"BATTER UP!": ARE YOUTH BASEBALL LEAGUES OVERLOOKING THE SAFETY OF THEIR PLAYERS?

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I. INTRODUCTION

Each summer, approximately eight million youths between the ages of five to fourteen participate in an organized baseball league in the United States.[1] While most youth baseball leagues require the use of batting helmets and full protective equipment for catch-

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1. UNITED STATES CONSUMER PRODUCT SAFETY COMMISSION, BASEBALL AND SOFTBALL RELATED INJURIES TO CHILDREN 5-14 YEARS OF AGE, A-5 (1984). The figure of eight million is based on estimates by the Sporting Goods Manufacturers Association and the United States Baseball Federation. Id.

ers,[2] baseball still accounts for the most injuries among all organized sports for players between the ages of five to fourteen.[3] Since this age group primarily consists of novice players, youth leagues must have an added responsibility to ensure their players' safety.

One of the most troubling realities in youth baseball is the absence of required safety equipment to protect young players from facial injuries. While amateur hockey leagues throughout North America have mandated the use of face masks,[4] most youth baseball leagues have failed to implement similar rules requiring protective facial equipment. The potential threat of injury in youth baseball is highlighted by the wide disparity in age, skill levels, and physiological differences between players competing in the same leagues.

Traditionally, youth baseball leagues have been shielded from legal liability for injuries to players or officials during a league game or practice session. Courts historically have accepted the assumption of the risk defense which recognizes that the participant generally accepts the risks inherent to the game.[5] Despite the courts traditional stance, facial injuries in youth baseball present a greater potential threat of liability for youth baseball leagues. Given the significant number of documented facial injuries in youth baseball, the availability of proven and inexpensive protective facial equipment,[6] and the diminishing applicability of the assumption of the risk doctrine,[7] a strong argument exists for imposing tort liability against youth baseball leagues that do not require the use of facial protection.

This article discusses the legal implications that may arise from

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2. OFFICIAL PLAYING RULES OF LITTLE LEAGUE BASEBALL, § 1.11-.17. (1989).

3. UNITED STATES CONSUMER PRODUCT SAFETY COMMISSION, PRODUCT SUMMARY REPORT 17 (1991).

4. OCULAR SPORTS INJURIES 83-86 (Dr. Paul F. Vinger ed., 1981). Mandatory facial protection is required by almost all North American high schools and in all youth hockey leagues. *Id.* at 85. In addition, the National Collegiate Athletic Association (NCAA) also enacted a mandatory face mask rule for all member institutions. *Id.*

5. *See, e.g.,* Dillard v. Little League Baseball, Inc., 55 A.D.2d 477, 476 (N.Y. App. Div. 1977). For a more detailed account of *Dillard, see infra* notes 23-29 and accompanying text.

6. Bob Fortuna, *For Safety's Sake,* CLEVE. PLAIN DEALER, July 8, 1992, at 1E, 8E. *See Protecting the Batter's Face,* N.Y. TIMES, May 11, 1991, at 48. The faceguard is designed to protect a batter's face from the pitched ball. The guard attaches to the sides of a standard batting helmet, preventing the ball from making direct contact with any portion of the face. The face guard sells for approximately fifteen dollars.

7. *See* J. Barton Goplerud, Note, *Liability of Schools and Coaches: The Current Status of Sovereign Immunity and Assumption of the Risk,* 39 DRAKE L.R. 759, 770 (1989).

the failure to mandate the use of protective facial equipment for all batters and baserunners in youth baseball. Part II reviews the courts' traditional acceptance of the assumption of the risk doctrine as a bar to recovery for a plaintiff who suffers a sport injury. Part II also discusses the limitations of the assumption of the risk doctrine as it applies to novice players injured in youth baseball and examines the recent changes by the judiciary and various state legislatures to restrict the use of the assumption of the risk doctrine in negligence cases. Part III illustrates the key factors that influenced amateur hockey and the National Collegiate Athletic Association (NCAA) to adopt a mandatory face mask rule. The rule changes in amateur hockey serve as a model which reflect the necessity for a uniform response to reduce the problems of facial injuries in youth baseball. Part IV argues that a duty exists for youth baseball leagues to protect its players from facial injuries. In conclusion, Part V examines the first case brought against a youth baseball league for failure to provide protective facial equipment. This case emphasizes the need for youth baseball leagues to recognize the dangers of the game and to mandate the use of protective facial equipment in order to avoid significant legal consequences.

II. NEGLIGENCE AND THE ASSUMPTION OF THE RISK DOCTRINE

A. *The Traditional Court Response to Sport-Related Negligence Actions*

In cases where a plaintiff seeks relief for an injury resulting from his voluntary participation in a sporting event, courts often must determine whether the defendant's negligence caused the accident.[8] Traditionally, a plaintiff could be barred from recovery if the court concluded that he assumed the risk of injury arising from the defendant's conduct.[9] In most sport injury cases, the courts have strictly applied the assumption of the risk doctrine.[10]

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8. The elements of negligence are (1) the existence of a duty; (2) a breach of that duty; (3) a causal connection between the defendant's conduct and the resulting injury to the plaintiff; and (4) actual loss or damage to the plaintiff. PROSSER AND KEETON ON THE LAW OF TORTS, § 30 (W. Page Keeton ed., 5th ed. 1984).

9. *See* Goplerud, *supra* note 7, at 771.

