Wisconsin Division of Criminal Investigation

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Reporting LEO:	**Jones, Shannon D (Milwaukee Special Assignments DCI / Wisconsin Division of Criminal Investigation)**
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Narrative begins on the following page.

On Friday, June 22, 2018, a meeting was held at the WI DOJ-DCI Milwaukee Field Office regarding an investigation of the City of Milwaukee Health Department (MHD), specifically as it related to its Childhood Lead Poisoning Prevention (CLPP) Program. The initial investigation had been conducted by Milwaukee County District Attorney Investigator (Inv) Robert Stelter. Present at this meeting were DCI Administrator Brian O'Keefe (now retired), DCI Eastern Region Director Ryan Shogren, DCI Milwaukee FO SAC David Klabunde, DCI SAs Shannon Jones and John Culver, and DA Inv Stelter. During the meeting, Inv Stelter provided general background information, including a State of Wisconsin Department of Health Services (DHS) report dated May 31, 2018, summarizing its review of the MHD CLPP Program. At the conclusion of the meeting, it was decided that the WI DOJ-DCI Milwaukee Field Office would continue this investigation, with DA Inv Stelter assisting, into potential criminal violations associated with the MHD CLPP Program.

The Milwaukee Health Department Childhood Lead Poisoning Prevention Program

According to an organization chart provided to DCI, MHD was organized into five different divisions, one of which was the Division of Disease Control and Environmental Health. The Disease Control and Environmental Health was divided into five different divisions, one of which was the Home Environmental Health (HEH) Division. HEH was responsible for the MHD CLPP Program, which was also known as the Lead Hazard Reduction Program.

The prevention strategy of the CLPP Program was, and still is, separated into two primary areas: primary prevention and secondary prevention.

The primary prevention program aims to mitigate lead hazards before a child becomes exposed. In addition, the program corrects hazards after exposure, through measures such as replacing windows. Federal grant funding is available for these purposes through the U.S. Department of Housing and Urban Development (HUD).

The secondary prevention program seeks to minimize adverse effects after MHD learns that a child has been lead poisoned. Through this program, MHD conducts investigations of the environment where the child lives (known as environmental investigations or environmental assessments), and seeks to mitigate the health risk to the child through nursing case management.

When a child was discovered to have an elevated blood lead level (EBLL), this was reported to the MHD for follow up by a Lead Risk Assessor and a Public Health Nurse. The child's name, address, and levels were then entered into a computer database referred to as Systematic Tracking of Elevated Lead Levels and Remediation (STELLAR). Thereafter, MHD was supposed to monitor the child and assess their environment for lead hazards. Some of the hazards could be

remedied on the spot, while others required the issuance of an order by MHD, directing the property owner to take certain remedial action in a specified period of time.

According to Wisconsin state statute, through authority delegated from DHS, MHD must conduct an environmental investigation in dwellings where there has been a report of a child under 6 years old with an EBLL. (Wis. Stat. § 254.166.) The Wisconsin Childhood Lead Poisoning Prevention (WCLPP) Program administered by DHS has established guidelines for local health departments when conducting these investigations. The investigation is conducted by a certified lead risk assessor or certified hazard investigators. If a lead hazard is found, by statute, MHD must issue an order requiring reduction or elimination of "imminent lead hazard" within 5 days and other lead hazards within 30 days. If the property owner does not respond to the order, MHD should take further action. After completing the investigation, MHD must send a completed report to DHS.

A child's case file should not be closed until it is determined that the child lives in a lead safe environment. To close a file, lead hazards should be controlled or eliminated within the child's environment, resulting in no new lead exposures. However, according to WCLPP Handbook (Chapter 6), a child's case file also can be administratively closed when a family moves and there is no forwarding address provided. The file also can be administratively closed when the parents or guardian refuse further public health intervention.

Concerns Raised Publicly about the Milwaukee Health Department CLPP Program

During the late summer of 2017, a child was released from a Milwaukee hospital after undergoing chelation therapy, a process to remove lead from the bloodstream. After the child's release from the hospital, the child returned to a residence where lead hazards had not been completely remedied. Public reporting of this incident prompted concern regarding the policies and procedures of the MHD CLPP Program.

