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THE SPECIAL COMMISSIONER OF INVESTIGATION
FOR THE NEW YORK CITY SCHOOL DISTRICT

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**AN INVESTIGATION INTO THE DEATH OF EIGHT-YEAR-OLD
QUENTIN MAGEE**

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CHRONOLOGY OF EVENTS QUENTIN MAGEE

- **September, 1991:** Quentin Magee, age 5, starts school in the New York City School District. He attends the P.811 special education program located at P.S.329 in Brooklyn.
- **May, 1994:** Quentin is transferred to the P.811 site located at P.S.136 in Queens because his family has moved.
- **October 28, 1994:** Quentin spends his last day at P.811. Quentin's grandmother calls P.811 and states that the Magees are moving. She provides no further information. Quentin does not attend school again until January 3, 1995.
- **November, 1994:** A member of Quentin's family calls Community School District 29 and again states that the Magee family is moving. Information about their new address is provided at this time, but no record of the call is made.
- **November 28, 1994:** The Board's Citywide Placement Office assigns Quentin to the P.396 special education program located at P.S.9 in Brooklyn. December 7, 1994 is chosen as Quentin's first day of school and ABLE Bus Company is instructed to begin bus transportation on that day.
- **December, 1994:** Quentin's mother informs bus driver Julius Tatum that her son is ill and must stay home, and that she will contact the school when her son is able to attend.
- **January 3, 1995:** Quentin arrives at school for the first time since October 28, 1994 when Quentin's mother, Margie Magee, brings him to P.396 for an orientation. Though Quentin has missed 37 consecutive days of school, no attendance investigation is conducted.
- **January 4 and 5, 1995:** Quentin attends school and is transported by ABLE Bus driver Julius Tatum and escort Wilda Smith. After January 5, he does not return to school until January 18, 1995.
- **January 17, 1995:** Margie Magee takes Quentin to see Julio Tardio, M.D., Quentin's pediatrician. He examines Quentin and writes a note stating that Quentin is fit to return to school.
- **January 18, 1995:** Quentin returns to school for the first time since January 5, 1995. He is transported to school by Tatum and Smith. Quentin's teacher and school nurses Alenthia Robertson and Wendy Walker are concerned about Quentin's deteriorated medical condition. The nurses examine Quentin and describe him as emaciated. Nurse Walker makes an attempt to contact Quentin's doctor and mother, without success.
- **January 19, 1995:** Quentin is transported to school by bus. He is taken on a field trip with the

other students in his class. Because Nurse Walker does not go to work this day, Agnes Aban, a substitute nurse, attends the class trip. She is provided with no instructions concerning Quentin's medical condition. Quentin is not examined and no calls are made to Quentin's doctor or mother.

- **January 20, 1995:** Quentin Magee dies. Earlier that morning, Quentin is picked up at home at approximately 7:15 a.m. and transported to school by bus. Bus escort Wilda Smith cannot state whether he was alive or dead during this bus ride. Quentin arrives at school at approximately 8:45 a.m., at which point it is discovered that he is not breathing and is stiff and cold to the touch. Nurse Robertson is summoned to care for Quentin because Nurse Walker has not yet arrived for work. Four calls are made to 911 and an ambulance arrives approximately 25 minutes after the first call is made. Nurse Robertson does not perform CPR because she believes that Quentin was dead by the time he arrived at school.

- **January 23, 1995:** Quentin's school records, requested on January 5, 1995, arrive at P.396.

INTRODUCTION

Eight-year-old Quentin Magee died in the early morning hours of Friday, January 20, 1995, sometime between 4:00 a.m., and 8:45 a.m., the time at which he arrived at his school, P.396 in Brooklyn. According to an autopsy performed by the Office of the Medical Examiner of the City of New York, Quentin died from having an excessive amount -- "a dangerously toxic level" -- of phenobarbital in his system, a drug that had been prescribed to control the seizure disorder from which he suffered. Contributing to his death were this seizure disorder, severe dehydration, and pneumonia. In addition, Quentin weighed a mere twenty-seven pounds at the time he died -- the same amount he weighed when he was only four years old.

