HEADCHECK HEALTH

THE OVERSIGHT GAP: MINOR HOCKEY SAFETY WHEN SYSTEMS DON'T SUPPORT YOU

A survey of 17 MHA leaders across Canada shows what happens when concussion protocols meet a volunteer-run world.

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Dr. Jennifer Hunnicutt is a licensed athletic trainer with a PhD in Health and Rehabilitation Science who has worked with athletes at all levels, including professionals and Olympians. She has held research roles at Emory Sports Medicine and the NBA Hawks Center and served as a provider for U.S. Figure Skating. Now the owner of Hunnicutt Writing and Consulting, LLC, she partners with global organizations to drive innovation in sports medicine and orthopedics.

EXECUTIVE SUMMARY

You did everything right. The system made the rest nearly impossible.

A survey of 17 Minor Hockey Association leaders across Canada reveals a consistent pattern: the people responsible for player safety are doing the work. The infrastructure available to support them is not keeping up.

Minor Hockey Association leaders across Canada have implemented protocols, trained their volunteers, and communicated expectations. They have done what was asked of them, often on nights and weekends, without pay, on top of everything else.

And yet, in their own words, injuries are discovered after the fact. Reports go unfiled until a parent follows up. Return-to-play decisions vary from team to team depending on who is standing on the bench that day.

This is not a story about people falling short. It is a story about what happens when professional-level safety requirements land in a volunteer-run system with no tools to support them. The Hockey Canada concussion protocol is thorough and well-designed. What it does not include is a way for an MHA leader to know, with certainty, that it is being followed consistently across every team in their association.

What This Guide Covers

This guide focuses specifically on injury tracking, concussion management, and return-to-play compliance. It does not address emergency action plans, abuse reporting, facility safety, or other critical but distinct safety domains.

About This Research

The findings in this guide draw from two sources:

1. MHA Leader Survey (February 2026)

- Participants: 17 leaders from Minor Hockey Associations across Canada.
- Roles included: Presidents, Executive Directors, Head Trainers, and Risk Managers.
- Method: Quantitative and qualitative survey.

2. Qualitative Analysis of MHA Leader Responses

- Each MHA leader rated their association in a number of areas on a quantitative scale and then was asked open-ended questions about how safety actually works in practice.
- Their answers revealed a consistent gap: systems that sound robust on paper break down in real-world, volunteer-driven environments.
- This report compares the numeric self-ratings with the themes and specifics that emerged from those open-ended responses.

Why this matters: This is an evidence-based look at what actually happens across Canadian minor hockey associations based on what leaders themselves told us, not just what they hoped was happening.

THE STATE OF PLAY

The Visibility Gap:
What Leaders Couldn't See Before

Most Minor Hockey Association leaders are deeply committed to player safety. They report feeling "good" about their systems because they have done the work to put protocols in place. The challenge is not a lack of effort. It is a lack of visibility into what actually happens across every team, every game, every injury.

Across key areas including training, compliance, and adherence to protocols, the majority of MHA leaders rate their approach as "good."

But when those same leaders were asked open-ended questions about how safety works in practice, a very different picture emerged.

88% of MHA leaders rate their overall safety effectiveness as "good." However their own open-ended descriptions of day-to-day execution reveal that those systems function poorly in practice. Training tells a similar story: while 65% of MHA leaders believe their staff are sufficiently trained, their own answers show that execution falls short. The pattern continues across compliance and adherence.

This is not a marginal gap. It is a fundamental misalignment between perception and visibility. What this tells us: MHA leaders are left to estimate compliance because they do not have metrics that capture real-world execution. Their own words reveal that visibility is the true gap. These are not motivation problems. They are measurement problems.

Comparison of MHA Leader Quantitative Self-Ratings vs. Qualitative Open-Ended Responses

MHA Leader Self-Assessment

	Good	Needs Improvement	Poor
Overall Effectiveness	88%	6%	6%
Training Sufficiency	65%	35%	0%
Compliance Tracking	59%	23%	18%
Adherence to Return-to-Play Protocols	70%	24%	6%
Communication	53%	47%	0%

For the full results, see Appendix A

Qualitative Summary

- **Volunteer Adherence and Tracking:** Protocol effectiveness is hampered by reliance on volunteers, lack of consistent buy-in for safety info sessions, and difficulty tracking volunteer competency. Injuries are often not reported, meaning proper protocol adherence cannot be confirmed.
- **Gap Between Elite and Grassroots Levels:** While elite streams excel at injury management, often with the help of Athletic Therapists (ATs), effectiveness falters at the grassroots level where coaches are volunteers and teams only have safety persons, not ATs.
- **Need for Simplicity and Education:** Current procedures are overly complex and should be simplified. There is a need for more education for both bench staff and parents.
- **Opportunity for Improvement:** The leaders recognize that there is always room for improvement and the ability to implement new procedures.