10. RESTATEMENT (SECOND) OF TORTS § 496C-E (1965). The Restatement states that a "plaintiff who voluntarily assumes a risk of harm arising from the negligent or reckless conduct of the defendant cannot recover for such harm." *Id.* The doctrine acts as a complete bar to a plaintiff's cause of action against a defendant's negligent act. *Id.* In asserting an assump-

Representative of the courts' indiscriminate application of the assumption of the risk doctrine are decisions ranging from the denial of recovery for an eleven year-old boy who was struck by a bat during a school recess baseball game[11] to a dismissal of an action brought by a professional baseball player who suffered a career ending injury when he slipped on a muddy field.[12] Neither decision took into consideration the age, experience, or intelligence of the plaintiff. In both cases, the courts ruled, as a matter of law, that the injured plaintiffs were precluded from maintaining their actions.[13]

In addition to accepting the assumption of the risk doctrine, courts also relied on the customary practices of a particular sport to help determine whether a defendant was negligent for failing to provide adequate protective equipment. In the context of baseball, the court in *Richmond v. Employers' Fire Ins. Co.*[14] dismissed a player's action against a student assistant coach for an injury that resulted when the coach's bat slipped out of his hands and struck the catcher during a fungo practice session of the college varsity baseball team.[15] The court held, in part, that negligence was not

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tion of the risk defense, the defendant must prove that the plaintiff had knowledge of the danger involved, appreciated its character, and voluntarily accepted the risk involved. *Id.* A subjective standard is usually employed by the trier of fact to determine whether the plaintiff assumed the risk. *Id.* The court determines the issue, as a matter of law, only in cases where a reasonable person could not reach any other conclusion. *Id.*

11. Gaspard v. Grain Dealers Mutual Ins. Co., 131 So.2d 831 (La. App. 3d Cir. 1961). In *Gaspard*, the plaintiff sought damages for personal injuries received when he was struck on the head by a baseball bat which slipped from the hitter's hands during a school recess period. *Id.* The court noted that a school administrator supervised the game, both boys were voluntary participants, and the plaintiff had played baseball numerous times before the incident. *Id.* at 832. The court denied recovery on the ground that the plaintiff assumed the risk of injury. *Id.* at 834.

12. Maddox v. New York, 487 N.E.2d 553 (N.Y. 1985). In *Maddox*, a major league baseball player with the New York Yankees suffered a severe injury while he was playing in the outfield during a game at Shea Stadium. *Id.* at 554. Maddox's injury arose when one foot became stuck in the mud while the other foot slipped in a puddle. *Id.* The plaintiff argued he was entitled to relief because he assumed only the risks of the game and not those associated with the playing field. *Id.* at 555. The court focused on the plaintiff's testimony in which he admitted that he had observed water on the field and had reported the poor condition of the field to a member of the ground crew. *Id.* In denying recovery, the court ruled that the risks of the game include the construction of the specific playing field. *Id.* The plaintiff assumed the risks of injury through his continued participation in a game in which he knew the hazards involved. *Id.* at 557.

13. *Id.* at 558; *Gaspard*, 113 So.2d at 834.

14. 298 So.2d 118 (La. App. 1st Cir. 1974), *cert. denied*, 302 So.2d 18 (La. 1974).

15. *Id.* The defendant coach was hitting fungoes from the third base line to various play-

involved since it was not customary for a catcher during a fungo game to wear protective equipment.[16]

Similarly, *Brackman v. Adrian*[17] involved a plaintiff who was injured while playing catcher during a class softball game.[18] The court dismissed the action against the supervising teacher and rejected the argument that she was negligent for failing to provide the plaintiff with a protective catcher's mask.[19] In finding no evidence of the defendant's negligence, the court did not address the issue of whether the plaintiff assumed the risk of injury.[20] However, the court did point to evidence indicating the plaintiff's skill and experience in playing softball as well as her testimony that she had seen others throw bats in a similar manner.[21] Central to the court's decision was its implied belief that the nature of softball does not require the use of protective equipment.[22] Both *Brackman* and *Richmond* demonstrated the courts' willingness, despite legitimate safety concerns, to reject negligence claims based, in part, on the common practices of the sport.

While courts have yet to confront the issue of whether a youth baseball league is liable for failure to mandate protective facial equipment, *Dillard v. Little League Baseball, Inc.*[23] illustrates the problems of extending the courts' traditional application of the assumption of the risk doctrine to such a case. In *Dillard*, a nine

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ers in the field. *Id.* at 120. The plaintiff was positioned near the coach in order to catch balls that were thrown by the fielders. *Id.* at 121. Upon defendant's request, the plaintiff positioned himself to the defendant's left when the bat slipped out of the defendant's hand and struck the plaintiff. *Id.* The court stated that the defendant was not negligent in instructing the plaintiff to change his position because his reasons for doing so were reasonable. *Id.* In addition, the court reasoned that even if it could be determined that the defendant was negligent, the plaintiff was barred from recovery because he assumed the risk of participating in the sport. *Id.* at 122.

16. *Id.* at 121.
17. 472 S.W.2d 735 (Tenn. Ct. App. 1971).
18. *Id.*
19. *Id.*
20. *Id.* at 740-41.
21. *Id.* at 738.
22. *Id.* The court asserted that:

> [i]t is common knowledge that the very nature of the game in question calls for the use of a softball as opposed to the regulation hard baseball and we also know that this game, which is played by many thousands of youngsters throughout the country, contemplates the pitching of a slow ball rather than the fast curve such as is thrown by baseball pitchers in the regular game of baseball.

Brackman v. Adrian, 472 S.W.2d 735, 738 (Tenn. Ct. App. 1971).

