safety officer, consider head umpire and board members.

4. Use 2006 Volunteer Application Form and check for sex abuse

- Must have managers, coaches, board members and any other persons, volunteers or hired workers, who provide regular services to the league and/or have repetitive access to or contact with players or teams fill out application form as well as provide a government-issued photo identification card for ID verification.
- Must conduct a search of appropriate governmental entity of the statewide sex offender registry, using 2006 Volunteer Applications, on all applicable volunteers.
- May conduct nationwide background check using resources such as rapsheets.com.
- LLB's web site provides access to information on free states' sex offender registries.
- Leagues in states without free access to registry, must still provide background check.
- Anyone refusing to fill out Volunteer Application is ineligible to be even league member.
- League president must retain these confidential forms for the year of service.
- Do not send in volunteers' forms. Do send a blank copy of the application form the league used.

5. Provide and require fundamentals training, with at least one coach or manager from each team attending (fundamentals including hitting, sliding, fielding, pitching, etc.)

- It is not necessary for the first aid and training fundamentals to be held before Safety Plan is submitted. It is acceptable for scheduled dates/locations to be listed to meet requirement.
- Document date, location, who is required to attend and who did attend. Intent is to provide training to ALL coaches and managers. The minimum is for one participant per team.
- Training qualifies volunteer for 3 years, but one team representative is still required to attend each year.
- High school, college or experienced league coaches can be great resources to give the clinic.
- Districts can assist by providing training sessions on a district-wide basis.
- Encourage coaches to pass fundamentals training on to their players at practices.

6. Require first-aid training for coaches and managers, with at least one coach or manager from each team attending

- It is not necessary for the first aid and training fundamentals to be held before Safety Plan is submitted. It

the ASAP 'Minimums'?

unchanged from 2005; are you doing more?

is acceptable for scheduled dates/locations to be listed to meet requirement.

- Due to their training and education, it is not necessary for licensed medical doctors, licensed registered nurses, licensed practical nurses and paramedics to attend first aid training in order to meet requirement; however, it is recommended that leagues utilize these professionals from their league/community to present the training.
- Other individuals who attend various outside first aid training and course are not exempt.
- Document date, location, who is required to attend and who did attend. Again, the intent is to provide training to ALL coaches/managers; minimum of one participant per team.
- Training qualifies volunteer for 3 years, but one team representative still needed each year.

7. Require coaches/umpires to walk fields for hazards before use

- Recommend leagues use form to track and document any facility issues needing to be fixed.
- Common sense activity — look for rocks, glass, holes, etc.
- Specify who is responsible for doing this — home coach, visitors, umpires cor all?

8. Complete the 2006 ANNUAL Little League Facility Survey

- This is a requirement each year. It can help leagues find and correct facility concerns before injuries occur.
- Provided with mailing to League Safety Officers, also available from web site — *http://www.littleleague.org/programs/asap/index.asp or email asap@musco.com*
- Excel spreadsheet included on CD for easy filing, recording for future use and records.
- Keep a copy on file for future needs. Little League does not maintain copies of surveys.

9. Written safety procedures for concession stand; concession manager trained in safe food handling/prep and procedures

- Local restaurant operators are good resource for training assistance.
- Training should also cover safe use, care and inspection of equipment.
- See concession suggestions: April and June, 2000 issues of ASAP News available on Little League's web site and Safety Officer Manual CD.

10. Require regular inspection and replacement of equipment

- Inspect equipment before each use by coaches and umpires.
- Use official LL bat ring to check bats before each use.
- Don't just discard bad equipment: destroy it or make it unusable to stop children from attempting to "save it" from waste.
- Recommend use form to remind coaches and to track equipment needs.

11. Implement prompt accident reporting, tracking procedure

- Accident forms to safety officer within 24-48 hours of incident is common.
- Forms are available through Little League website and now on CD.
- Track "near-misses" as a proactive tool to evaluate practices, avoid future injuries.
- Share information on accidents and "near-misses" with District staff.

12. Require a first-aid kit at each game and practice

- Many leagues have a complex, but each team needs some form of first-aid kit for off-site practices or travel/tournament games.
- Local hospitals and medical supply companies are good sources.
- If necessary, fund through special drive.

13. Enforce Little League rules including proper equipment

- Most Little League rules have some basis in safety — follow them.
- Ensure players have required equipment at all times, even catchers warming up during infield.
- Make sure coaches and managers enforce rules at practices as well as games.
- Remind managers, coaches they are not allowed to catch pitchers (Rule 3.09); this includes standing at backstop during practice as informal catcher for batting practice.