Data Deep Dive

Diving deeper into the open-ended responses reveals a more nuanced story.

Why "Good" Feels Right But Leaves Gaps

- Many MHAs rate their injury management protocols as "good," but their own descriptions reveal a lack of confidence in how those protocols function in practice.
- As one leader noted, "We do have procedures in place to be higher [in our self-rating], but we rely on our volunteers to adhere to it."
- This reflects a broader pattern: policies may be well-defined, but their effectiveness depends heavily on consistent execution at the team level. Execution relies on volunteers, and therefore "good" becomes difficult to sustain.

The Compliance Paradox

- Leaders frequently identify compliance as an area that "needs improvement," yet many still believe that protocols are being followed in most situations.
- At the same time, they acknowledge a critical limitation: they lack reliable ways to track whether those protocols are actually being followed.
- Without clear visibility into what is happening across teams, compliance becomes an assumption rather than a measurable outcome.

The Communication Breakdown

- Communication is often cited as a strength, with email serving as the primary method for sharing injury management protocols and updates.
- However email is inherently reactive and relies on people to read it and retain it.
- Leaders recognize the limitations of this approach. The result: injuries and incidents are often reported after the fact.

Beyond Inefficiency: The Privacy Risk of Email

When injury reports, baseline assessments, or medical clearance forms are sent via standard email (particularly through US-hosted providers like Gmail or Outlook), that health information may be stored on servers outside Canada.

For associations subject to PIPEDA or provincial health privacy laws, this creates potential compliance exposure. A centralized, Canada-hosted system eliminates this risk while solving the tracking problem.

What Hockey Canada Actually Requires

Hockey Canada's Concussion Protocol (updated 2025) lists out requirements for all members including but not limited to these areas:

1. **Pre-season education mandate:** All players, parents, coaches, trainers, safety personnel, and officials must review and submit a signed Pre-season Concussion Education Sheet before the first practice or game.
2. **Immediate removal and red flag action:** Any player with a suspected concussion must be removed from activity immediately; if red flag symptoms (e.g., loss of consciousness, seizures, worsening headache) appear, call an ambulance and do not move the player.
3. **Mandatory medical referral:** When no licensed healthcare professional is on site, a player with suspected concussion must be referred to a medical doctor or nurse practitioner for diagnosis as soon as possible.
4. **Structured return-to-sport with medical clearance:** Before progressing to non-contact training (Step 4), players must complete the Return-to-School Strategy (if applicable) and provide a Medical Clearance Letter from a medical doctor or nurse practitioner. Each step requires a minimum 24 hours.
5. **Documentation and reporting responsibility:** The player or parent/guardian must provide the Medical Assessment Letter (diagnosis) and Medical Clearance Letter to coaches, safety personnel, and association administrators for injury reporting and surveillance.

In order to track if these requirements are being met, most MHA leaders rely on memory, paper forms, or email. Few could easily confirm that all five were being met consistently across all teams .

Key Takeaways from the Data

The good news is that MHA leaders are aware of the challenges within their systems. And in many cases, they are openly acknowledging where things are breaking down.

The gap lies in translating that awareness into systems that can support consistent, real-time execution across an entire association.

So how can associations close this gap?’

A Note to Our Readers

If you are a Minor Hockey Association leader reading this, you have likely already done the hard work: you have implemented protocols, trained volunteers, and communicated expectations. You have done what was asked of you.

The gaps described in this guide are not evidence of neglect. They are evidence of a system that asks volunteers to do professional-level actions without professional-level tools. You are not the problem. The infrastructure gap is.

The associations that close this gap are not "smarter" or "more compliant." They simply added visibility where none existed before.

FROM INSIGHT TO ACTION: RETHINKING PLAYER SAFETY

The data shows that improving injury management is not about adding more policies. It is about adding visibility. MHA leaders are not failing. They are flying blind.

Across Minor Hockey Associations, three system-level patterns emerge that separate inconsistent safety practices from those that are more reliable and effective.

01

Pillar 1: Solving the "Volunteer Burden" Problem

Across Minor Hockey Associations, player safety depends heavily on volunteers. And that dependency creates risk.

What Leaders Are Experiencing

- "Volunteer time to implement all of these things" remains a consistent challenge.
- Ensuring consistent execution across dozens of teams is difficult to manage at scale.

What the Data Reveals

- When qualified staff are present, injury reporting is more consistent.
- When responsibilities fall to volunteers, reporting becomes significantly more variable.