23. 55 A.D.2d 477 (N.Y. App. Div. 1977).

year-old little league pitcher struck an umpire with a pitch thrown during a called time out.[24] The plaintiff brought suit against Little League Baseball asserting that, while the league supplied him with a mask and chest protector, the league was negligent in its failure to provide a protective cup.[25] In reviewing the trial court's ruling that the plaintiff assumed the risk of injury,[26] the appellate court first placed particular emphasis on the skill and experience of the injured plaintiff,[27] and, second, asserted that it was not the duty of little leagues to provide protective cups to umpires.[28] The court concluded that the risks associated with umpiring were reasonably foreseeable and the plaintiff could have purchased his own protection inexpensively and avoided injury.[29]

The *Dillard* decision raises significant questions as to whether the court's reasoning could be applied to negligence suits against youth baseball leagues for their failure to provide novice players with adequate facial protection. Presently, it is not customary to provide protective facial equipment in youth baseball.[30] The following questions then arise: Does the absence of this equipment mean that future decisions will be based on customary practices despite documented evidence of a high frequency of facial injuries in youth baseball leagues? Is the assumption of the risk doctrine applicable

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24. *Id.* at 478. During the course of a Lyncourt Little League game, the plaintiff umpire called time-out so the catcher could retrieve a pitch that had sailed to the backstop screen. *Id.* While the plaintiff turned his attention from home plate, he was struck in the groin by a pitch thrown by the nine-year old pitcher. *Id.*

25. *Id.*

26. *Id.* at 481. The trial court granted defendant's motion for summary judgment and dismissed plaintiff's complaint. *Id.* at 482.

27. *Id.* at 481. The court noted that the plaintiff had previously coached a little league team and was aware of the wild pitches and erratic play associated with nine year-old players. *Id.*

28. Dillard v. Little League Baseball, Inc., 55 A.D.2d 477, 481 (N.Y. App. Div. 1977). The court relied on the affidavit of the Recreational Director for the City of Syracuse, who testified that as a Little League umpire with twenty-two years of experience he had never been provided a protective cup or athletic supporter. *Id.*

29. *Id.* The court made the distinction between the protective cup, which is personal to the individual umpire, and shin guards, face masks, and chest protectors which are provided by the league and can be used by more than one umpire. *Id.* The court also noted that "[p]layers, coaches, managers, referees, and others who, in one way or another, voluntarily, participate must accept the risks to which their roles expose them." *Id.* at 479.

30. While Little League Baseball has yet to mandate the use of protective facial equipment, some youth leagues, like Dixie Youth Baseball, and individual teams have required that protective face shields be worn. Louis Mayeux, *Dixie Asks Batters to Don Masks, Additions to Helmets Will Be Made Mandatory in Three Years*, ATL. J. & CONST., Oct. 30, 1992, at H1.

in cases where plaintiffs seek relief for facial injuries suffered while playing youth baseball?

B. The Weakening and Limiting Effect of the Assumption of the Risk Doctrine

While historically courts have widely accepted the assumption of the risk doctrine in sport injury cases, the doctrine is not an effective defense in cases involving facial injuries to novice players in youth baseball leagues. For most players, youth league baseball represents their initial introduction to the sport. While league organizers attempt to group players by skill level, a wide variation in ability and physical development still exists among players competing in youth leagues.[31] The lowest level of Little League Baseball contains players ranging from eight to twelve years of age.[32] As a result, an eight year-old playing in his first season may be forced to bat against a stronger, more physically mature player capable of throwing pitches with great speed.[33] In addition, a young pitcher may display periods of erratic control[34] while those in the field may exhibit wild and unpredictable throws. Similarly, less experienced batters display slower reaction times and are at greater risk of being hit by a pitched ball.[35] While this is to be expected in a league consisting of youths who are first learning to play the game, it is also not surprising that baseball players in the five to fourteen age group suffer more eye injuries than in any other sport.[36]

In light of the realities associated with youth baseball, should an eight, ten, or twelve year-old novice player be expected to appre-

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31. *Gil Tauber*, 53 SIGHTSAVING (1984). C.A. Morehouse, former Professor of the Sports Research Institute at Pennsylvania State University, noted the significance of the wide variation in the development of children of the same age as follows: "At 12, one kid may have the physique of a 16 year-old while another may not only look 10, but also have a 10 year-old's reaction time." *Id.*

32. LITTLE LEAGUE BASEBALL, INC., THIS IS LITTLE LEAGUE 4 (1985).

33. Richard Price, *Baseball Injuries Lead Kids' Hit List*, BOS. HERALD, April 16, 1990, at 39.

34. Even the best of youth baseball pitchers do not display the control of older and mature players. In the 1992 Little League World Series Championship, Long Beach, California, starting pitcher, Ryan Beaver, hit five batters.

35. *See* Price, *supra* note 33.

36. Baseball accounts for 26% of the total number of eye injuries suffered by players between the ages of five to fourteen in all sports and recreational activities. NATIONAL SOCIETY TO PREVENT BLINDNESS, 1991 EYE INJURIES ASSOCIATED WITH SPORTS AND RECREATIONAL PRODUCTS (1992).

ciate the potential danger of facial injuries that may arise in a league game? Given the age, lack of experience, and varying skill levels of players in youth baseball, the assumption of the risk doctrine should not preclude recovery in cases involving facial injuries.

Over the years, courts and state legislatures have recognized the limitations of the assumption of the risk defense and completely rejected or severely limited the application of the doctrine. In *Diker v. St. Louis Park*,[37] the plaintiff, a ten year-old boy, sought recovery from the City of St. Louis for personal injuries sustained when he was struck by a hockey puck while playing goalie on a public ice skating rink.[38] The Minnesota Supreme Court focused on the defendant's reliance on the assumption of the risk doctrine.[39] While the court conceded that the danger of being hit by a puck while playing hockey should be apparent to the mature mind, the testimony revealed that the plaintiff froze and was unable to duck or evade the oncoming puck.[40] The *Diker* court concluded that the boy's age and inexperience attributed to his delayed response and, as a result, he should not be precluded from recovery, as a matter of law.[41] In *Diker*, the court recognized that neither the assump-

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37. 130 N.W.2d 113 (Minn. 1964).

38. *Id.* The hockey puck hit the plaintiff near the eye and the plaintiff sustained serious personal injury. *Id.* The jury returned a verdict of seventeen thousand dollar in favor of the plaintiff and the defendant appealed. *Id.*

39. *Id.* at 118.

40. *Id.* at 119. The court stated that:

> [t]o a person of mature judgment the possibility or even the probability that an unskilled 'goalie' with limited skating ability would 'freeze' in the path of a flying puck would seem to be readily anticipated. However, with respect to a plaintiff not yet eleven, we feel that the jury could find as it did, apparently, that because of his youth he should not be precluded from recovery as a matter of law.

