

# GETTING THE LEAD OUT: THE LEAD POISONING CRISIS IN NEW JERSEY



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## The Lead Poisoning Crisis in New Jersey

Thousands of New Jersey children are being poisoned each year in the one place they should be safe from harm – their homes.

Thirty years after the federal government banned the sale of lead paint and a decade after it completed its phase-out of lead in gasoline, childhood lead poisoning remains one of the State's most stubborn and enduring public health crises.

While entirely preventable, lead poisoning has irreversible health consequences for children who are exposed – usually through ingestion of lead-based paint chips or lead-contaminated dust (lead dust) – to even very small quantities of this deadly substance.

Despite the efforts of multiple government agencies to eradicate lead contamination and address the childhood lead poisoning problem in this State, the problem remains severe and the systems designed to eliminate it need to be improved.

A field investigation by the Department of the Public Advocate (DPA) has uncovered gaps in the systems designed to protect our children. We found lead dust levels exceeding the federal standard in 82% (85 of 104) of the homes we visited. The lead dust levels in these homes were significantly high. We also observed shamefully shoddy abatement and clean-up work and interviewed families of children whose blood lead levels actually rose after abatement.

With these findings in hand, we reached out to the Departments of Health & Senior Services (DHSS) and Community Affairs (DCA), each of which has responsibilities for responding to lead poisoning or remediating lead paint hazards. We forged strong partnerships with those agencies over the past several months that led to immediate steps to begin to address failures in our system of responding to lead poisoning.

The current system results in staggering costs for our children and our economy. Lead poisoning can cause brain damage, developmental delays, reduced IQ, reading and learning disabilities, behavioral problems, hearing impairments, and hyperactivity. Lead exposure can also impair the development and functioning of vital organs and can result in convulsions, coma, and even death. Because lead-poisoned children experience lifelong physical and developmental disabilities and often exhibit increased behavioral problems, they require additional public services in order to lead productive lives.

Tragically, this chronic public health problem disproportionately affects the youngest and poorest among us, principally children who live in deteriorating urban housing built before 1978, when the sale of residential lead-based paint was outlawed.

The time has come for State and local governments to increase their efforts to prevent lead poisoning, to treat lead-poisoned children, to assist affected families, to remediate lead-burdened housing and, finally and forever, to eradicate this problem.

## **The Department of the Public Advocate's Focus on Lead Poisoning**

During the past year, the DPA launched an extensive investigation designed to assess State and local efforts to respond to lead-poisoned children and to identify ways to strengthen the State's lead poisoning prevention efforts.

Working with information provided by our partners, we analyzed data and sought stakeholder feedback about the State's lead poisoning response and prevention efforts.

What we found and heard is alarming:

- New Jersey regulatory standards regarding lead poisoning require revision. Under current State regulations, an environmental investigation of a child's home is not required until his or her blood lead level reaches 20 micrograms per deciliter of whole blood or he or she has two consecutive blood lead levels of 15 micrograms or more.
- New Jersey's housing stock is disproportionately lead-burdened. It is estimated that 60 percent of New Jersey's housing stock – about two million units – were constructed before 1978, when the sale of lead-based paint was banned. In contrast, only 40 percent of housing stock nationwide is estimated to contain lead-based paint. Worse, about one million units in New Jersey were built before 1950, when household paint contained extremely high levels of lead pigments.
- The lead poisoning problem in New Jersey is significant. In FY 2005, of all the children under six years of age screened for lead in New Jersey, 2.4 percent or 4,048 children, were found to have a level at or above 10 micrograms per deciliter, the federal CDC level of concern. According to the CDC, New Jersey's rate of poisoning is not only above the national average, but also above other northeastern States, such as New York and Massachusetts, that have similarly old housing stocks.
- The lead poisoning problem is not uniform across the State. The percent of children tested who are in fact lead-poisoned is much higher in our older urban areas: Irvington (7.85%); East Orange (7.29%); Newark (6.45%); Trenton (6.10%); Paterson (5.05%); and Camden (3.63%). To put the scope of the problem in perspective, Newark is home to 3.6 percent of the State's children under six years old, but accounts for 15.8 percent of lead-burdened children of that age.