Yankees Star Pitches Pilot

Yankees star Mike Mussina answers pitch count questions

Why is it important for Little League to offer a pitch count program to Little Leagues now?

Mike: "I think the Little League Pitch Count Program is important now because more and more kids are playing more and more baseball. They start earlier in the year, they play longer through the summer, they're playing longer through the fall and they're starting at younger ages.

"These kids are throwing the baseball just so many more times now than kids 10 years ago, than kids 20 years ago; certainly when I was young I never played as much baseball in a year as the kids do today. And naturally the kids that can pitch are going out there and pitching.

"I think it's important to remember we only have so many throws in our arms, and these kids are just getting started playing baseball and we need to take care of them. And because of all the baseball being played, I think it's important that we don't send them out there to pitch too much, and more than they can physically handle."

"We're very fortunate to have Mike on our International Board of Directors and as a valued counsel for many issues," Stephen D. Keener, president and chief executive officer of Little League Baseball and Softball, said. "Mike is dedicated to his community, to Little League, and to the sport of baseball, so he was willing to help us get the word out about this important program."

How does your own experience as a Little Leaguer factor into your decision to support the Little League Pitch Count Pilot Program?

Mike: "It factors in a little bit, I think. When I was growing up, we did whatever we could do to spend the time. There weren't video games – there certainly weren't computers – the way they are today. We spent more time outside, but at the same time, baseball didn't run from the first day that there was no snow on the ground until the first day it started to snow in the winter. We did other things: swim, play basketball, play tennis, play golf, to do anything else, skateboarding, bikes… you name it, we tried to do it.

"Baseball season for me, living in the Northeast, was 20 games, 22 games. Practice started at the beginning of April, mid-April; the season ended the middle of June. And then whenever the All Star team stopped playing, if you happened to make that team, (that was it) until I was in high school, when you could play in other leagues of high school age.

"When you're developing and learning how to play, I didn't play too much baseball; I didn't pitch too much. If it has a factor in what I think of this program, it might a little bit. I don't know, but you see too many kids now in their teens having surgeries that adults in my business are having. It's too early to see kids having elbow surgery and shoulder surgery at 17 and 18 years old. I vote for doing the best we can to take care of them, and that's why I support this program."

Speaking as a member of the Little League International Board of Directors, what was the process that resulted in the Little League Pitch Count Pilot Program?

Mike: "From my understanding of the program, the preparation that went into it was not something that was thrown together in a week or a couple of months. It was talked about for quite a few years. A lot of questions were asked to a lot of experienced people, people who know kids, who know arms, who know baseball.

"And pulling all the resources together, we sat down with what we thought was a decent idea and fine-tuned it a little bit and tried to find a medium that works for everybody. And the kids can still go out there and pitch, and pitch most of the baseball game and sometimes pitch the whole game; and not be asked to go out and do it again tomorrow or two days later. I think that's the important part.

"There are two factors that go into pitching injuries, one you throw too much, and you don't get enough rest in between. And if we can try to deal with both of those, I think the program is going to be successful."

Would you recommend the Little League Pitch Count Pilot Program for al llocal Little Leagues?

Mike: "I would recommend this program for leagues to start using it. I think it can only help the kids.

"It will get more kids out there pitching and give more kids a chance to experience what it's like to be in control of the game a little bit. And yet at the same time not ask the very best kids to go out there and pitch your whole season for you. Your very best kids are going to play in these other leagues, they're going to travel, and are going to pitch for them once in a while, too.

"I think it would be great if everybody took this into their league and presented it to them and incorporated it into the way they teach baseball. This may become part of the rules in the near future so why not try it out and see how it works for you. I think it's going to be a success."

Mike Mussina,
New York Yankees pitcher and Little League International Board of Directors member

Pilot Program Pitching In

The new Optional Pitch Count Program – offering new baseball regulations changing pitching restrictions from innings pitched to maximum pitch counts – is rolling out to all interested leagues this year, and may be a view of the future.

Joe Losch, senior vice president of Little League International, spoke about the program at a "Little League Road Show" in Brooklyn Center, MN, recently. He noted the test program in 2005 followed 50 leagues' pitchers, but the pilot program in 2006 is available to all leagues.

In promoting the program, Losch said depending on the results from participants this year, pitch counts "will probably replace the weekly innings standard in the future" for baseball players. Softball is not viewed to be as hard on pitchers' arms, so is not included in this program. It is for baseball divisions only.

He pointed out the number of pitches allowed may change, so it's important to get many leagues involved now, to get good feedback on program. That way if it is made mandatory for baseball in the future, it will work for everyone.