Diker v. St. Louis Park, 130 N.W.2d 113, 119 (Minn. 1969).

41. *Id.* In reviewing the application of the assumption of the risk doctrine, the *Diker* court also examined Farinelli v. Laventure, 172 N.E.2d 825 (Mass. 1961), and Te Poel v. Larson, 53 N.W.2d 468 (Minn. 1952), two contributory negligence cases in which the age of the injured plaintiff was a determining factor in the outcome of the case. In *Farinelli*, a ten year-old girl was injured when knocked down while skating at a roller rink. *Farinelli*, 172 N.W.2d at 825. The court held that the girl was not contributorily negligent, as a matter of law, and that her "conduct must be judged in the light of her immaturity . . . [and] the lack of the [sic] caution and judgment natural to youth." *Id.* at 827. *Te Poel* involved a young boy who was struck by a truck while attempting to cross a county road. *Te Poel*, 53 N.W.2d at 468. In evaluating the defendant's assertion of contributory negligence, the *Te Poel* court noted that "[w]hile [the plaintiff] was a boy of at least average intelligence, he only was 9 1/2 years old. *Id.* at 469. He is chargeable only with that degree of care commensurate with his age and intelligence." *Id.* The court concluded that the jury should have decided the issue of whether the plaintiff acted as an ordinary prudent boy of his age. *Id.*

tion of the risk doctrine nor the contributory negligence theory could be applied using adult standards in cases involving youths.[42] The court's emphasis on the factors of age and experience were central to its conclusion that the ten year-old plaintiff should not be denied recovery as a matter of law.[43]

Rutter v. Northeastern Beaver County School District[44] perhaps best illustrates the courts weakening position on the use of the assumption of the risk doctrine as an effective defense in sport tort cases. In *Rutter*, a sixteen year-old boy suffered a severe injury when he was struck in the eye while participating in a high school summer football practice.[45] At the time of the injury, the plaintiff was playing in a game of jungle football[46] and was not wearing protective equipment. In reversing the lower court's ruling in favor of Northeastern Beaver County School District,[47] the Pennsylvania Supreme Court abolished the assumption of the risk doctrine except in instances of express assumption of the risk, strict liability, or where specifically preserved by statute.[48] Justice Flaherty concluded that the assumption of the risk doctrine caused unnecessary difficulties in its application and was duplicative of more widely understood concepts of duty and contributory negligence.[49]

While many courts have either modified or abolished the assumption of the risk doctrine,[50] a number of state legislatures

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42. *Diker*, 130 N.W.2d at 119.

43. *Id.* at 120.

44. 437 A.2d 1198 (Pa. 1981).

45. *Id.* at 1200. Rutter was injured when a player on the opposing side hit him in the right eye with an outstretched hand, causing blindness due to a detached retina. *Id.* at 1198.

46. The game of jungle football is a variant of two-handed touch football. *Id.* at 1201. Each team had four downs in which to score. *Id.* Once the offensive team snapped the ball, it could throw any number of forward or backward passes until the other team tagged the ball carrier with two hands or a pass fell incomplete. *Id.*

47. Rutter v. Northeastern Beaver County School District, No. 1042 (Pa. Commw. 1972). The trial court held that plaintiff had assumed the risk of injury and that he failed to establish a case of negligence. *Id.* The appellate court affirmed the decision. Rutter v. Northeastern Beaver County District, 423 A.2d 1035 (Pa. App. 1980), *rev'd*, 437 A.2d 1198 (Pa. 1981).

48. *Rutter*, 423 A.2d at 1209. The court cited to the Pennsylvania Worker's Compensation Act which abolished the assumption of the risk doctrine as a defense. *Id.* The statute reads, in pertinent part, that:

> (a) [i]n any action brought to recover damages for personal injury to an employee in the course of his employment, or for death resulting from such injury, it shall not be a defense . . . (b) that the employee had assumed the risk.

71 PA. CONS. STAT. § 41(a)(b) (1982).

49. *Rutter*, 437 A.2d at 1209.

50. *Id.* at 1209, n.5. The *Rutter* Court noted 19 jurisdictions which lessened or com-

have also limited the application of the doctrine through the passage of comparative negligence statutes.[51] The system of comparative negligence creates a general scheme of liability in proportion to fault where the defense is no more than a variant of contributory negligence.[52] The declining acceptance of the assumption of the risk doctrine and the advent of comparative negligence statutes have a positive effect for any future plaintiff seeking relief for a facial injury suffered in a youth baseball game, but the courts still must wrestle with the larger issue of who is ultimately responsible for providing adequate facial protective equipment.

III. THE SIGNIFICANCE OF THE MANDATORY FACIAL PROTECTION REQUIREMENT IN AMATEUR HOCKEY

The issue of who should be responsible for providing protective facial equipment for participants in youth baseball may, in part, be answered by examining the development of the mandatory face mask rule in amateur hockey. Until the early 1970s, amateur hockey leagues paid little attention to the number or frequency of injuries occurring in games or at practice sessions.[53] Even though data documenting the high incidence of eye and facial injuries in hockey was not widely available, the seriousness of the problem was evident. In 1970, Dr. Paul F. Vinger[54] noted that in a single month he treated five patients who had suffered severe eye injuries while

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pletely abolished the impact of the assumption of the risk doctrine. *Id.*

51. H. WOODS, COMPARATIVE LAW, § 6:1, at 134 (2d ed. 1987). States include Connecticut, Massachusetts, North Dakota, Pennsylvania, Oregon, and Utah. *Id.* The Pennsylvania statute states, in pertinent part, that:

> In all actions brought to recover damages for negligence resulting in death or injury to person or property, the fact that the plaintiff may have been guilty of contributory negligence shall not bar a recovery by the plaintiff or his legal representative where such negligence was not greater than the causal negligence of the defendant or defendants against whom recovery is sought, but any damages sustained by the plaintiff shall be diminished in proportion to the amount of the negligence attributed to the plaintiff.

