Predominant experiences with and perceptions of the RAN process in the Head Start community

Background

OHS has reported to NHSA and the Head Start community that there has been a significant uptick in the number and severity of reported health and safety incidents, which often triggers OHS conducting a RAN review. At the same time, NHSA has increasingly heard from members of the Head Start community that the RAN review process has become confusing, frustrating, and difficult to navigate. Many have shared that they believe this review process and the approach OHS has taken around health and safety incidents over the last two years have created a culture of fear and frustration among the workforce resulting in growing mistrust between OHS and grant recipients, and distracting from their ability to work proactively to prevent these incidents from happening.

NHSA had the opportunity to work closely with OHS a decade ago when OHS worked diligently to improve the monitoring process from an "I gotcha" mentality to a more transparent and timely process that identified both the strengths and weaknesses of individual grant recipients. Since those significant improvements were implemented to the planned FA1 and FA2 reviews, grant recipient directors have continued to express satisfaction with the FA1 and FA2 process because, in general, it is seen as a fair and balanced process. Conversely, the reporting process around child health and safety incidents and the following RAN process has become deeply destabilizing, unclear, and unfair in its approach.

Everyone in the Head Start community, including OHS, NHSA, and grant recipients, wants to see significant health and safety incidents rooted out so that no child is ever harmed within Head Start classrooms. With that as a baseline assumption, the following summarizes the major repeated concerns NHSA has heard, includes direct quotes where appropriate, and offers possible solutions for OHS to explore now and as new Program Performance Standards and subsequent changes to the monitoring process are considered, finalized, and implemented. This document is intended to provide feedback, insights and recommendations specifically related to reporting health and safety incidents, including those that do not result in a RAN review.

Summary of Concerns

1. The RAN process lacks timeliness, transparency, and clarity, leaving grant recipients – and individual staff – in long periods of deep uncertainty and stress.
2. The RAN process is inconsistent with safety science, relying on measures that, while intending to boost child health and safety, are not based on research.
3. There is no differentiation between one-time, quickly corrected errors and more significant systemic incidents; oversight should also allow for staff growth and learning from less than best practice behavior.
4. There is confusion about the application of different definitions that OHS uses.
5. The data that has been reported nationally has been sensationalized and does not tell the complete picture of health and safety within Head Start grant recipients. This is having a negative impact on Head Start's overall reputation in the external community as well as a deep impact on staff morale.

Concerns

The following section summarizes the major concerns and questions NHSA has heard from leaders in the Head Start community. This is not an exhaustive list, but one focusing on repeated or multiple concerns raised by grant recipients in different regions and by different types of grant recipient.

1. The RAN process lacks timeliness, transparency, and clarity, leaving grant recipients – and individual staff – in long periods of deep uncertainty and stress.

The mental toll of this on directors and staff is difficult to quantify, but it is significant, enduring, and unnecessarily demoralizing.

> **In their words:** "First of all, we didn't even know we were involved in a RAN review. We got no notice. There was an incident I reported in September, a couple weeks after school started, and it came back with no finding of child abuse. But in March, we received a notification in HSES that a RAN review was conducted in November, and it was determined that we now had a deficiency, and that we had to do an immediate corrective action plan in 3 days!
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> When I inquired how we could have a review and not even know about it, I was told that it was conducted virtually based on the information I submitted from the reporting. No one ever talked to me during this process. And then I was told that we were selected for a RAN review from a random number system based on a computer algorithm.
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> This has been extremely stressful for us ever since. We are all on edge, stressed out, and it has impacted our entire agency morale. We feel very betrayed by Head Start with this process."

After an incident is reported to the regional office, there is no established timeline for OHS to complete the review/investigation. Months can go by without any communication after the initial report is made. Reports are often issued 4-12 months after the incident. In contrast, state licensing investigations are generally completed and reports/findings issued within 45 days. States' findings often differ from OHS findings and often have far fewer consequences. It's unsettling for grant recipients to receive the outcome of the state investigation, in a timely manner, where no major issues are found, and then to receive the OHS report, up to a year later, designating a recipient as deficient.

Grant recipients have little knowledge of what happens after a health and safety incident is reported to the regional office. They do not experience any exchange of information with OHS about an incident. Written information as requested by the regions (or by OHS via the regions) is sent to the RAN process but few know what that actually means. Some recipients have been told after notifying the region of an incident that "no further action" is necessary but the regional staff will not put that comment in writing.