Public records requests followed for MHD records, including electronic communications between MHD Commissioner Bevan Baker and others on his staff. MHD Compliance Analyst Ali Reed helped compile records in response. During her review, she discovered communications between Commissioner Baker and MHD Public Health Nurse Director Tiffany Barta that Reed regarded as troublesome. Reed noted how there were discussions regarding "another chelated child released from the hospital into a lead hazard environment." This observation was brought to the attention of MHD Public Health Planning and Policy Director Sarah Zarate.

Zarate noted how she had been in previous meetings with MHD employees from the CLPP Program, during which there were concerns raised regarding the program's policies and procedures. She indicated she later informed Commissioner Baker and MHD Health Operations

Administrator Sandra Rotar of her concerns about what Zarate described as "service delivery issues" of the CLPP Program. Zarate stated that, in the early winter of 2017, she asked that this information be provided to the Mayor's Office.

In the interim, MHD Southside Grant Coordinator Benjamin James had sent an email to members of the City of Milwaukee Common Council. The email displayed James' resentment of the MHD for not compensating him for perceived earned vacation and not promoting him (after being hired by the State of Wisconsin). James also outlined how there were troubles associated with the CLPP Program.

Zarate again expressed concern regarding the Mayor's Office not being informed of the current status of the CLPP Program. She stated there were at least two meetings held and at the end of one of the meetings, she noticed that there were still no discussions regarding the CLPP Program. She recalled stating, "You guys have not gotten to this yet, but I think you should focus on the bigger picture . . . . Which is, service delivery issues [of the CLPP Program]."

A follow-up meeting was scheduled to brief the Staff Members of the Mayor's Office. According to Zarate, during this follow-up meeting, the Staff Members of the Mayor's Office left the meeting shocked and alarmed. They all left the meeting after discussing the need to immediately brief the Mayor regarding the service delivery issues of the CLPP Program.

At the next meeting, the Mayor and his Staff Members were briefed in detail via a PowerPoint presentation regarding the issues with the CLPP Program. The Mayor's Office directed MHD to produce a report within ten (10) days regarding these issues. At approximately this time, MHD Commissioner Bevan Baker resigned.

Zarate stated that at this point, Ali Reed also brought to Zarate's attention Reed's concerns about certain documents Reed reviewed while helping to respond to the public records request. Zarate said that the City of Milwaukee City Attorney's Office told her that they would be seeking the advice of the Milwaukee County District Attorney's Office on how to proceed. The Milwaukee County District Attorney's Office thereafter initiated an investigation. As indicated above, the investigation was later transferred to the WI DOJ-DCI Milwaukee Field Office, with SA Shannon Jones assuming lead investigator responsibilities.

Milwaukee Health Department Self-Assessment

In response to the directive from the Mayor's Office, the MHD conducted a self-assessment of its CLPP Program, and issued a report dated January 29, 2018. The findings of that report were as follows:

- Structure and Operations

- Program capacity was limited due to both insufficient staffing and existing staff responsibilities not reflecting functional duties.
- Program staff were inadequately trained for job duties. In addition, the program had insufficient policies and procedures in place to support ongoing program operations.
- The program infrastructure decreased program accountability.
    - The STELLAR database did not meet the program's needs. Additionally, environmental investigation documentation within the system was "virtually nonexistent," which meant that some files for the program were on paper, while others were electronic. Furthermore, the system could not be used to issue permits nor could it be used to issue orders.
- Department primary and secondary prevention activities were not fully coordinated and integrated.
- Low program morale had led to high turnover among program staff (particularly Lead Risk Assessors) and this further decreased program capacity.

- Primary Prevention Activities
    - Program promotional and education materials required updating and enhancements.
    - Relationships with community partners were deteriorated, reducing the MHD's reach within the community.
    - The program had developed adversarial relationships with contractors who were responsible for carrying out abatement work.
    - The program did not consistently meet HUD grant performance benchmarks and did not assure an adequate spend down of funds.
    - The program established unnecessary and burdensome eligibility criteria on property owners.
    - The program failed to create a pipeline of homes to enroll in Primary Prevention. This led to gaps in the workload.

  - The program should explore additional funding sources and opportunities to improve the distribution of drinking water filters that were certified to remove lead.