42 PA. CONS. STAT. § 7102 (1982).

52. Li v. Yellow Cab Co., 532 P.2d 1226, 1241 (Cal. 1975).

53. *See* OCULAR SPORTS INJURIES, *supra* note 4, at 83.

54. Dr. Paul F. Vinger is an ophthalmologist and the Director of the Vision Performance and Safety Service at the New England Eye Center. In addition, he is an Assistant Clinical Professor of Ophthalmology at the Harvard Medical School. Dr. Vinger has written numerous articles on sport-related eye injuries and played an integral role in the adoption of the mandatory face mask rule in amateur hockey.

playing hockey.[55] As a result, Dr. Vinger initiated a data collection system at his private practice to monitor eye injury problems in hockey.[56] Also, Vinger began a series of communications with state high school officials and sports administrators in 1971, marking the first organized effort for facial protection in hockey in the United States.[57]

As a result of Dr. Vinger's efforts, the Amateur Hockey Association of the United States (AHAUS) formed the Committee of Safety and Protective Equipment to investigate and consider the adoption of standard safety equipment in 1973.[58] The following year, a survey of 124 Massachusetts high schools revealed 209 eye and facial hockey injuries over a six week period.[59] In early 1975, Dr. Vinger and Dr. Thomas Pashby[60] combined efforts to promote the need for facial protection in hockey throughout North America.[61] Later that same year, the American Society for Testing Materials formed a subcommittee to write a standard for hockey face masks.[62] Despite continued resistance from coaches, face masks were adopted as voluntary protective gear for all Massachusetts high school hockey teams effective at the start of 1975-76 season.[63] During the same season, the Connecticut Amateur Hockey Association promulgated a mandatory face mask rule for all players.[64]

Perhaps the most significant development occurred prior to the 1976-77 season when AHAUS adopted a mandatory face mask rule for the approximately four hundred thousand players participating in Junior Classification or lower.[65] The result of this mandate

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55. *See* OCULAR SPORTS INJURIES, *supra* note 4, at 83.

56. *Id.*

57. *Id.* While leaders in amateur hockey were reluctant to support the use of face masks, presentations made to coaches and athletic directors at a sports medical seminar in Concord, Mass., in 1972, generated a wave of grass roots support for the concept. *Id.* at 84. Dr. Vinger reported that the seminar spawned hundreds of talks and articles that called for the adoption of a mandatory face mask rule. *Id.* Dr. Vinger also noted that supporters were more than balanced by those in opposition to the concept of full face protection in hockey. *Id.*

58. *Id.*

59. *Id.*

60. Dr. Pashby is an ophthalmologist and a member of the faculty of Medicine at the University of Toronto. Dr. Pashby was the principal leader in the movement to require facial protection in amateur hockey in Canada. He currently serves as the chairman of the Technical Committee on Protective Equipment for Hockey and Lacrosse Players, Canadian Standards Association (CSA).

61. *See* OCULAR SPORTS INJURIES, *supra* note 4, at 84.

62. *Id.*

63. *Id.* at 85.

64. *Id.*

65. *Id.* Only paid gate Junior A and Junior B teams were not required to wear a face

sparked a wave of rule changes requiring the use of the hockey face mask. By 1979, almost all United States high school hockey teams were required to wear facial protection.[66] Before the 1980-81 season, the National Collegiate Athletic Association (NCAA) also instituted a mandatory face mask rule for all hockey players participating in intercollegiate athletics.[67] Finally, in October 1980, AHAUS and the Canadian Amateur Hockey Association (CAHA) agreed to honor each other's mask certification standards at all contests between the two nations.[68]

The evolution of mandatory facial protection in amateur hockey spanned a decade, but the necessity for greater protective equipment eventually convinced coaches and players, who held archaic macho attitudes or feared that additional equipment would alter the style of play dramatically, to wear protective equipment.[69] Today, the achievements of those who lobbied for adequate facial protection in amateur hockey are reflected in the widespread use of face masks by both novice players in youth leagues as well as older, experienced players in intercollegiate competition.[70]

Unlike the amateur ranks, the National Hockey League (NHL) and the minor professional leagues continue to resist imposing a mandatory face mask rule, despite the compelling arguments in favor of a mandatory face mask rule made by former victims of eye injuries.[71] One such victim is Hector Marini, a former NHL All-Star with the New Jersey Devils who lost his left eye after being hit by a puck in a minor league game.[72] Only after suffering the injury did Marini consider the importance of a mandatory face shield rule in professional hockey.[73] According to Dr. Vinger, by

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mask. *Id.*

66. *Id.*

67. *Id.* In addition, the NCAA adopted the wire-mesh-mask-helmet combination for goalies. *Id.* The form fitting face mask was banned after the wire-mesh-mask-helmet combination proved to be significantly more effective in preventing injuries. *Id.*

68. *Id.* AHAUS adopted the certification standards of the Hockey Certification Council (HECC) while CAHA abides by those of the CSA.

69. Dr. Paul Vinger et. al., *The Hockey Face Guard: Health Care Costs and Ethics, in* SAFETY IN ICE HOCKEY 58, 61 (C.R. Castaldi and Dr. Earl F. Hoerner, 1989).

70. *See* OCULAR SPORTS INJURIES, *supra* note 4, at 85-86.

71. Craig Neff and Robert Neff, *A Prescription for Safety*, SPORTS ILLUSTRATED, Jan. 13, 1986, at 7.

72. *Id.*

73. *Id.* Marini emphasized that "[i]t seems more apparent than ever that all hockey players should be required to don eye shields. Why I never wore a shield still amazes me . . . It's so easy to lose something so precious." *Id.*

the time the average professional hockey player's career is over he will have suffered 2 lost teeth, 1.1 fractured facial bones, and 15 lacerations requiring sutures.[74] Despite evidence of career ending injuries,[75] professional hockey has yet to recognize the need for facial protection.