> **In their words: "**At our RAN meeting, we requested to see the notes that were being sent forward to central office to make a determination on what type of action they were taking. We wanted to make sure that what was being sent forward fully reflected what we shared with them. We were told no. When we received our report back with the findings, inaccurate information was in the report. When

we had our meeting with our Program Specialist to review the findings, we asked if we could record the meeting so that our Board chairperson, who was present at the meeting, could share it with other Board members. We were told no. When we received minutes back from the meeting, it was clear that either the meeting was recorded or transcribed due to the level of detail and direct In their words: s from those of us who spoke at the meeting. This was done without our knowledge."

Worse, when recipients are told no further action is required, several have shared that they were shocked to receive a deficiency report months later. One grant recipient shared that they received a deficiency determination with one sentence: "the teacher struck the child." They felt that they received very little context or relevant detail to fully understand the situation and why it rose to the level of a deficiency.

In contrast, when state licensing and/or child welfare systems investigate, as is often required in these incidences, actual visits are typically made to the grant recipient within a few days of reporting the incident, and the investigator conducts several interviews and is able to gather valuable data, which provides context surrounding the incident, including whether it was an intentional act or not.

In their words: "In March 2024, we received a letter stating we had been in a review in November of 2023 thanking our board and policy council for their participation. However, we were found in non-compliance because of a situation that was reported. An EHS teacher put a child in timeout and had them pulled by the arm. The child was not hurt, but it was an unacceptable action that in our policies and procedures results in termination for pulling, pushing, pinching, etc. a child by or on the arm. She was terminated immediately. The parent was notified and was understanding. We also notified licensing and reported in HSES within the required timeframe. No one called to discuss this and there was no review in November 2023 as stated, and the board and parent council were not involved in any way. Yet we are now going to be monitored due to this review that didn't happen. We were told it was a uniform letter but that the incident was still considered in non-compliance even though we followed all the regulations and policies."

In their words: "I recently had a RAN interview after several incidents occurred at one of our sites. I received no communication about the review ahead of time. My program specialist called and asked if I had time to jump on a video call with her and someone else about one of the incidents. I did, and so I joined the call a few minutes later. Only then did I realize that the purpose of the call was the RAN interview. Since I did not have time in advance to pull up relevant documents, they asked me to submit those via HSES correspondence after the call was over. I have submitted the requested information and have not yet received any kind of response. The first incident occurred in January 2024. The RAN interview took place in June.

I am used to less than desirable responsiveness from our regional office. However, it seems like something as serious as a RAN Review would be more of a priority and would involve more communication."

2. The RAN process is inconsistent with safety science, relying on measures that, while intending to boost child health and safety, are not based on research.

The approach taken by the Administration on RAN has created a stressed and zero error culture that is not consistent with the latest research in safety science.

As described by Casey Family Programs, "**safety science** involves applying scientific methods, research, and tools to understand, assess, and manage safety. In the context of child protection, this means using an evidence-based approach to inform preventive and responsive actions, rather than basing policy and practice decisions on emotion or assumption. When we employ safety science, we identify and apply lessons learned based on the best available research and evidence.

Experts in the field of safety science seem to agree that organizational culture is an important piece of the puzzle. **Other safety critical industries have recognized that a culture of fear and blame does not promote learning from error, and it can result in decreased organizational effectiveness and compromised safety.** Today, research is increasingly available to guide child protection agencies in creating a **safety culture** that is more effective in protecting children from harm. This includes balancing individual and system accountability by examining system factors."

This does not appear to be the approach being taken at the present time, which is creating a stressed environment leading to unintended negative outcomes that will not ultimately result in a climate of greater health and well-being for the children in Head Start.

In their words: "One thing I found particularly distressing about my meeting with the Program Manager and the person who oversees reviews is that what the person who oversees reviews seemed to care about most was showing to the OIG that they are intervening on these situations and disciplining programs. That to me reads like in order to prove their worth, they are out to get programs. I thought that attitude went away 10 or so years ago. Clearly it's back. I'm also concerned that this approach is going to keep programs from reporting in the future because they have made it such a difficult and contentious process."

In their words: "The need to report every child incident, even if the lapse was for a second, is creating a toxic work environment for the front line staff, but also for us as leadership. It's very demoralizing. It creates a culture of fear and blame and staff are scared to work here if it means that their personal actions or inactions, even if it just happened once, can cause the agency to go into recompetition. We eventually cleared the deficiency, however, it created a lot of extra work, took an insurmountable amount of time and lots of pressure. I found myself wanting to retire early or find another job away from Head Start. I don't think it's fair to have the actions or inaction of a single teaching staff member reflect badly on the entire agency and entire staff.