- Secondary Prevention Activities
  - The program had insufficient documentation practices, making it difficult to determine what level of service was provided to children with confirmed elevated blood lead levels.
  - More focus should be placed on increasing community capacity for confirmatory tests so proper interventions could be provided without delay.
  - The program was not consistently delivering interventions to children with elevated blood levels.
    - Environmental investigations were not consistently completed as required by state statute and MHD programmatic goals and policies. Inconsistencies were found at every step of the process and documentation was substandard.

U.S. Department of Housing and Urban Development Audit

Following the MHD self-assessment, in February 2018, HUD conducted an on-site audit of the MHD CLPP Program. The primary objective of the audit was to "monitor compliance with grant requirements, including a limited review of the case files and financial records associated with the grant." The audit focused on the MHD primary prevention program, as the area of the CLPP Program receiving HUD grant funding.

HUD issued a report summarizing its audit on May 21, 2018. Among the findings of the audit relevant to the DCI investigation were as follows:

- Program compliance was "significantly lacking." There was a lack of supporting documentation. HUD also observed that the program manager had prearranged site visits in advance. The HUD report further noted that "ineffective methods" of lead hazard control were "promoted and accepted."
- MHS was behind in benchmarks for the HUD grant award.

- MHD had insufficient supporting documentation for contractor performance.

- Lead hazards identified in the environmental investigation were not clearly included in the scope of work assigned to contractors.

During the course of its review, HUD also discovered homes with lead hazards that had not yet been abated. HUD noted how reimbursement by MHD for the abatement cost for these homes should have never been considered because the homes were not in compliance with the HUD guidelines. Also, according to the individual who led the audit, MHD Richard Gaeta (the Field Supervisor for the MHD CLPP Program) was clueless as to the regulations / procedures of HUD. Gaeta also had a "horrible attitude" and displayed "no remorse" regarding his actions or the lack thereof.

Due to the deficiencies identified in the audit, HUD froze federal grant funds until the CLPP Program was in compliance. MHD worked to address the findings in the HUD audit, and the grants funds were eventually reinstated.

Wisconsin Department of Health Services Review

Also following the MHD self-assessment, beginning in approximately February 2018, DHS conducted its own review. From January 1, 2012 through December 31, 2017, there were a total of 491 children in the City of Milwaukee with elevated blood lead levels reported to MHD. Of those 491 case files, DHS elected to conduct an in-depth review of 108 case files, based on a combination of choosing specific files as well as a random sampling method to get a representative cross section of the cases within the time range.

DHS summarized its review in a report dated May 31, 2018. In the report, DHS noted findings and corrective actions in three key areas: program administration, nursing case management, and environmental investigations. Like the MHD self-assessment, in general, the DHS report noted poor program management and record keeping. The specific findings were as follows:

- Program Administration

    - Existing program policies and procedures could not be provided to DHS reviewers by MHD.

    - Annual program objectives with outcome measurements could not be provided to DHS reviewers by MHD.

  - The MHD protocol for EBLL intervention did not comply with Wis. Stat. ch. 254 or DHS guidance.
  - MHD could not provide criteria used for opening or closing cases.
  - MHD could not provide criteria for opening and closing environmental investigations.
  - Files for nursing cases and environmental investigations were not available upon request by the DHS reviewers.
  - Data entry into STELLAR database was often inconsistent, unclear, and in conflict with information in the paper file.

- Nursing Case Management
  - Nursing case files were missing.
  - Public health nurse (PHN) case management was not initiated for all EMLL cases.
  - PHN home visits were not conducted for all EBLL cases.
  - Nursing case closure was inconsistent and not in compliance with state program minimum EBLL case closure criteria.

- Environmental Investigations
  - Environmental investigation files were missing.
  - Environmental investigations were not conducted for all EBLL cases.
    - 24 percent of children's primary residences (26 of the 108 case files) had no record of an environmental investigation being conducted.
  - Files had no documentation that a full lead risk assessment was conducted
    - None of the 108 reviewed records had a completed risk assessment report filed.
  - Environmental investigators did not provide a lead clearance report.
    - None of the 108 reviewed records had a completed clearance report filed.

- 26 percent of environmental investigations that included ordered lead abatement were closed indicating remediation completed with no evidence in the file that clearance had been conducted (i.e., no dust wipe results).