What This Means

- This is not negligence. It is inconsistency.
- Volunteers are being asked to perform professional-level responsibilities without the systems to support consistent execution.

What High-Performing Associations Do Differently

- Reduce reliance on memory and prevent burnout by guiding volunteers through protocols step-by-step.
- Implement systems that standardize reporting and decision-making across teams.

02

Pillar 2: Scaling Expertise Across the Association

Across associations, one pattern is clear: when qualified medical staff are involved, safety outcomes improve.

What Leaders Are Experiencing

- Athletic therapists are consistently identified as key drivers of effective injury management.
- Some leaders note that a head therapist role is "more important than a head coach" in ensuring player safety.

What the Data Reveals

- Trained professionals enable faster injury recognition, more accurate reporting, and more consistent return-to-play decisions.
- Outcomes improve significantly when medical expertise is present.

What This Means

- This is a scaling problem.
- Even the most experienced professional cannot be at every rink, creating a gap between elite and grassroots levels.

Note for Smaller Associations

Not every association can afford or access an athletic therapist. Alternatives include:

- Designating a non-medical Player Safety Lead trained in the process of injury tracking.
- Pooling resources across 2 or 3 small associations to share a consulting safety director.
- Starting with a tracking system first. You cannot improve what you cannot measure.

The goal is not to become a professional sports organization. The goal is to stop missing injury reports. Start there.

What High-Performing Associations Do Differently

- Establish a Head Trainer or Director of Safety role. Ideally a medical professional, but for smaller associations a dedicated non-medical Safety Lead who owns the tracking process.
- Equip this role with tools that give them the ability to "be everywhere at once."

03

Pillar 3: Closing the "Find Out Later" Gap

Across associations, one theme is consistent: injuries are often identified after the fact. As one MHA leader said: "We find out later on many occasions injuries are not reported."

What Leaders Are Experiencing

- Injuries and incidents are often identified after the fact.
- Enforcement of protocols is expected but difficult to verify in practice.

What the Data Reveals

- Without consistent tracking, compliance depends on individuals rather than systems.
- Injury reporting is often incomplete or delayed when not standardized.

What This Means

- This is an accountability gap, not just a communication issue.
- Accountability requires proof. Email chains and paper forms are not acceptable.
- If incidents are not documented in real time, there is no reliable way to confirm whether protocols were followed.

What High-Performing Associations Do Differently

- Shift from informal reporting to centralized, real-time tracking systems.
- Create a structured record of incidents and return-to-play protocols across all teams.

THE 20% SOLUTION: BUILDING AN INFRASTRUCTURE FOR OVERSIGHT

Across the data, Minor Hockey Association leaders are requesting:

1. Volunteer Support (Pillar 1)
2. Qualified Staff (Pillar 2)
3. Oversight (Pillar 3)

But these outcomes cannot be realistically achieved when each team operates independently.

The key takeaway from this research:
The gap lies in infrastructure.

High-performing associations close this gap by implementing a shared system that connects teams, standardizes processes, and creates real-time visibility across the entire organization. Instead of relying on individuals to remember, interpret, and execute protocols, they build environments where protocols are guided, tracked, and reinforced consistently.

In practice, this means shifting from a collection of teams operating independently to a single accountable system.

Associations that have made this shift report:

- Fewer "found out later" incidents
- Reduced administrative burden on volunteers
- Clearer insurance claim documentation
- Better communication between coaches, trainers, and parents

THE NEXT STEPS FOR YOUR ASSOCIATION

This report has outlined the visibility gap and the three pillars that separate inconsistent safety practices from reliable ones.

The question is not whether your association has protocols. The question is whether you can see that they are being followed on every team, for every injury, every time.

For a deeper look at how associations are closing this gap including real-world examples, specific tools, and a step-by-step implementation framework, request the companion guide:

The Oversight Shield: Real-Time Concussion Tracking Without the Paperwork
Download the full playbook, including case studies, assessment rubrics, and a free oversight review offer.