We are now turning to **safety science**. I think that the OHS needs to invest in current programs and provide programs with quality safety science training if they are wanting to support us. This is the training we are getting that I think that the OHS should provide for programs: www.collaborative-safety.com/. It was highly recommended by our Board Chair who works in a similar industry and has had that training in his company and has had positive effects.

3. There is no differentiation between one-time, quickly corrected errors and more significant systemic incidents; oversight should also allow for staff growth and learning from less than best practice behavior.

The current RAN process appears to overlook the importance of context – when an incident is caused by an individual staff's shortcoming, mistake or lack of knowledge about best practice vs. a deeper grant recipient-wide problem. This is an important distinction especially since prevention of future incidents is a primary goal of the RAN process. If an incident is due to an individual staff's misstep, then the grant recipients should be held accountable for how they and their internal systems dealt with such an incident. If, however, the review determines that the issue is with internal systems or processes not aligned with best practice and the Head Start Program Performance Standards, then the accountability should rise to a different level of accountability. This differentiation is not clearly present in the current reporting process.

> **In their words:** "It is demoralizing and bad business practice to punish the programs who self-report incidents, and RAN does not consider how the program addressed it. The correct way to handle it is to evaluate how the program handled the incident. Human error is real."

> **In their words:** "We self-reported a teacher popping a child on the bottom, provided video, terminated the teacher, collected documentation from a witness, notified the parent, notified Policy Council and Board, and reported it to our state licensing. The state found "no substantial finding". Head Start (RO) began the process of putting us "on trial", assigning TTA folks that were more concerned about how we worded the Plan of Action and meeting with us about 5 times (talking down to us), and it took almost 13 months before we were notified that the corrective action was approved or cleared. No one wished this to happen. We train our staff on CA/N, mandatory reporting, positive guidance, Standards of Conduct, encourage "Tap Out" if staff get frustrated or need a break, monitor classrooms, provide systematic and intensive coaching to staff, and do not tolerate mistreatment or punitive action with children. We terminated the staff immediately and had all staff sign Standards of Conduct forms along with providing virtual training on CA/N. The whole process was horrible, time-consuming, took way too long and so disrespectful.

4. There is confusion about the application of different definitions that OHS uses.

Using the Office of Head Start's RAN Informational Session powerpoint on ECLKC and RAN Review for FY24 as references, grant recipients have shared that they have ongoing questions and areas of confusion about how to apply the definitions to the situations they are confronting.

a. **Emergency Incidents**
   Emergency Incidents include physical abuse that is intentional, sexual abuse, and serious child injury. While all three are understandably deemed as "emergency," there may be circumstances in which an event may be considered a "serious child injury" and yet also be accidental through no fault of the grant recipient or their staff.

In their words: "We know how important gross motor play contributes to children's physical and cognitive skills and we know accidents can happen during gross motor play, even when children are well supervised. We are so fearful of the consequences of reporting a safety incident, even when it's a clear cut accident, that we are cutting back on gross motor activities and we know that's not best practice."

b. Significant Incidents

As written, the definitions of several of the five types of Significant Incidents (verbal or emotional abuse; neglect; inadequate supervision; unauthorized release; and inappropriate conduct) are overly broad, leading to deep uncertainty as to what constitutes a significant reportable incident. Does the term *"significant incident"* mean the incident must be reported but the incident could result in a deficiency, or ANC or no finding?

- "*Inappropriate conduct:* Any behavior of interaction between an adult and child/ren that is not best practice." This area is very concerning – no one is able to meet a standard of perfection in their jobs every hour of every day. What happens when the staff's interaction with the child was less than optimal but in no manner harmful or abusive but just not best practice? Even the labeling of not-best-practice moments as "inappropriate conduct" is stigmatizing, and implies something far beyond the minor incidents that are swept up in the definition. Further, would this be a reportable incident, and considered significant?
- Beyond obvious cases, what else may constitute *"verbal or emotional abuse"* given how it is defined to mean when the adult's actions or inactions cause harm to a child's psychological or intellectual functioning? This area is nebulous and, without more clarity and practical examples, grant recipients will remain confused.