The hockey model demonstrates that only league rule changes can properly ensure the wide spread use of facial protective equipment. Evidence of a dramatic reduction in facial injuries in amateur hockey is testimony to the impact of a mandatory face shield rule. In the ten years following CAHA's mandatory rule requiring the use of face masks by all minor hockey players, not a single eye injury had been recorded by a player wearing a certified face protector.[76] It is clear that the mandatory use of the face shield has directly lead to the almost complete elimination of all eye and face injuries in amateur hockey.[77] Without similar league requirements in youth baseball, macho attitudes and false fears will continue to prevail over safety considerations.

IV. The Duty of Care in Youth Baseball Leagues

The continued presence of facial injuries in youth baseball presents a real threat of legal action against youth leagues who fail to mandate the use of proper safety equipment. In examining the viability of a negligence action against a youth baseball league, the central issue is whether the defendant was under a duty to conform to a particular standard of conduct in light of the apparent risk.[78] In determining this issue, the court must consider whether the defendant could reasonably foresee that a failure to take reasonable

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74. Frank A. Mastrangelo, *Eye and Face Injuries in High School Hockey Cutting Down Risks*, *in* SAFETY IN ICE HOCKEY 52 (C.R. Castaldi and Dr. Earl F. Hoerner eds., 1989).

75. *See* Neff, *supra* note 71. One such incident involved Pierre Mondou of the Montreal Canadiens. Mondou was poked in the left eye in a game against the Hartford Whalers in March 1985, and he retired from hockey the following year with impaired vision.

76. Tom Pashby, *Epidemiology of Eye Injuries in Hockey*, *in* SAFETY IN ICE HOCKEY 30 (C.R. Castaldi and Dr. Earl F. Hoerner eds., 1989).

77. According to Dr. Vinger:

> [e]ye and face injuries accounted for two-thirds of all injuries in ice hockey prior to the introduction of the mandatory eye and face protector. The [widespread] use of these protective devices has eliminated eye and face injuries while keeping the fun and appeal in the game.

PAUL F. VINGER AND EARL F. HOERNER, SPORTS INJURIES 127-28 (2d ed. 1986).

78. *See* PROSSER AND KEETON, *supra* note 8, at § 53.

care would likely result in injury to the plaintiff.[79] The court must balance a number of factors in determining whether such a duty exists. The court must consider (1) the likelihood of the injury, (2) the magnitude of the burden of guarding against it, (3) the consequences of placing the burden on the defendant, and (4) public policy considerations.[80] When applying these factors, a convincing argument can be made that youth baseball leagues have a legal duty to protect their players from the threat of facial injuries.

A. The Statistical Likelihood of Injury

While few comprehensive studies documenting the frequency of facial injuries in baseball exist, objective evidence is available that reveals the severity of the problem. In 1981, the United States Consumer Product Safety Commission (CPSC) released a major study examining sport-related injuries.[81] The CPSC report focused on injuries to persons five to fourteen years of age in fourteen selected sports.[82] The results of the study revealed significant safety risks to children playing youth baseball.[83] The CPSC reported that youths suffer an estimated 359,400 medically attended baseball injuries annually.[84] In addition, the study estimated 121,700 annual hospital emergency room-treated baseball injuries in which forty percent were to the head and face, the highest percentage among all body parts.[85]

In 1984, the CPSC published a more concentrated study focusing on youths five to fourteen years of age participating in orga-

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79. *Id.*

80. *Id.* at n.24. *See* Vu v. Singer Co., 583 F. Supp. 26, 29 (N.D. Cal. 1981), *aff'd,* 706 F.2d 1027 (9th Cit. 1983), *cert denied,* 464 U.S. 938 (1983), and Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 342 (Cal. 1976).

81. UNITED STATES CONSUMER PRODUCT SAFETY COMMISSION, OVERVIEW OF SPORTS-RELATED INJURIES TO PERSONS 5-14 YEARS OF AGE (1981).

82. *Id.* at 1. The Commission chose the 5-14 age group because it closely approximates the ages of elementary and junior high school children and is a standard age grouping for data used in statistical reports. *Id.* at n.1. The fourteen sports in the study included were baseball, basketball, football, golf, gymnastics, hockey, lacrosse, racquet sports, soccer, tetherball, track and field, trampoline, volleyball, and wrestling. *Id.* at 1.

83. *Id.* at 7. Study results revealed that baseball injuries accounted for 29% of all sport-related injuries in the specified age group. *Id.*

84. *Id.* at 1. The study derived estimates of medically attended injuries by multiplying estimates of emergency room-treated injuries by factors based on the National Center for Health Statistics, Health Interview Survey. *Id.* at n.2.

85. *Id.* at 31. The National Electronic Injury Surveillance System (NEISS) provided the estimates of emergency room treated injuries.

nized baseball and softball.[86] The report estimated that hospitals treated 86,500 children for baseball injuries in 1983.[87] Thirty-four percent of all these injuries were related to the head and face.[88] Although the 1984 study did not include an analysis on the impact of safety equipment, it did recognize that face protection for batters and runners could reduce the incidence of facial injuries, which occurred at nearly three times the rate as head injuries in organized play.[89]

More recent reports demonstrate that the risk of facial injuries to children playing youth baseball continues to be significant. The United States Eye Injury Registry (USEIR)[90] reported that in Alabama, twenty-three percent of those suffering severe eye injuries while playing baseball were hit by a thrown ball.[91] The 1990 Consumer Product Safety Commission Product Summary Report[92] revealed that hospitals treated approximately one hundred and forty thousand children between the ages of five and fourteen for injuries while playing baseball.[93] George Rutherford, the principal author of the 1981 and 1984 CPSC reports, estimated that nearly half or 40,600 of the injuries suffered by children in organized baseball were a result of being struck by the ball.[94] Rutherford noted that of those children struck by the ball, forty-six percent or 18,700 of

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86. *See* UNITED STATES CONSUMER PRODUCT SAFETY COMMISSION, *supra* note 1.