Quentin's life was that of a profoundly disabled child, confined to a wheel chair, without the ability to dress, feed, or clean himself. He suffered from severe cerebral palsy, a disease that is defined as impaired muscular coordination and power resulting from damage to the motor centers of the brain, usually occurring at or before birth. Quentin was debilitated by the disease -- he could not speak and had little control over the movements of his own body. Thus, he was totally dependent on others, and was completely vulnerable. Yet, he was alert at times, according to many of the people questioned in connection with this case, demonstrated by the fact that he laughed, cried, and communicated by moving his eyes and making sounds. In the final days of his life, according to witnesses employed at P.396 or involved in his transportation to school, his only visible expression was pain: he whimpered, wept silently, and appeared to suffer a great deal. In describing the child's physical deterioration in his final days, one witness stated that Quentin was emaciated, "skin and bones," and so frail-looking that this witness was afraid to touch Quentin for fear that by merely touching him she would hurt him.

This report examines the role played by school personnel during the final days and hours of Quentin Magee's life: what these individuals did and what they might have done to help this child. It also focuses on the failure of the school attendance monitoring system which should have alerted school officials that a severely handicapped child was absent from school, without explanation, for eight weeks. He returned to school after this prolonged absence, only to die several days later.

This report also describes the work of two supervisors, one a nursing supervisor and the other a

former senior official in the Division of Special Education, who were asked to report on the performances of their subordinates as those performances affected Quentin Magee. Both submitted reports that concealed failures of their personnel and of Board regulations and procedures, rather than undertaking meaningful examinations of how these individuals might have better served Quentin, and how the regulations and procedures might be improved.

Also included here is a brief description of the medical care that Quentin received in the final days of his life from his own doctor, who is not in any way connected to the New York City Board of Education.

Unfortunately, we cannot give a complete account of the facts surrounding Quentin Magee's death due to his mother's refusal to answer questions regarding the death of her son. Quentin died sometime between 4:00 a.m. and 8:45 a.m. on the morning of January 20, the latter being the time at which he arrived at school. The City Medical Examiner who conducted the autopsy believes it more likely that Quentin died during the early part of this time frame rather than the later. Because Quentin's mother, Margie Magee, prepared her son for school that day, she is obviously a crucial witness in this case. However, when asked to cooperate with this investigation, Ms. Magee exercised her Fifth Amendment right against self-incrimination and refused to answer questions about Quentin unless she was guaranteed that no agency was conducting a criminal investigation in connection with his death and that she would be subject to no criminal charges. Similarly, Margie Magee's mother, Maddie Magee, who periodically cared for her grandchild, also failed to respond to our efforts to speak with her in connection with this case.

Given the lack of cooperation from essential witnesses -- Quentin's mother and maternal grandmother -- and the inattention of school bus personnel charged with his care who failed to note Quentin's condition on the morning he died, some questions surrounding his death might never be answered: Did the child die before, during, or after he took the bus to school? Was he alive and merely sleeping when his mother delivered him to the school bus, or was he already dead? If someone is responsible for Quentin's death, who is it? This report seeks to provide as much information as possible, given the constraints we faced, about these and other important questions concerning

Quentin's death.

BACKGROUND OF OUR INVESTIGATION

Quentin Magee died early in the morning on a school day, Friday, January 20, 1995. He came into contact with a number of adults the morning he died, including his mother, a school bus driver, a bus matron, school personnel who received him from the school bus, a teacher, and, finally, two school nurses, followed by EMS paramedics who responded to emergency calls made by his school. We have interviewed all of these witnesses, with the exception of Quentin's mother and grandmother who, as noted above, refused to answer our questions.

In addition, we spoke to many other people responsible in some way for Quentin's care in the last year of his life, including his doctor and the home-care attendants hired to provide after-school care for Quentin. We also interviewed members of his family and numerous school officials at the various public schools he attended. In all, more than three dozen individuals were questioned in connection with this report.