This report was produced using survey responses and follow-up interviews with MHA leaders across 17 associations. For questions or to participate in future research, contact marketing@headcheckhealth.com

HEADCHECK HEALTH

THANK YOU

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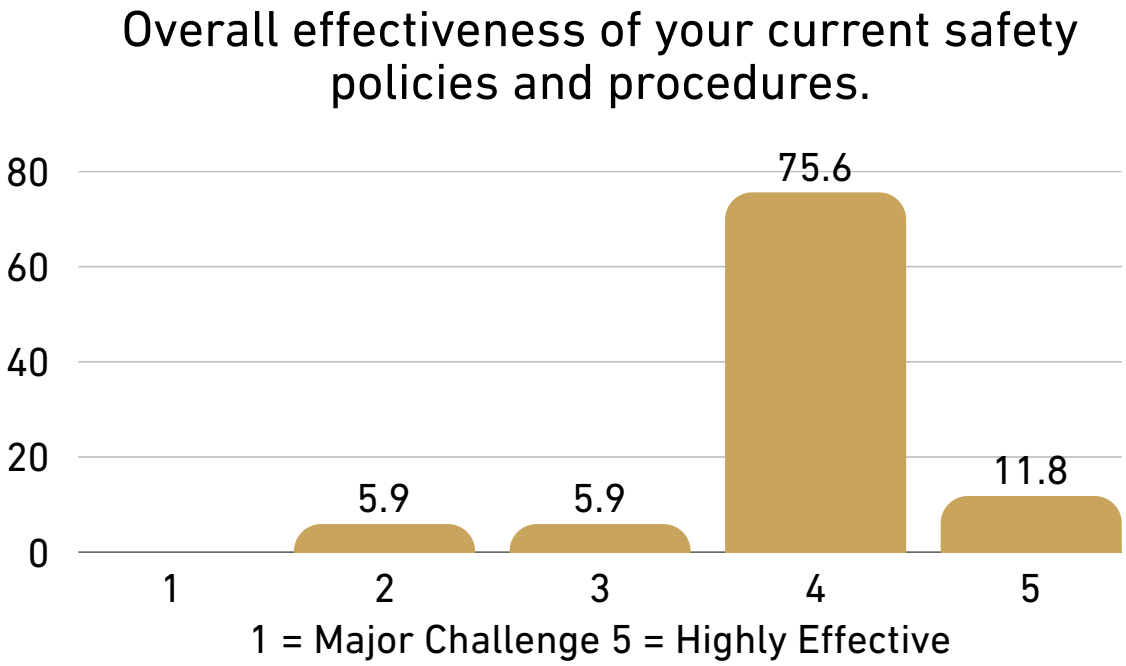
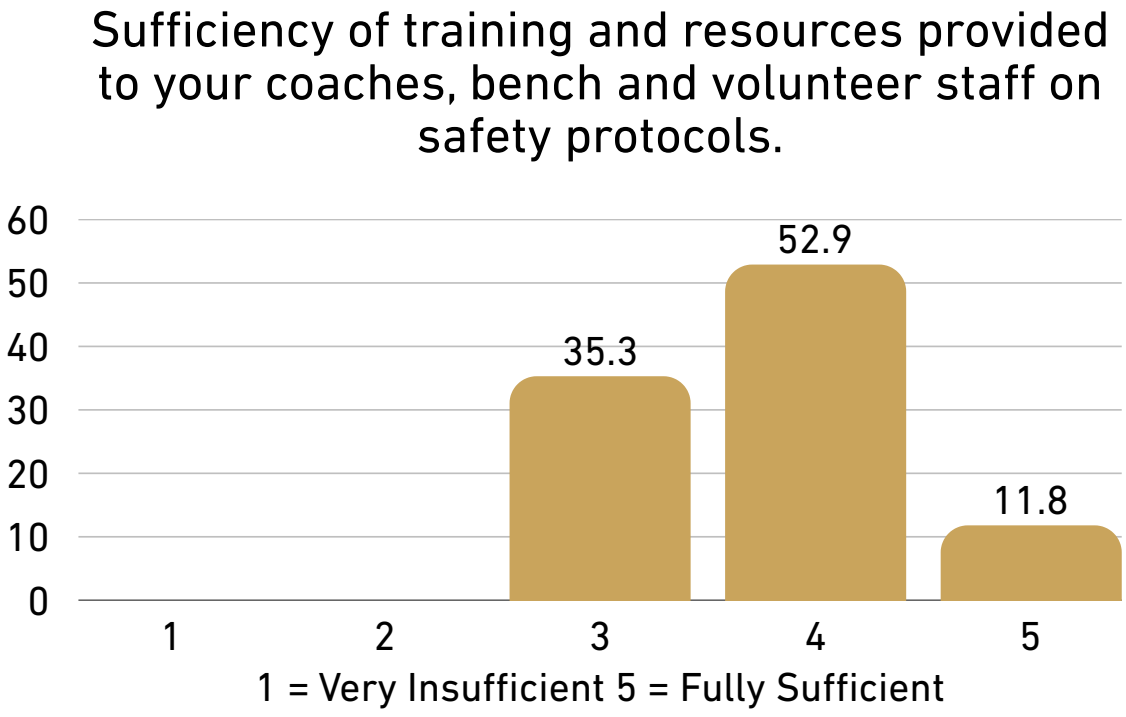
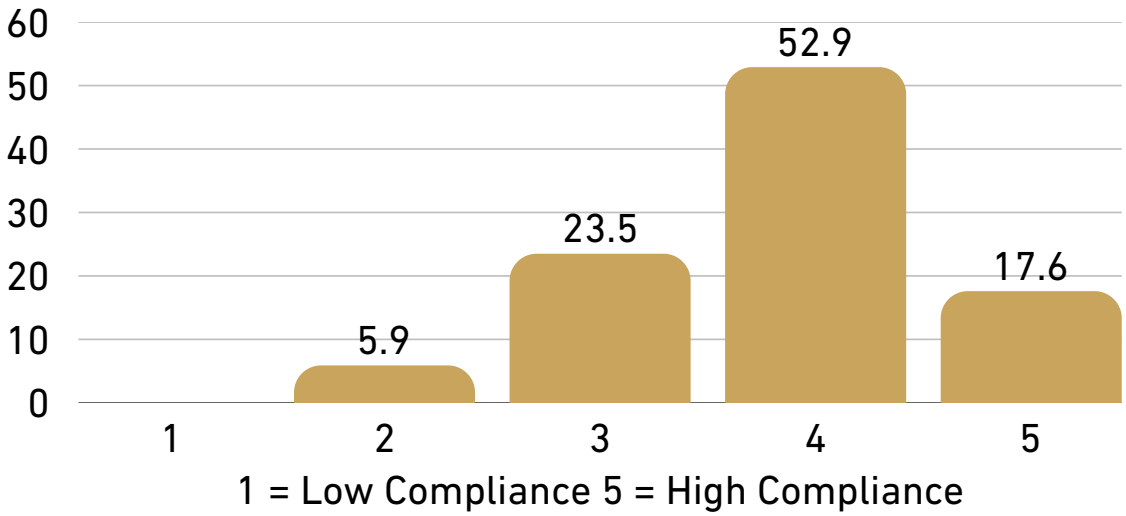
MHA Leader Self-Assessment Results