What's worse, it is likely that the number of children poisoned is understated. Despite a universal screening law that requires a child to be tested twice by the age of 26 months, many children in the State have never been tested. For example, according to FY 2006 statistics, only 66% of the children born in FY 2005 had been tested.

- There are significant delays and inefficiencies in the system. It can take months and even years for a home to be abated after a child is first known to be lead-poisoned. In the five cities for which we have specific data, abatements were ordered in only about 60 percent of the cases where a child had been poisoned and, of those, over 20 percent never happened.

Even where abatements take place, they are not always adequate. Abatement contractors get away with shoddy, inferior work because legal standards governing their performance are amorphous. In some cases, the same individual who performed the remediation also conducted the clearance inspection, which is the final re-inspection certifying that a dwelling is lead-safe. This is a clear conflict of interest, and DCA has taken action to resolve this problem.

- Children are being re-poisoned in homes that should have been lead-safe. In the five cities for which we have specific data, there were hundreds of addresses where repeat poisonings occurred. In a particularly heart-breaking case, an eight-year-old Newark boy suffered severe brain damage as a result of a blood lead level of 65 micrograms per deciliter – which is 6.5 times the CDC level of concern – only to be moved to another lead-burdened house – where he was poisoned again.
- The high cost of a failing system. While the human cost is incalculable, childhood lead poisoning significantly burdens State resources because it increases health care and education costs and requires the State to provide long-term services to individuals who suffer from developmental or other disabilities or who intersect with the juvenile justice, criminal justice, or mental health systems as a result of behavioral problems.
- Families are often left without information, financial assistance, and housing alternatives. Although funding is available to relocate families in lead-burdened housing, fewer than 100 families have been able to use this funding in the last three years. Too many bureaucratic obstacles are built into the system, including a lack of lead-safe houses, a lengthy application, and a policy that puts a six-month cap on temporary relocation assistance in motels. This cap is unrealistic because it takes longer than six months, on average, for a property to be abated.

In short, what we found and what we heard – from parents of poisoned children, from urban advocacy organizations, from housing inspectors, and even from abaters themselves – was that the systems designed to address and prevent childhood lead poisoning are, at best, fragmented and inadequate and, at worst, ripe for negligence and fraud.

Armed with, and concerned about, this information, we decided to launch our own field investigation and began testing lead dust levels in residential dwellings in five cities – Trenton, Camden, Newark, East Orange, and Irvington – that together accounted for 31 percent of all reported lead poisonings in FY 2005. All of the addresses we tested had

undergone a lead inspection within the past ten years. About one-third of the addresses had been abated as well.

The results of our field work revealed a system broken at each step.

### **The Public Advocate's Lead Field Study Reveals a Failing System**

After being trained by the Philadelphia Childhood Lead Poisoning Prevention Program, DPA staff visited residential addresses in the five cities and took up to 12 lead dust samples from floors, window sills, and window wells.

We found lead dust levels exceeding federal standards in 85 of the 104 homes we visited, a staggering 82 percent. Even if you discount the 25 residences where the only elevated samples were from the window wells – areas that may be exposed to ambient lead dust from exterior sources – the results are still compelling. Sixty of the residences (57%) had elevated lead dust levels in at least one window sill or floor test.

The lead dust levels we recorded in some homes were extremely high. The action level for window wells is 400 micrograms of lead dust per square foot. In East Orange, we found a home with a window well that contained 26,000 micrograms of lead dust per square foot, or 65 times the action level. The action level for window sills is 250 micrograms per square foot. In Trenton, we found a home with a window sill lead dust level of 9,900 micrograms per square foot, or nearly 40 times the action level. In Irvington, 12 of 21 homes had elevated levels of lead dust on the floor.

In addition, we observed shoddy and inadequate abatement and clean-up work in some of the homes we visited. We saw ill-fitting windows, exposed electrical wires wrapped around water pipes, exposed electrical switches, leaded material inadequately covered by sheet rock, and piles of lead dust left on a furnace and inside a closet.

To our dismay, we interviewed families of children whose blood lead levels actually rose after their homes had ostensibly been abated. We interviewed the family of a child whose blood lead level went from 7.3 micrograms per deciliter pre-abatement to 16.4 one month after the abatement. Another child's blood lead level rose from 8.4 micrograms per deciliter pre-abatement to 15 post-abatement.