We have also reviewed the findings of the New York City Police Department detectives who investigated Quentin's death and concluded that no crime had been committed. Initially, the Kings County District Attorney's Office agreed with those findings and concluded that no criminal prosecution was warranted. The District Attorney's Office conducted a further review of the case as a result of this investigation but came to the same original conclusion. However, the Office of the Medical Examiner has modified its initial finding that Quentin died of natural causes. A summary of the revised findings of the Medical Examiner's Office is included in this report.

QUENTIN'S LIFE

Quentin Magee was the first of two children born to Margie Magee, who presently lives in Brooklyn with Quentin's younger sister. Quentin's father, Derrick Stanley, apparently did not regularly see or provide care for Quentin. However, his maternal grandmother, Maddie Magee, sometimes lived in Quentin's home and periodically took care of him while Quentin's mother was at work. Quentin's

days were divided between school, where he was enrolled in a special education program, and home, where he was cared for by either his mother, his grandmother, or a home-care attendant hired to provide after-school care during the hours his mother was at work.

He started school at the age of three, when he was enrolled in a pre-kindergarten program administered by the United Cerebral Palsy Foundation. At age five, in September, 1991, Quentin entered public school. Before he started school, the Board of Education Division of Special Education performed a pre-enrollment evaluation of Quentin as it is required to do with all special-needs children entering the school system. That evaluation describes Quentin as a child who requires total assistance in all areas of daily living and who is unable to dress, wash, or feed himself. It also states that Quentin appeared to "have a sweet and pleasant disposition."

The Board's Committee on Special Education reviewed Quentin's records and devised a program for him several months before the start of school. The committee decided that Quentin needed to attend a special program in which he could receive speech and language therapy as well as physical and occupational therapy. It was also agreed that Quentin needed a twelve-month school year in a "specialized instructional environment."¹ The twelve-month program was prescribed because the committee found that Quentin needed continual instruction in order to maintain his progress. For Quentin to have a summer break would likely mean the loss of much of what he had accomplished in school. Thus, his failure to attend school should have been a matter of concern to everyone involved in his education, a subject discussed later in this report.

Carol Brady was in a unique position to track Quentin's development in school. Ms. Brady was a unit coordinator of a

¹ A "specialized instructional environment" is defined in the Board's 1994 guide entitled "A Parent's Guide to Special Education for Children Ages 5-21" as: "a self-contained special education class or program with no more than 12 students that may be located in a special education school or a community school. Mainstreaming and opportunities for contact with general education students may be limited. Adult assistance is provided for academic and behavioral remediation throughout the school-day."

special education program housed² at P.S.329 in Brooklyn when Quentin Magee was first brought there for school orientation in September 1991. Ms. Brady recalls her first impression of Quentin to be that of a child who was alert and cheerful, communicating with his eyes. She also recalls that, in addition to a wheelchair, Quentin required both a harness and a neck brace to provide the body support he needed to remain upright in his chair. She also remembers being aware at the very start that Quentin was thin and was only able to eat foods in puree form. Consequently, his nutritional intake and weight would be constant concerns.

In May 1994, Carol Brady saw Quentin again, for the first time in approximately two years, when he and his family moved to Queens. By this time, Ms. Brady had become an assistant principal for the P.811 special education program working out of the satellite site housed in P.S.136. Ms. Brady recalls that Quentin appeared to recognize her and seemed happy to see her again. She remembers noting that Quentin had grown taller since she had last seen him, but she did not notice that he appeared unusually thin or sickly.

For the next six months, Quentin attended the special education program at P.811, and no records indicate any remarkable changes in his health. Nor did Carol Brady notice any significant difference in his appearance or demeanor. He

² The Division of Special Education utilizes a system of satellite schools, which are attached to existing general education schools within each community school district. This means that particular areas inside various general education school buildings are set aside for use by special education students. This allows more interaction between the special education students and the general education students. The satellite schools are administered by each special education program's main site, and not by the school where the satellite is housed. Each special education program is considered to be its own school, but is designated as "P." instead of "P.S." Quentin Magee was originally assigned to a satellite site of special education program P.811 located at P.S.329 in Brooklyn. He subsequently transferred to the P.811 site located at P.S.136 in Queens during May of 1994, and finally transferred to the P.396 special education program, a different program within the Division of Special Education, located at P.S.9 in Brooklyn.

attended this school for the last time on October 28, 1994. From that day until January 3, 1995, Quentin Magee was absent, without explanation, from school.