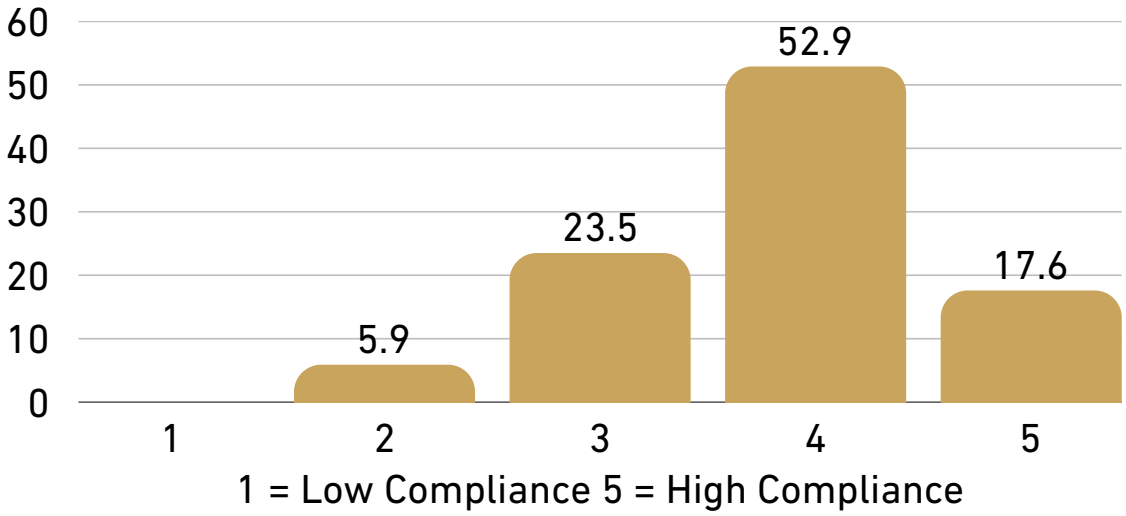




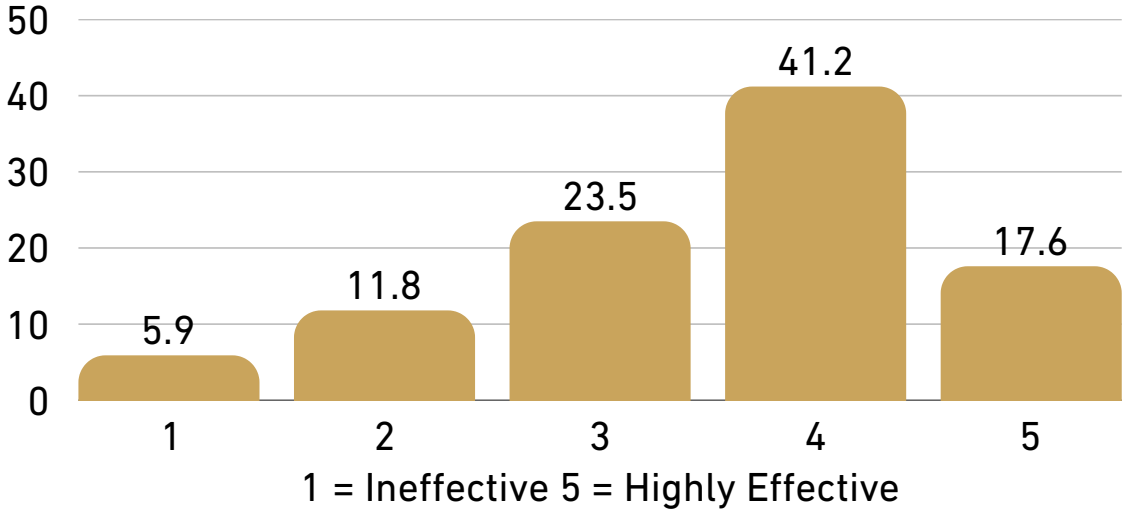
Level of compliance and adherence to safety protocols by your staff during the season.



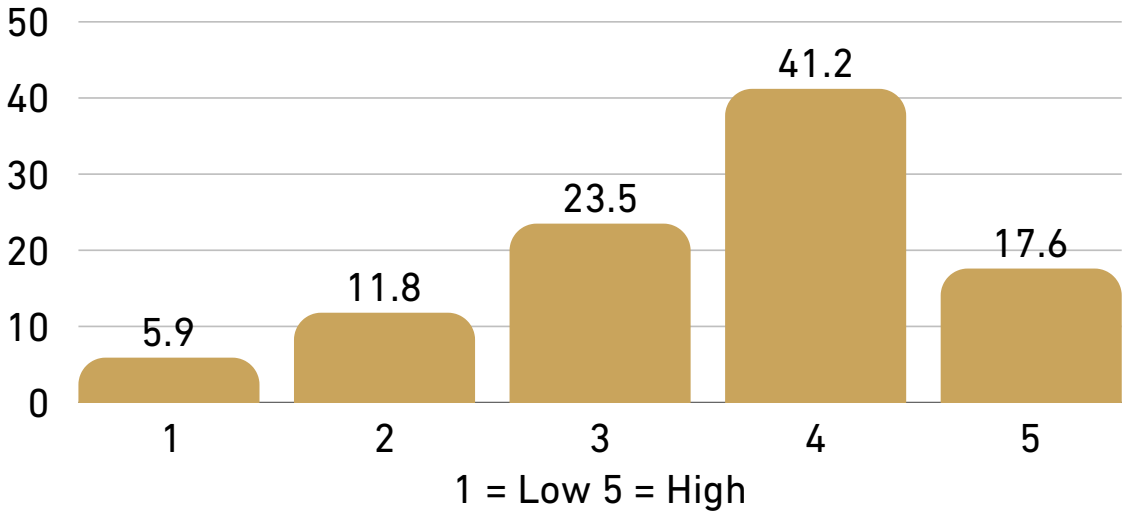
Level of compliance and adherence to safety protocols by your staff during the season.