"Managers were forced to develop more pitchers (in the test program)," he said, but "it took away the very competitive managers from wanting to have Johnnie pitch over 100 pitches in a game.

"We found that many coaches were tracking pitches anyway," he said of last year's test program. The participating managers, many of whom were reluctant at first to try this new approach, "admitted after the program was over it was successful," Losch stated.

When a pitcher reaches the maximum number of pitches for a day according to their age, that pitcher will be allowed to pitch out the batter without any penalty. However, Losch stated if a 12-year-old pitcher is at 60 pitches in the middle of a batter and pitches even one more pitch to retire that batter, the pitch count for that day will be 61, moving the pitcher into the four days' rest requirement, not the three days' rest for 60 pitches.

So the option will force coaches to better manage their pitchers, in deciding who will pitch today, and how much, to know how many days' rest will be required before they can pitch again, he noted.

Many teams will have to develop more pitchers if their league adopts this option, Losch stated, especially for tourneys. But that is good from a player standpoint of getting an opportunity to pitch. "They'll have to expand the number of pitchers beyond the two or so 'star' pitchers," Losch said, to play and meet the requirements on rest.

He noted the new pilot program is supported by orthopaedic surgeons, who view it as "very progressive."

Little League believes the restriction on the maximum number of pitches thrown will potentially aid in keeping baseball pitchers' arms healthy, but only if the players and players' parents communicate with managers about other programs the player may pitch in. Creating a maximum pitch count with a set rest system won't aid a pitcher's arm health if he is pitching in another program on his off days.

But feedback by those using the new optional regulation will set the future direction for this. "Once we get this rolling, we're going to come out with a survey on how this is working. And your feedback will help determine where this goes," Losch concluded.

Curveball Study Underway

People concerned about arm injuries point to the curveball as a problem for young pitchers. Joe Losch, senior vice president of Little League International, said the curve ball issue might deserve more study. Some authorities say the curveball shouldn't be taught to youngsters until growth plates in the arm have stopped major growth after puberty. However, medical research hasn't proven this conclusively, he said.

He noted Little League will be carefully watching a 5-year program to study the effect of the curveball on young pitchers' arms, and considering what ramifications it has for Little League. The study is being funded by a grant from the Boston Red Sox. After this study has given Little League more information, the issue of curveballs can be better addressed, he said.

What's Inside

2 Reduce Injuries Now
Replace your standard bases to help reduce leg injuries

4 Commotio Cordis
Do you know how to battle this potentially fatal injury?

8 Doing 'Minimums'?
Make sure you are at least meeting the 13 requirements for your safety program

10 Mussina Pitches In
Yankee's Mike Mussina pitches new Pitch Count Pilot Program

Helpful tips for safety

Website offers SOR info

A new tool is available to assist local leagues in completing required volunteer background checks. The National Sex Offender Public Registry, coordinated by the Department of Justice, is a joint effort between states hosting public sex offender registries and the federal government.

This web site, **www.nsopr.gov**, provides a search tool allowing a user to submit a single national query to get information about sex offenders. There are a number of search options available on the site; however users performing searches for Little League purposes, at a minimum, must select the "state-search" option on the site. Little League International recommends leagues select the "national-search" option which will exceed the minimum requirement and provide a check in every state with the exception of Oregon and South Dakota.

The criteria for searching are limited to the information available in each individual state. Also, because information is hosted by each state and not by the federal government, search results should be verified by the user in the state where the information is posted. So if a user has questions or needs further information on the results of a check, he or she should log on to an individual state's sex offender registry for clarification. For more information, or to do a search, go to **http://www.nsopr.gov**.

While the DOJ's National Sex Offender Registry is a great improvement over individual state sexual offender registries, Little League International strongly recommends leagues use Rapsheets to perform background checks. Rapsheets currently conducts a nationwide check in all states except Hawaii and South Dakota.

Rapsheets also includes information regarding not only sex-based offenses, but also includes data regarding additional criminal convictions in various states. Rapsheets is available to leagues at **https://littleleague.rapsheets.com/** and costs $1.50 per name checked.

PO Box 3485 / 539 US Rt. 15 Hwy
Williamsport, PA 17701

ASAP News

ASAP News is a service of Little League Baseball® and Softball facilitated and published by Musco Lighting
P.O. Box 808
Oskaloosa, Iowa 52577

© March 2006, Little League® and Musco Lighting™

24 Hour Hotline:
800/811-7443
Fax: 641/672-1996
E-mail: asap@musco.com

All materials in the ASAP News may be reprinted by chartered Little Leagues without prior permission.

Non-Profit Org.
U.S. Postage
PAID
Williamsport, PA
Permit No. 90