### **DPA's Response to the 85 Families Living in Residences with Elevated Lead Levels**

When the DPA field investigation identified families living in residences with significantly elevated lead dust levels, we took immediate action to inform them and recommended that they have their children's blood lead levels checked. We made a social worker available to these families to help them navigate the lead bureaucracy and access abatement and relocation assistance. The social worker also advised families of interim cleaning techniques that would reduce lead contaminated dust levels in the home and therefore minimize the risk of exposure. Finally, the social worker encouraged

families to get their children tested for lead. We also sought the help of Legal Services of New Jersey to provide legal assistance to the families.

The result of our efforts to date is that at least 31 children have been tested for lead. Families of 16 children did not share the blood test results with us, but of the remaining 15 children, 8 had a blood lead level above 10 micrograms, the federal level of concern. At least three of the properties have already been remediated, and there are plans in the works to remediate at least two other properties. At least five other families have permanently relocated.

We also immediately reached out to the other State departments who share responsibility for lead. Their response was swift and decisive.

DHSS instructed local health departments to re-inspect the 85 residences. Follow-up is ongoing.

Medicaid and the Office of the Child Advocate also joined forces with us and worked to ensure that children in the homes we visited who are Medicaid-eligible are enrolled and receiving appropriate services.

### **The Bigger Problem and the Contours of a Solution**

After beginning to assess and respond to the needs of the 85 families we identified in our sample, we turned our attention to the larger problem. New Jersey's system to address childhood lead poisoning is designed to include the following steps:

- Health care providers should screen children to determine if they have elevated lead levels in their blood.
- If a child is found to be poisoned, the child's residence should be inspected for lead.
- If a lead problem is found in the home, the child and his family should be relocated to lead-safe housing while the home is abated.
- The lead hazard should be abated.
- Clearance testing should be conducted to ensure that the residence is safe.

In practice, the system needs to be improved at every step.

### **BLOOD SCREENING**

Although there is a universal screening law, the reality is that not all children in the State are tested.

## Recommendations/Interim Responses:

- Prioritize blood screening efforts to focus on children living in residences where others have previously been poisoned and to target neighborhoods where children are most at-risk.

*DHSS will begin mapping the incidence of lead poisoning geographically using Geographic Information System technology. This information will be shared with municipalities to help steer local screening and prevention efforts.*

- Review the feasibility and desirability of prenatal screening.

*DHSS will meet with stakeholders to study the idea of implementing prenatal blood lead screening of all pregnant women and newborns.*

- Increase blood screening rates of children under the State's care.

*The Department of Children and Families (DCF) will review and, if appropriate, will revise, current policy to emphasize that screening for lead poisoning is a component of the Early and Periodic Screening Diagnosis and Treatment (EPSDT) guidelines. EPSDT is Medicaid's program for the provision of comprehensive and preventive child health services for children under the age of 21, including screening for elevated blood lead levels. Children in out-of-home placement in New Jersey receive Medicaid while in care and are eligible for EPSDT services.*

## INSPECTIONS

Current State regulations do not require an environmental investigation (inspection) of a child's home until his or her blood lead level is 20 micrograms per deciliter or a persistent level of 15 micrograms or higher. Both of these levels are too high to trigger inspections considering that lower levels of exposure to lead dust can have harmful long-term effects on children.

In the DPA investigation, we identified some instances in which three or more children were sequentially poisoned in different units of a multi-unit dwelling. This occurs because current law permits the inspection and abatement of only the unit where a child has already been lead-poisoned, and does not mandate that preventive action be taken with respect to the other units in the building where children may live.

Also, we found that children were sequentially poisoned within the same unit. One reason is that inspectors are only required to look for lead hazards – that is, currently deteriorating paint. This ignores the reality that lead-based paint that is not currently deteriorating inevitably will break down and will pose a hazard to children.

## Recommendations/Interim Responses:

- Reduce lead poisoning environmental intervention level to 10 micrograms per deciliter.

*DHSS will review its current standards and is expected to promulgate regulations this spring to begin to align the State environmental intervention level with the CDC level of concern.*

- Ensure that all units of a multi-unit dwelling are inspected when one unit is found to have lead paint hazards, and notify all families of the potential lead hazards in the building.