87. *Id.* at 2. The estimates only included emergency room-treated injuries. *Id.*

88. *Id.* at 5.

89. *Id.* at 16.

90. The USEIR is an eye injury surveillance system serving 28 states and four international states. Voluntary reports by ophthalmologists to state ophthalmology society-sponsored eye injury registries provided data on serious eye injuries involving significant and permanent structural or functional damage. Presently, data collection is continuing and the USEIR can only provide preliminary statistics. This article refers to data collected by the Eye Injury Registry of Alabama, established in 1988. While only 2,072 eye injuries exist in the data base, this population may provide some insight into the frequency and severity of eye injuries to children playing youth baseball.

91. EYE INJURY REGISTRY OF ALABAMA, BASEBALL/SOFTBALL INJURY REPORT (1992).

92. UNITED STATES CONSUMER PRODUCT SAFETY COMMISSION, PRODUCT SUMMARY REPORT (1990). The Product Summary Report is an annual compilation of data derived from product associated injuries treated in the emergency rooms of hospitals that participate in NEISS. *Id.*

93. *Id.* Similar to prior CPSC studies, these injuries were only estimates based on baseball injuries treated in hospital emergency rooms. The injury figure includes both organized and informal baseball. *Id.*

94. George Rutherford, Address at the National Summit for Safety in Youth Baseball and Softball (Sept. 6-7, 1991) (transcript available from the United States Consumer Product Safety Commission). Rutherford based his remarks on data obtained from the CPSC 1990 Product Summary Report. *Id.*

the children sustained injuries to the head and face.[95] A breakdown of the 1991 CPSC report illustrates that baseball accounted for more eye injuries to youths ages five to fourteen than any other sport.[96]

Despite the varying difference in the number of eye injuries reported by the CPSC from 1981-91, it is clear that the data available significantly underestimates the frequency of the injuries. The CPSC injury estimates are based only on injuries treated in emergency rooms at selected hospitals participating in the National Electronic Injury Surveillance System (NEISS).[97] According to Dr. Vinger, specialized eye care hospitals or family physicians treat a large majority of eye injuries.[98] While more precise data is needed,[99] the CPSC information reveals that facial injuries in youth baseball significantly outnumber those in all other sport-related activities.[100] Though Little League officials have consistently disputed the published data on facial injuries in youth baseball,[101] the CPSC studies have all concluded that the likelihood of suffering a facial injury while playing youth baseball is significantly greater than even the most physical contact sports.[102] It is not a coincidence that both amateur hockey and football require the use of protective facial equipment.

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95. *Id.*

96. NATIONAL SOCIETY TO PREVENT BLINDNESS, *supra* note 36. Baseball accounted for the highest percentage total, 26.4%, of eye injuries among the fourteen selected sports in the five to fourteen year-old age group. *Id.* The next highest percentage totals were in basketball, 10%, and football, 8.4%. *Id.* The large gap between baseball and the other sports accentuate the need for safety measures to reduce the high incidence of eye injuries in youth baseball.

97. The NEISS estimates are calculated from a sample of hospitals which statistically represent institutions with emergency treatment departments located within the United States and its territories. *See supra* notes 81-85.

98. Telephone Interview with Dr. Paul F. Vinger, Ophthalmologist, Harvard Medical School (Mar. 14, 1993).

99. Unfortunately, the CPSC and USEIR represent the only two major organizations involved in monitoring eye and/or facial injuries in baseball.

100. NATIONAL SOCIETY TO PREVENT BLINDNESS, *supra* note 36.

101. *Little League Safety Record, Injuries Decried on "20/20"*, DET. FREE PRESS, July 21, 1981, at 2F. Mr. Nestel contacted the Little League Baseball offices in Williamsport, Pennsylvania, but the League would not disclose or discuss any of its internal data concerning injuries in Little League Baseball sponsored games.

102. *See supra* note 96 and accompanying text.

B. The Burden of Providing Protective Facial Equipment

Whether a defendant has a duty to exercise reasonable care in protecting the plaintiff against injury is partially dependent on the magnitude of the burden of guarding against such injury and the consequences of placing this burden on the defendant.[103] One method of assessing the burden is through an economic or cost-benefit analysis. In *United States v. Carroll Towing Co.*,[104] Judge Hand provided a formula, B<PL,[105] which compares the benefits of safety precautions to the costs of accident avoidance. Due to the lack of data available on the number and average cost of facial injuries in youth baseball, it is not possible to provide a precise application of the Hand formula. However, based on the injury information currently available, the Hand formula can be useful in evaluating whether youth baseball leagues have a duty to require facial protection.

In applying the Hand formula to the youth baseball model, the burden of protecting against accidents, B, is measured by the cost of providing the protective face guard. Assuming it costs $15.00 to equip each of the team's seven batting helmets with a face guard,[106] the average cost per player on a fifteen person team is approximately seven dollars.

Determining the right side of the Hand formula equation is more difficult. Based on an annual estimate of fifty thousand injuries to the face and head[107] among the eight million[108] participants ages five to fourteen in organized youth baseball, the probability, P, of such an accident occurring is .00625, or slightly above six tenths of one percent. Since studies have not been conducted

103. *See* PROSSER AND KEETON, *supra* note 8, at § 53.

104. 159 F.2d 169 (2d Cir. 1947), *reh'g denied*, 160 F.2d 482 (2d Cir. 1947).