We also note that these definitions are not consistent with proposed revisions to the Standards of Conduct in the NPRM (1302.90), which include overly broad definitions of prohibited staff behavior, such as a prohibition on "emotionally harmful or abusive behavior, defined as behaviors that harm a child's self worth or emotional well-being." On its face, this prohibition would include telling a child it's time to head in from the playground if it results in tears.

In their words: "It takes a while to really get to know our kids' personalities and temperaments. Some children are very resilient while others may be more sensitive and fragile. A child feeling badly or crying, especially in the beginning of the school year, can happen but that doesn't mean that the teacher was emotionally abusive."

c. Substantial or Systemic Failure

Despite every effort, sometimes significant lapses occur, including those that impact a child's health or well-being. Grant recipients that have policies and procedures in place and can demonstrate that they responded appropriately, and that there is no additional underlying root cause (e.g. lack of staff training), should not be considered to have a Systemic Failure.

The issue of whether or not there is a root cause behind a lapse in judgment or procedure is causing grant recipients to put on a show with a flurry of activity to demonstrate responsiveness

that can be seen by the reviewer as corrective action. While sometimes these steps are necessary, often grant recipients are taking a “more is more” approach, resulting in hours of work, whose value is unclear, for them and for federal staff.

In their words: “A parent made a complaint against a male teacher and inappropriate behavior with her daughter. Our policy is to immediately remove the employee from the classroom and place on administrative leave pending the outcome of an investigation. This was reported to licensing, Department of Children's Services (who do the official investigation), and in HSES. We had two teachers and a foster grandparent in the classroom plus cameras. It took DCS 3 months to get the investigation completed and determine it was an unfounded accusation. This determination was reported to licensing and in HSES. However, we were still required to have a meeting with our program specialist to determine a root cause of this incident. We explained there was no "root cause" due to the fact that it was an unfounded accusation per DCS. OHS is going to continue investigating this and said it could still result in a FINDING! How can it be a finding if we followed all the correct procedures, and the "experts" (DCS) said it didn't happen? We were still made to go through all the questions of the root cause meeting anyway and still don't know what OHS will decide.”

5. The data that has been reported nationally has been sensationalized and does not tell the complete picture of health and safety within Head Start grant recipients. This is having a negative impact on Head Start’s overall reputation in the external community as well as a deep impact on staff morale.

The OIG report states that “1 in 4 grantees over a 5 year period (Oct. 2015 - May 2020) had an adverse finding, encompassing 1,029 individual incidents.” However, to put this in perspective, this is about 200 incidents per year across the entire country, and includes incidents where a child was not harmed. Meanwhile, over this period of time, several *million* children were served by Head Start and Early Head Start, in over 55,000 classrooms across the country.

While we do not dispute the numbers of incidents being reported and do not want to minimize the seriousness of some incidents, the use of data is only showing a one-dimensional view of health and safety that lacks context. For example, in Florida in 2023, there were 17 findings in 58 programs (42,718 slots) – two were significant (one abuse and one egregious lack of supervision of a child with disabilities) while the other 15 involved issues such as errors in reporting, staffing issues, finance, and supervision during transition times.

We have also heard that active supervision has significantly reduced the number of “lack of supervision” violations (such as a child left on a bus) as well as the average length of time involved in each, or releases to an unauthorized person. Is this true? Also, how many “lack of supervision” incidents resulted in harm to the child?

In their words: “Last year was the WORST year of my entire Head Start career which spans over 20 years now. Last year, we self-reported several unsupervised child incidents where children were not harmed and we got hit with a deficiency. Prior to this, in the last several federal reviews we have not

had any findings. Our financial audits are clean. We are a high functioning program that happens to hire human beings to work in our classrooms. We train diligently on child safety and have strong monitoring systems in place, however, as leadership, we are at the mercy of human beings forgetting policies or inadvertently leaving kids unsupervised for a few minutes due to a variety of reasons."

We have also heard what many in the Head Start community consider the possible causes of this increase in reported incidents. Potential reasons might include teacher churn which is reducing the quality of interactions between children and teachers; increased use of cameras capturing more interactions; pandemic-related impact on children and families; higher ratios compared to a few years ago; and changes in reporting rules. If we are going to prevent future incidents, it is critical to analyze and understand, in partnership between OHS and the Head Start community, what is truly going on in programs and communities, and the society at large.

In their words: "Because of our high number of vacancies, we are frequently having to close classrooms providing inconsistent operations for children and families. This is increasing the number of challenging behaviors in the classroom, increased stress and burnout for staff, which then causes staff turnover. It's a vicious cycle."