*DHSS will review the practice of local health departments with regard to multi-unit dwellings. If appropriate, DHSS will propose rules that will require local health departments to notify in writing all tenants in a multi-unit dwelling where a child has been poisoned by lead in one of the building's units. Tenants will be informed that dangerous levels of lead have been found in the building and will be given educational materials and told where to have their children tested.*

*DHSS will also identify which local health departments are willing to perform lead inspections on demand so long as the resident bears the cost.*

- Reform laws to require among other things that, during a lead inspection/risk assessment, all lead in a dwelling be identified, immediate hazards be remediated, and a plan for maintenance and continuing inspections be developed to ensure that other leaded surfaces do not deteriorate.

## **RELOCATION**

Our field investigation revealed that there are not enough lead-safe houses in which to relocate families temporarily while their homes are being abated. As a result, families spend many months living in motels, sometimes in areas plagued by drugs and violence, while waiting for dilatory landlords or abatement companies to make their home safe for their return. In other instances, children with high blood lead levels have to remain in hospitals longer than their treatment warrants because they cannot be released to their lead-burdened home and there is no temporary lead-safe housing available.

Many families told us that they were left to find lead-safe housing on their own and that State or local agencies provided them with little help beyond giving them outdated housing lists. Other families ran out of relocation funds before their home abatement was complete.



Recommendations/Interim Responses:

- Increase stock of lead-safe housing available for temporary or emergency relocation.
- Reform law to impose strict time limits between the initial identification of a child as lead poisoned and abatement of his or her home.

*DHSS will review current regulations with an eye toward establishing or shortening timeframes by which the local health department, the abatement company, and the property owner must ensure that the inspection, abatement, and clearance functions for which they are respectively responsible are completed.*

- Reform policy to ensure that relocation assistance extends until abatement is completed.

## **ABATEMENT**

Funds for abatement are available through the Lead Hazard Control Assistance Fund. According to statistics provided by DCA, however, only 34 abatement projects have been completed from the Fund's inception in July 2005 until January 1, 2008. This under-utilization is due largely to a lengthy application process and a lack of public awareness.

Another major problem is that an unacceptably high percentage of abatements are never carried out. For instance, of the 2,276 abatements that were ordered in the five selected cities between 1996 and 2007, 492 (22.4%) didn't happen.

During our field investigation we also witnessed shoddy and substandard abatements. This inferior work stems in part from the lack of clarity and specificity in the legal standards governing abatement. In addition, there are few licensed abatement contractors who do residential abatement work in New Jersey, and thus little competitive incentive to produce high quality work.

Recommendations/Interim Responses:

- Streamline the application process for the Lead Hazard Control Assistance Fund.

*DCA will offer greater technical support to persons completing the application for the Lead Hazard Control Assistance Programs. DCA and DPA will collaborate on examining the feasibility of simplifying the application.*

*DCA will continue to accept the dust wipe results from the DPA's field investigation as evidence of a lead dust hazard for purposes of eligibility for low-interest loans for remediation of lead hazards.*

- Increase enforcement of existing laws requiring abatement.

*DHSS will undertake a study to identify addresses where more than one child has been poisoned. Multiple offender properties with outstanding abatement orders will be identified and property owners will be provided assistance to abate the properties voluntarily or, as necessary, by court order.*

- Investigate the most feasible way to increase the pool of licensed abaters.

*DCA will review its list of Certified Lead Abatement Contractors and update this list twice a year at a minimum. DCA will also highlight those contractors who still perform residential abatements.*

- Reform the legal standards governing the quality of abatement.

*DCA will review its monitoring of all certified evaluation and abatement contractors and, if appropriate and feasible, propose amendments to work practice regulations.*

## **CLEARANCE**

Our investigation revealed irregular trends in the process that is supposed to ensure that a residence is “clear” of lead following an abatement. This clearance must be granted before a lead-poisoned child and his family can return home.

In one home we visited, clearance was granted even though there was lead dust everywhere, and the home was left in a substandard condition that would not pass a routine building code inspection.

In other instances, homes were “cleared” on the same day the abatements were completed, a physical and logistical impossibility given that State law requires a clearance inspector to take dust wipes and send them to a lab for analysis before determining that a home is lead-safe.

