Review of Childhood Lead Poisoning Prevention Program

OFFICE OF THE COMMON COUNCIL – CITY CLERK

LEGISLATIVE REFERENCE BUREAU

SCOPE - I

This memorandum outlines the management of the Childhood Lead Poisoning Prevention Program (CLPPP) by the Milwaukee Health Department (MHD) prior to January 17, 2018, when the Mayor Tom Barrett reported preliminary data to the Steering and Rules Committee suggesting services had not been properly provided to Milwaukee children with elevated levels of lead in their blood during the 3-year period from 2015 to 2017.

SCOPE -- II

- Forty-four interviews with 26 people.
- Analyzed data on CLPPP operations.
- Analyzed “raw data” on MHD operations.
- Analyzed data provided by the Municipal Court.

FINDINGS

- Lack of reliable data for analysis.
- Failure to use enforcement powers.
- Insufficient regard for state-mandated service delivery.
- Management deficiencies – reporting, reliance on STELLAR, verification of preliminary EBLLs & locating EBLL children.

TIMELINE

- October 6, 2017 - Meeting to address inadequate nurse training.
- Nov. 21 or 22 - Commissioner informed of possible EBLL service-delivery failures.
- December 13 - AIM report.
- January 4, 2018 - MHD staff report to Chief of Staff.
- January 5 - MHD & mayoral staff meeting.
- January 8 - Meeting with the Mayor and the Commissioner and staffs.
- January 11 - Commissioner resigns.

EARLY DATA

- Preliminary mixed with confirmed test results.
- January 11 or 12, 2018, separated data suggest a 3.8% service-delivery failure vs. initial suggestions of 55.1%.
- MHD 17th and 31st reports suggested a 1.6% service-delivery failure.

STATE STATUTE

- Monitor the development and growth of children reported with EBLLs.
- Inspect properties linked to a EBLL child for lead hazards.
- Ensure identified lead hazards are abated.

SERVICE DELIVERY FAILURES I

1. MHD audit of 320 EBLL cases found 119 (37%) lacked paper files of inspection.
2. Wisconsin Department of Health Services audit of 491 EBLL cases.
   - No orders to abate lead hazards identified in 13 (18%) of the 72 cases reviewed.
   - No Public Health Nurse (PHN) site visits were conducted for 21 (19%) of the 108 EBLL cases reviewed.
   - No paper file or STELLAR entry for 7 (6%) of the 108 EBLL cases reviewed.

SERVICE DELIVERY FAILURES II

Data extrapolated by LRB from STELLAR

- No inspector assigned to 27% of EBLL cases between 2015 to 2017.
- Lead hazards identified in 39 properties in 2015 and 2016 had not been abated by yearend 2017.
- No records of inspection results for 140 properties (2015-2017) referred for inspection.

FAILURE TO ENFORCE

- Inspection entry.
- Failure to use enforcement powers.

	2013	2015	2017
Abatement orders		77	34
Citations issued		46	1
Direct abatements	12	3	0

DEFICIENCIES in SERVICE DELIVERY I

1. Ignorance of, or disregard, for State-mandated obligations.
   - Winter order compliance exemption
   - HSA substituted for PHN & LRA for EBLLs between 15-19 µg/dL
   - Closing cases when “trending nicely downward”.
   - Failure to use direct abatement powers.
2. Misguided policy decisions.
   - Cessation of citation issuance.
   - Failure to use property entry powers.

DEFICIENCIES in SERVICE DELIVERY II

Deficiencies in management.

- Lack of reporting of program results
- Reliance on STELLAR as an operations management tool

LACK OF INITIATIVE

- Confirmations of preliminary test results
- Locating of EBLL children
- STELLAR workaround

RECOMMENDATIONS - I

- Require specific, regular management reports.
- Identify when enforcement powers should be initiated.
- Use an investigator to locate difficult-to-find children. .

RECOMMENDATIONS II

- Verify the domicile of lead-poisoned children.
- Verify reported preliminary EBLL test results.
- Go door-to-door to encourage blood-lead testing in high incidence areas.
- Educational campaign for landlords to promote blood-lead level testing of tenant children.
- Install window liners instead of replacement windows.