- Paper records had incomplete supporting documentation of the investigation.

- Orders were not always written when hazards were found or did not include remediation of all identified hazards.

- The MHD policies changed in mid-2016 and did not comply with state law requiring environmental investigation for children who have two venous BLLs of >+ mcg/DL taken at least 90 days apart. The DHS report noted that beginning in approximately June 2016, environmental investigations were no longer done in homes where these children resided.

- The DHS review noted: "No single environmental investigation file reviewed by DHS was complete and able to fully support the actions and decisions of the MHD investigators."

In sum, the report concluded that there was an "overall lack of consistent program policies, procedures and standards of practice needed to ensure program compliance and interventions for all children who require it."

In its May 2018 report, DHS identified various corrective actions by MHD necessary for compliance. MHD responded to the DHS review with a Corrective Action Plan in July 2018. Over the next couple of years, MHD worked with DHS on progress towards the items in the Corrective Action Plan. Based on the progress of MHD, in March 2021, DHS notified MHD that DHS was closing out the Corrective Action Plan, while noting areas for continued future improvement.

Public Health Foundation Audit

Beginning in late 2019, a non-profit organization called the Public Health Foundation (PHF) conducted another audit of the MHD CLPP Program. PHF conducted an on-site case review of CLPP Program case files involving children with an EBLL from January 1, 2012 through December 6, 2019. The audit involved an in-depth review of a random sample of 5 percent of the cases from 2012 through 2017, and 10 percent of the cases from 2018 and 2019.

With respect to the 2012 through 2018 time frame, the conclusions of the audit were as follows:

- Changes to MHD protocols in 2015 and 2016 did not adhere to state statutes and regulations.
- DHS guidance was not followed.
- There was limited quality assurance, monitoring, or oversight.
- There was no ongoing internal or external programmatic auditing.
- There were minimal training materials or orientation manuals for new staff.
- Written policies were lacking.
- Procedures were followed inconsistently and relied on word of mouth.
- On EBLL cases, there were no team meetings or regular review.
- There was minimal continuing education of staff and maintenance of staff certifications.
- MHD policies and procedures for employee performance, management, discipline, and accountability were lacking.
- There was wide variability in how different personnel performed the same job duties.
- Supervision of CLPP Program staff was lacking or inconsistent.
- There was poor record keeping and documentation practices, including no training or policies on documentation.
- Housing abatement decisions were inconsistent, with no demonstrated prioritization of children with lead poisoning.
- There was no culture of quality or focus on continuous improvement.

The audit noted that, during 2018 and 2019, the MHD CLPP Program demonstrated "significant improvements." For example, the MHD intervention protocols became aligned with statutory requirements, and written policies and procedures started being used "to assure continuity and decreased variability in the program." The audit also identified several recommendations for future improvement.

DCI Investigation

The reviews conducted by MHD, HUD, DHS and PHFSA uniformly concluded that the MHD CLPP Program suffered from inconsistent and poor documentation, which necessarily affected the DCI investigation of potential criminal violations.

At the outset of the investigation, SA Jones sought copies of the 491 case files relating to children with elevated blood lead levels reported to MHD from January 1, 2012 through December 31, 2017—the same files that formed the basis for the DHS review and subsequent Corrective Action Plan by MHD. SA Jones was informed that a subpoena was needed because of Health Insurance Portability and Accountability Act (HIPPA) concerns. SA Jones obtained subpoenas with the assistance of the Milwaukee County District Attorney's Office. On October 3, 2018, SA Jones served a subpoena at MHD. On October 26, 2018, MHD informed SA Jones that the requested files were all within a room at MHD and ready for review.

SA Jones also sought information on these same case files from DHS. On October 25, 2018, SA Jones met with DHS Section Chief (SC) Shelley Bruce. At that time, SC Bruce turned over two boxes of records in response to the subpoena, relating to the 108 case files that were subject to the DHS review earlier in 2018. SA Jones also requested a list of the names of the infected children and addresses that needed abatement.

In March 2019, assisted by DCI limited term employees Michael Wilkerson and Erin Godown, SA Jones reported to MHD to conduct an initial review the 491 case files. The DCI investigative team wanted to compare the files maintained by MHD with the files were produced by DHS. But when the DCI investigative team examined the case files located at MHD, they were scattered across 18 boxes and were extremely disorganized, preventing a systematic review.