In their words: "The amount of physical aggression children are exhibiting along with lack of impulse control is driving many staff from the profession and field. Numerous children are still in diapers at the age of 4 or even 5. We have had excellent new teachers 'retire' from the field in a few years' time due to the behavior challenges."

Finally, it is also important to understand what is going well and whether there were any areas of improvement and/or growth over the past 10 years. These data can help tell a more full picture of the reality, what improvements have been made and why, and help the T/TA system focus on the most important areas where training is needed.

Recommendations

The following section includes potential solutions to the challenges shared above. These suggestions come from the Head Start community and, while not exhaustive or complete, could help alleviate the detrimental impacts of the current system.

1. **The RAN process lacks timeliness, transparency, and clarity, leaving grant recipients – and individual staff – in a period of deep uncertainty and stress.**

   Possible solutions:

   - Speed up the review process.
   - Set timeline goals for the process that are shared with grant recipients – and meet them.
   - Have a process for identifying and resolving straightforward incidents at a more rapid timeline.
   - Have a process of providing status updates on a regular and predictable basis.

- Provide notice when an incident will not move forward through the RAN process, instead of leaving the grant recipient in limbo after a reported incident.
- In the initial RAN review and follow-up RAN review, OHS should be clear what actions the grant recipient must take to achieve full correction.

2. **The monitoring process is inconsistent with safety science, relying instead on measures that, while intending to boost child health and safety, are not based in research.**

   Possible solutions:
   - Reassess the RAN process through the lens of safety science, examining whether penalties for errors are proportional to the violation and whether a climate of fear and mistrust is hindering the ultimate goal of improving child health and safety.
   - Publish the research basis for whatever RAN policies and procedures OHS has committed to implementing.

3. **There is no differentiation between one-time, quickly corrected errors and more significant systemic incidents; preventing staff growth and learning when less than best practice behavior has occurred.**

   Possible solutions:

   Adjust the RAN process to:
   - Distinguish between human error/staff behavior that was okay but not best practice (and was corrected) from more egregious incidents and not require reporting of the former;
   - Require – and enforce – rapid resolution of singular incidents that were swiftly and fully corrected;
   - Clearly distinguish between a significant one-time incident and systemic failure; and
   - Provide written statements of acknowledgement when there are no findings so that grant recipients are ensured the issue is closed.

4. **There is confusion about the application of different definitions that OHS uses.**

   Possible solutions:
   - A “serious child injury” should not automatically be considered a deficiency, but rather, should be based on the facts and circumstances surrounding the event, including the grant recipient’s subsequent actions post-event.
   - Revise the definition of inappropriate conduct such that it allows for less than best practice behavior, including a degree of human error and a learning opportunity on the part of the adult.
   - Clarify the full extent of what may constitute “verbal or emotional abuse” as well as what does not.
   - Define the difference between significant one-time failure (also known as a “substantial failure”) and significant incident, acknowledging that an incident may indeed be significant, including those resulting in harm to a child, while also not being considered “systemic” in nature.

- Provide examples when a one-time occurrence results in a systemic deficiency. Grant recipients do not understand how a one-time incident could have a systemic cause or two incidents several years apart in entirely different locations.
- Create a category of “no root cause” events that reduces the burden of busywork forms of corrective action, or when there were no findings but the protocol requires a root cause.

5. **The data that has been reported nationally has been sensationalized and does not tell the complete picture of health and safety within Head Start grant recipients. This is having a negative impact on Head Start’s overall reputation in the external community as well as a deep impact on staff morale.**

   Possible solutions:
   - Examine ways to present monitoring data with more nuance and context, instead of solely from a deficit-based perspective. For example, include areas of improvement, areas of growth over time, and/or separate out incidents where a child was harmed vs when they were not from the overall number of reported incidents.
   - Assess what is causing the increase in incident reporting, and whether the proposed response – more reporting – will actually improve health and safety.

Conclusion

NHSA appreciates the opportunity to share these concerns and possible solutions with OHS and the federal government. In conducting our conversations, we remain impressed by the dedication of the Head Start community to identifying achievable solutions that will improve services and safety of children in our classrooms. NHSA is eager to help strengthen the partnership between OHS and the Head Start community through this work and we hope that these concerns are taken into consideration as decisions are made about potential changes to the Head Start Program Performance Standards.