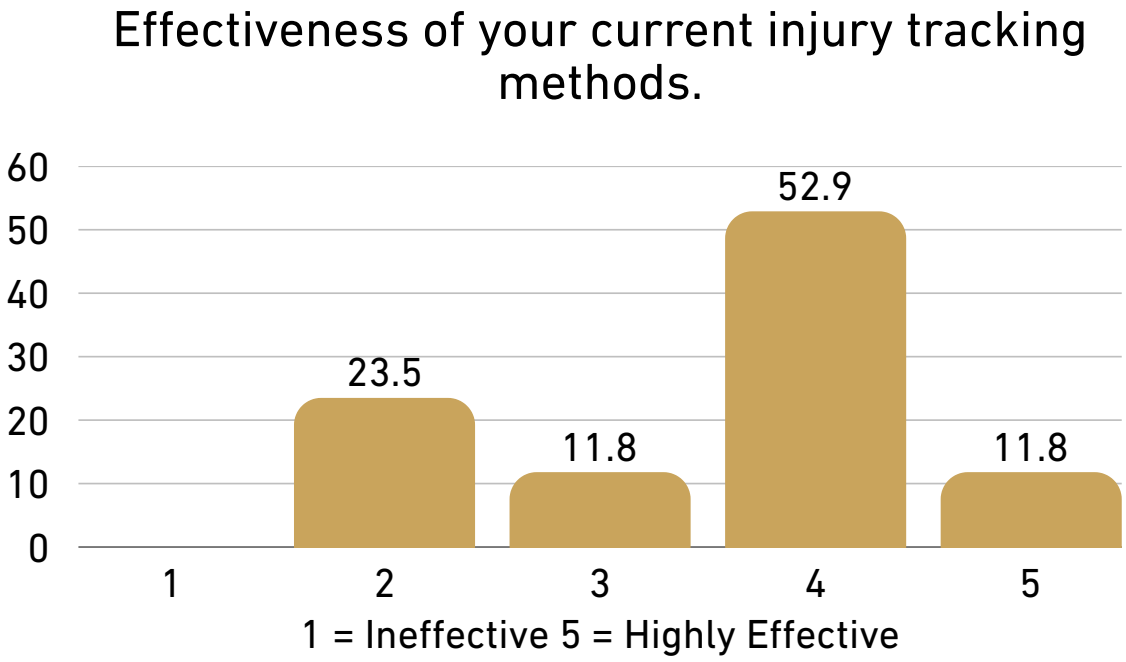


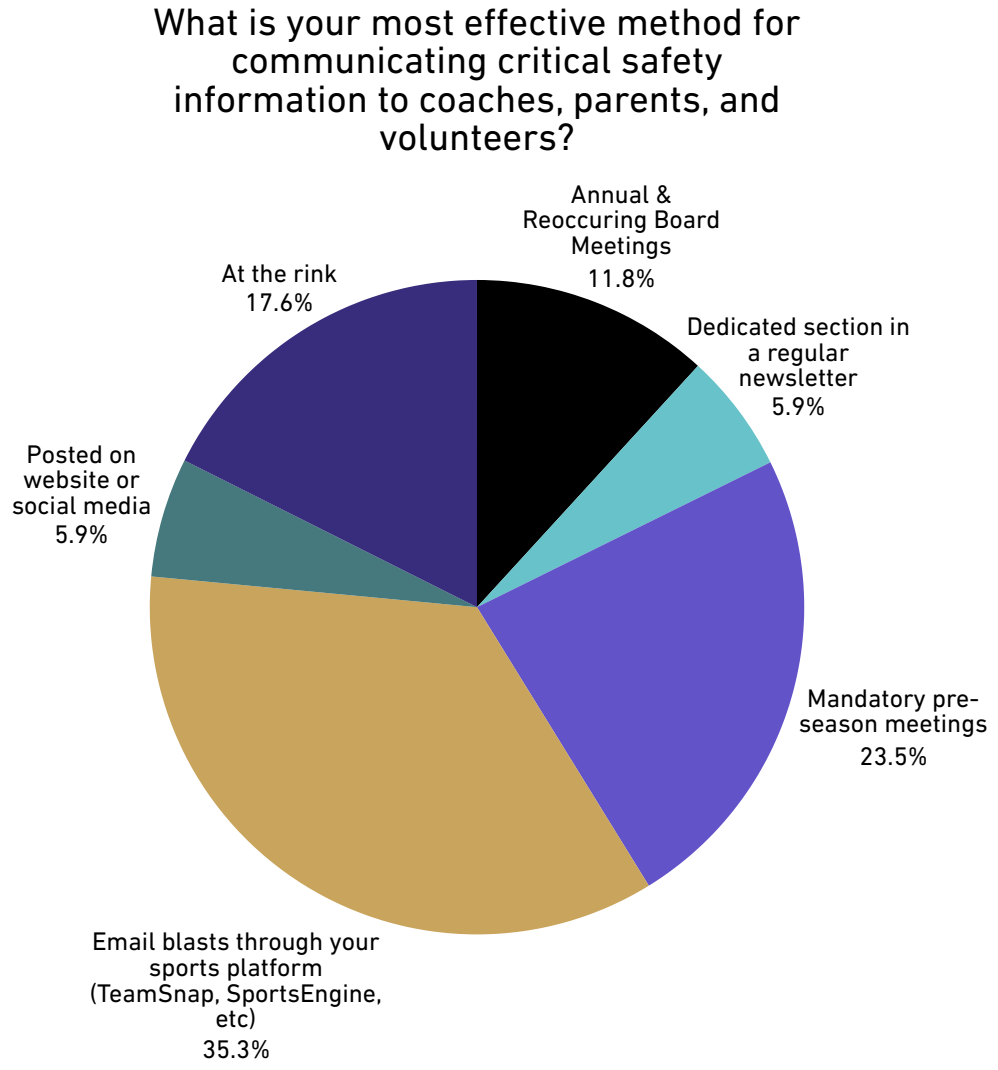
Effectiveness of communication between leadership and parents regarding safety issues and protocols.