Due to the extreme disorganization of the MHD records, DCI decided to concentrate on files relating to children with the highest EBLLs. Ten (10) files were selected, and a list was generated that reflected various information, including the names, addresses, dates opened, status of case, activity, initial levels, final levels, investigating assessors and nurses, and other examinations performed.

During the course of the investigation, the DCI investigative team conducted approximately 29+ interviews. The interviews consisted of current and previous employees (retired, resigned, transferred, and terminated) of the CLPP Program. The interviews included but were not limited to interviews of MHD managers, supervisors, lead risk assessors, nursing staff, and other staff. DCI also interviewed contractors involved with the primary prevention program, as well as families of the case files involving children with the highest EBLLs.

With respect to the case files involving the children with the highest EBLLs, the DCI investigative team noted that there was a general lack of consistent documentation in their files. In interviewing the family members of those children, the individuals consistently remarked about poor follow-up by MHD relating to their cases. They did not, however, single out any one individual as responsible.

Over the course of the interviews with MHD personnel, the following general themes emerged:

- Poor retention
- Distrust among staff and personnel
- In-fighting between personnel
- Chronically understaffed
- Management issues (staff vs. managers) (managers saying staff were the problem)
- Difficulty locating files
- Poor file management Employees not meeting basic requirements
- Policies not documented
- No firm guidelines on work procedures

Interviews were attempted of the individuals responsible for managing the MHD CLPP Program. Bevan Baker and Richard Gaeta both declined to be interviewed. Lisa Lien was interviewed, and echoed the various challenges associated with the CLPP Program recounted by others. She confirmed that the program was shorthanded on both nurses and lead risk assessors. Lien also said that families were hesitant in allowing MHD personnel in their residences. Lien stated that it was difficult to track the location of children with elevated blood lead levels, and that MHD did not have the authority to force parents to submit their children to additional testing. Lien said that they tried their best with the resources available.

During interviews with MHD personnel, SA Jones heard rumors in connection with the primary prevention program of people possibly inflating the number of windows needing remediation in exchange for a kickback of money. In addition, there was speculation about overpayments from the HUD funding being paid to certain contractors, with kickbacks being provided to CLPP Program personnel.

To follow up, the DCI investigative team attempted interviews of contractors that DCI was informed may cooperate with the investigation. The name that resonated numerous times in the interviews of CLPP Program personnel was Felix Questrell. SA Jones was informed that Questrell had inside knowledge of the kickback allegations.

The DCI investigative team made several attempts to interview Questrell. SA Jones was informed by Questrell that although he had lots of information to offer, he would not initially cooperate because the CLPP Program owed him money for completed work, and he feared the repercussions of giving up detailed information.

The DCI investigative team then reached out to another contractor who allegedly had been forced out of the approved City of Milwaukee Contractor's List by personnel from the CLPP Program. That contractor, Camar Tyler, had heard the rumors of kickbacks within the CLPP Program, but had no direct knowledge of how this was occurring. SA Jones also inquired if Tyler knew Questrell and he responded that he did. SA Jones and the DCI investigative team expressed the importance of speaking with Questrell and Tyler indicated he would contact Questrell. Tyler stated that once Questrell knew he had been down to speak with us in person, Questrell would definitely cooperate and call us.

About a week later, SA Jones received a phone call from Questrell. He stated things were better for him and he had spoken with Tyler. Questrell informed SA Jones that he would call in one week and schedule an interview. Questrell died before he could be interviewed. Other than the rumors and speculation identified by MHD personnel, the DCI investigative team did not discover any documentation that supported the kickback allegations.

The DCI investigative team also attempted to observe the residences that had windows replaced utilizing HUD funding through the primary prevention program. SA Jones requested and received a list from MHD that included the addresses, date completed, and number of windows replaced under the CLPP Program from 2015 through 2019. To verify that the windows had in fact been installed, SA Jones also compiled a sample list of addresses from MHD. The DCI investigative team visited twenty-three (23) residences, all of which appeared to contain newly-installed windows. Based on this review, there did not appear to be a discrepancy between the funding awarded by HUD and the contractor work overseen by MHD.

More detailed information regarding the summary above is located in the other reports in the case file.