105. *Id.* at 173. Under Judge Hand's formula, B is the burden, or costs of precautions, P is the probability that an accident will occur, and L is the loss if the accident does occur. *Id.* The right side of the equation measures the benefits of accident avoidance while the left side represents the costs of preventing the accident. *Id.*

106. Youth baseball leagues usually require that each team provide a minimum of seven batting helmets. *See* OFFICIAL PLAYING RULES OF LITTLE LEAGUE BASEBALL, *supra* note 2, at § 1.16. The cost figure in this analysis is based on the average retail price of a face guard.

107. This figure represents a conservative estimate of the number of facial injuries occurring annually in youth baseball. Rutherford noted that in 1990 approximately nineteen thousand facial injuries occurred based on the limited data collected from NEISS. *See* Rutherford, *supra* note 95.

108. *See* UNITED STATES CONSUMER PRODUCT SAFETY COMMISSION, *supra* note 1 and accompanying text.

analyzing the average medical costs of facial injuries in youth baseball, it is necessary to look at related data collected in youth hockey. In 1982, Dr. Harriet G. Tolpin and Dr. Judith Bentkover estimated that the average cost of an eye injury in hockey was $1,586.[109] Not accounting for the significant increase in health care costs over the past decade, this analysis will apply the same average injury cost used by Dr. Tolpin and Dr. Bentkover. Using these conservative estimates, the benefits of accident avoidance, $9.91,[110] exceed the cost, $7.00, of providing facial protection for each player. As a result, requiring youth baseball leagues to provide facial protection places only a minimal burden on the leagues. Much of the costs of participating in a youth baseball league is subsidized by team fundraisers. While Little League Baseball argues that the cost of requiring facial protection is too great,[111] the reality is that each participant needs only to raise an additional $7.00 in order to ensure adequate facial protection and prevent serious injury.[112]

C. Public Policy Considerations

As a matter of public policy, those who sponsor youth baseball leagues should be responsible for ensuring that the game is safe for the players. Youth leagues have recognized the importance of requiring batting helmets and protective catcher gear.[113] While the face guard is Little League approved, it is only worn on a voluntary

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109. DR. PAUL F. VINGER AND DR. EARL F. HOERNER, SPORTS INJURIES: THE UNTHWARTED EPIDEMIC 46 (2d ed. 1986). The doctors relied on findings from a 1972 study performed by Dr. Vinger, who collected the data from a study of 38 ocular injuries suffered by hockey players during a three-year period. *Id.* Dr. Tolpin and Dr. Bentkover converted the cost figure from Dr. Vinger's study into 1980 dollars. *Id.* The cost figure only reflects the direct costs and does not include indirect costs. As a result, Dr. Vinger's cost figure does not purport to represent the total average cost of an eye injury in hockey.

110. The benefits of accident avoidance is the product of the probability, P, of an accident occurring and the loss, L, if the accident does occur. *See supra* note 105 and accompanying text. In the example, .00625, P, is multiplied by $1,586, L, to arrive at the benefits of accident avoidance.

111. *See* Fortuna, *supra* note 6, at 1E, 8E. The Little League's argument is unconvincing when one considers the higher cost of providing face shields for players in amateur hockey. Despite a cost of $36.00 per face shield, nearly two and a half times the cost of a baseball face guard, amateur hockey has maintained a mandatory face shield rule successfully for the past decade. *Id.*

112. Local businesses will likely contribute the additional funding knowing that their support will have a favorable impact on the safety of the game.

113. *See* OFFICIAL PLAYING RULES OF LITTLE LEAGUE BASEBALL, *supra* note 2, at § 1.17.

basis. Without a league rule, those players or teams that voluntarily choose to wear face guards may be subject to ridicule and taunting from their fellow peers. Requiring all teams to provide face guards would eliminate any stigma associated with wearing added protective equipment. Additionally, in leagues where errant throws and pitches, sometimes exceeding seventy miles per hour,[114] are an inherent part of the game, protective equipment must be provided to ensure the safety of these novice players. In all sports, organizers of youth leagues must have a duty to ensure safety first.

VI. CONCLUSION

Despite the reluctance of most youth baseball leagues to adopt a mandatory face guard rule, the looming threat of legal liability may force the leagues to respond. In June 1992, a twelve year-old boy, Billy Rowe, filed a $1.1 million lawsuit against Little League Baseball for facial injuries suffered when Rowe was hit by a thrown ball during a Warwick Little League team scrimmage on May 19, 1991.[115] While the Little League continues to deny the need for required facial protection in youth baseball,[116] the Warwick Little League responded to the Rowe incident by adopting a mandatory face guard rule at the beginning of the 1992 season.

While amateur hockey avoided similar court battles by implementing a mandatory face mask rule, Dixie Youth Baseball is the only major youth baseball organization to approve rule changes requiring face guards in its baseball and softball leagues.[117] The new rule will be fully implemented by 1995 and will impact over two hundred and forty-three thousand players under the age of

114. *Dixie Leagues' Decision to Use Mask a Wise One*, ATL. J. & CONST., Nov. 1, 1992, at 12.

115. *Lawsuits*, NEWSDAY, June 25, 1992, at 147. Rowe was struck in the eye by an errant throw while running to first base. *Id.* The injury fractured the floor of the orbit on the left side of Rowe's face. *Id.* Despite a successful operation, it is not expected that Rowe's vision will be completely restored. *Id.* Rowe's case is presently pending before the Orange County Supreme Court in New York. *Id.*

116. Woody Anderson, *Playing It Unsafe in Little League*, HART. COURANT, July 14, 1991, at C1.

117. Mayeux, *supra* note 30, at 1H. Dixie Youth Baseball covers eleven southern states, including Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Virginia. Dixie Youth Baseball is one of the largest youth baseball programs in the country, serving boys under the age of 13. Dixie Softball offers recreation softball for girls under the age of 20.

twelve.[118]

Hopefully, the action taken by Dixie Youth Baseball will persuade other youth baseball leagues that the primary responsibility for safety lies with the youth baseball organizations. Unfortunately, the courts probably will be forced to resolve this issue, a situation that does not bode well for the youth baseball leagues.

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118. *Id.*