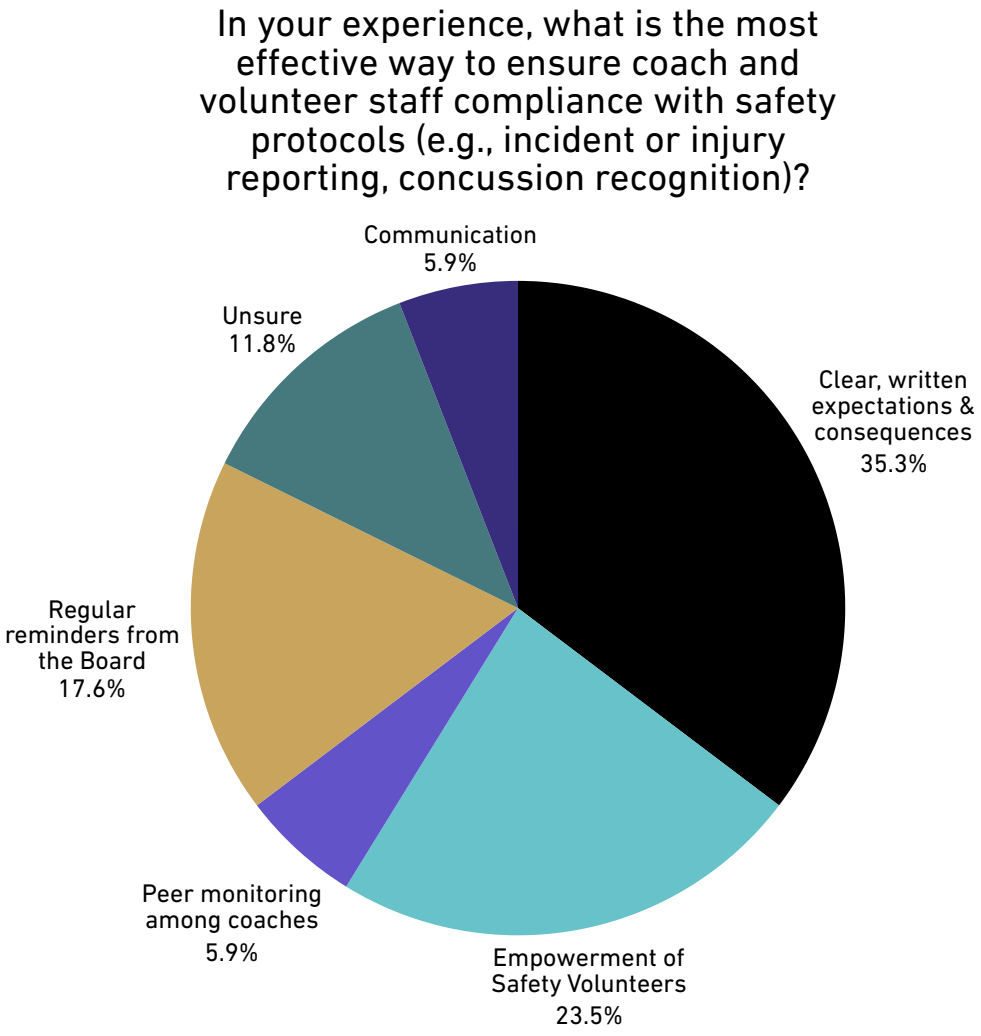


Level of your ability to track of compliance and adherence to safety protocols by your staff during the season.




Effectiveness of your current injury tracking methods.
60
50
40
30
20
10
0
52.9
23.5
11.8
11.8
1
2
3
4
5
1 = Ineffective 5 = Highly Effective


What is your most effective method for communicating critical safety information to coaches, parents, and volunteers?
Annual & Reoccuring Board Meetings 11.8%
Dedicated section in a regular newsletter 5.9%
Mandatory pre-season meetings 23.5%
Email blasts through your sports platform (TeamSnap, SportsEngine, etc) 35.3%
Posted on website or social media 5.9%
At the rink 17.6%


In your experience, what is the most effective way to ensure coach and volunteer staff compliance with safety protocols (e.g., incident or injury reporting, concussion recognition)?
Communication 5.9%
Unsure 11.8%
Clear, written expectations & consequences 35.3%
Regular reminders from the Board 17.6%
Peer monitoring among coaches 5.9%
Empowerment of Safety Volunteers 23.5%