Finally, the law did not prohibit the same company from performing both the abatement and the clearance inspection on the same project. This was a clear conflict of interest.

Recommendations/Interim Responses:

- Increase monitoring and oversight of the clearance function.
- Suspend or revoke the licenses of negligent abaters and clearance inspectors, and take legal action against fraudulent abaters and clearance inspectors.
- Prohibit companies and their subcontractors from performing both lead abatement and clearance functions on the same remediation project.

*DCA has issued a rule proposal to prohibit the same company or its subcontractor from performing both the abatement and the clearance functions on the same project.*

## **EDUCATION**

Our investigation revealed that there is a significant lack of knowledge among New Jersey residents about the existence of lead hazards in this State. This is so although ample information on this issue is available from a wide variety of sources.

Recommendation/Interim Responses:

- Create and disseminate easily understandable and accessible public education materials that outline the dangers of lead poisoning and how families can get needed services.

*DHSS will develop new lead educational materials and make them available to local health departments, nonprofits, consortiums, lead coalitions, primary care providers, and other lead education organizations.*

*DHSS will create a one-page handout on the dangers of all blood lead levels. DHSS will provide guidance to physicians and other medical professionals concerning the dangers of lead poisoning including the danger of low-level exposure.*

*The Department of Education will make available to districts, charter schools, and nonpublic schools lead education materials developed by DHSS and/or DPA for distribution to teachers/administrators, guidance counselors, nurses, and parents of pupils attending that school.*

- Educate the public about the existence and types of lead hazards.

*DHSS will develop new educational materials to increase awareness of non-paint sources of lead poisoning including consumer products such as toys and jewelry.*

*DCF will undertake a review of the current training for resource family and child care youth residential inspection staff regarding recognition of lead paint hazards. Following such review, DCF will, if appropriate, implement in-service training or informational sessions to assist all DCF inspection staff in recognizing and identifying such lead paint hazards as part of the licensing and inspection process.*

*DCF will also review current policy and, if appropriate, consider additional in-service training for resource family parents on the topic of recognition of lead paint hazards, requirements regarding lead paint testing, and information regarding treatment of lead exposure.*

## INTER-AGENCY COLLABORATION

Our investigation also revealed that responsibility for lead is spread across multiple State agencies and that the system would benefit from increased collaboration and information-sharing among these agencies.

Recommendation/Interim Responses:

- Agencies should increase their information-sharing capability and work cooperatively toward solutions.

*To improve the timeliness, accuracy, and efficiency of the lead data match system, the Department of Human Services and DHSS will work together to enhance data collection and, if appropriate, include in the DHSS case management database a field that would allow for the collection of a child's medical insurance information.*

*DHSS and the DCA will collaborate to develop a Memorandum of Understanding that will allow the agencies to cross-match the addresses of lead-poisoned children with the results of cyclical inspections of multiple dwelling units .*

### **The Municipal Response to DPA's Findings**

DPA also reported our findings and recommendations to the five municipalities that were the subject of our field investigation. The municipalities have responded in a number of positive ways. First, all five have agreed to have comprehensive lead inspections performed at all of the addresses we identified as having potentially dangerous levels of lead dust. The municipalities have also been working to assist individual families with lead-burdened children that the DPA identified. Finally, DPA is working with the affected cities with the goal of reaching an agreement on a series of broad-based reforms that the cities can immediately put into practice.

## NEXT STEPS

As reflected in our work so far, the State's system, like many across the nation, is heavily weighted toward reducing or eliminating lead exposure only **after** a child has already been poisoned.

As a result, our investigation and this initial report deal mostly with this "secondary prevention." However, only primary prevention – reducing a child's exposure to lead hazards **before** the child is ever poisoned – can eliminate childhood lead poisoning.

Our system must be reformed both to minimize the damage to children who are already poisoned and to prevent others from ever being lead poisoned. To this end, the DPA will continue to work with our sister agencies, local governments, families with lead-burdened children, and community advocates to identify specific statutory, regulatory, and policy changes that are necessary to improve our State's current lead poisoning

response and prevention efforts. We also plan to work closely with State legislators to develop comprehensive reform to the systems for responding to and preventing lead poisoning.