A LONG AND UNEXPLAINED ABSENCE

On October 28, 1994, Quentin Magee's grandmother, Maddie Magee, called the school office at P.811 and informed an employee there, Jane Schlau, that Quentin's family was moving from Queens to Brooklyn and that Quentin would be leaving the school. The grandmother did not, however, give any forwarding address or make any inquiries about a new school for Quentin.

Nor did she give a moving date. Instead, she merely informed the office that Quentin would no longer be attending P.811. Ms. Schlau made no note of the fact that Quentin would not be returning. Thus began a lengthy and unexplained absence for Quentin which was not properly handled by Board administrative officials.

As noted earlier, a student with special needs like those of Quentin must remain in his school environment year-round in order to avoid regression. For example, Quentin suffered from a severe overbite, which, combined with his other disabilities, made eating and drinking extremely difficult tasks. One of the goals of his Individualized Educational Program was to teach Quentin to close his mouth around his spoon or his cup so that he could better keep the food in his mouth and swallow it. The training to meet this goal was necessarily repetitive and frequent. Without continuity in this type of occupational therapy, a child such as Quentin could be expected to lose the ability to perform this task. Because of the need for continuity, there are specific

attendance tracking rules and regulations in place that must be followed for students within the Division of Special Education. These are in addition to the attendance regulations that apply to all students, both special education and general education alike. In fact, the Division of Special Education has its own attendance bureau, called the Attendance Improvement Office, which is separate from the attendance bureaus within each community school district that monitor general education students.

In an attempt to understand the many attendance rules and procedures in place and how they are utilized by the Board employees charged with attendance responsibilities, we reviewed the Board's 1990-91 School Attendance Manual (hereafter, "Attendance Manual"), along with Regulations of the Chancellor and the P.811 1994-95 attendance plan. What we found were regulations and guidelines which in some instances are irreconcilable with each other or too vague to implement.

For the purposes of this report, we have tried to describe the rules and procedures in clear, easy-to-understand language, even though such language is not utilized in many of the rules themselves. Therefore, this report may appear to give the rules and procedures a clarity which they in fact lack.

The Attendance Manual's stated purpose is to serve as a "guide and a tool to help establish a solid foundation for student attendance programs," and, as such, it is the manual used by Board personnel to institute attendance procedures. It is supposed to explain the rules regarding the attendance of all students, in both the general and special education divisions. However, while the Attendance Manual is fairly clear with regard to monitoring the attendance of general

education students, it does not give a clear presentation of how all special education students are to be monitored. Adding to the confusion, the 1990-91 manual has not been updated, even though some of the attendance regulations concerning special education students have been changed. We learned in the course of this investigation that the new regulations are not automatically distributed to attendance personnel, whose job it is to follow the rules in tracking student absences. Rather than receiving copies of the new regulations, attendance personnel usually are simply given the manual, which is both out of date and somewhat unclear on the procedures to be followed for special education students. It is hardly surprising then, that the personnel who were supposed to trigger an attendance investigation in Quentin's case did not do so because they failed to understand the rules and procedures.

In spite of this confusion, an examination of the attendance rules demonstrates that there are two mechanisms that should have resulted in an investigation of Quentin's prolonged absence. The first of the two is the Attendance Teacher's Absentee Report, otherwise known as "Form 407." According to the rules,³ if, after no more than ten days of unexplained absence and after the school has attempted to contact the parent, the student remains absent with no explanation, a Form 407 must be completed and forwarded to the appropriate bureau of attendance. Similarly, a Form 407 must be issued when a student has been transferred to another school but a request for the student's records or for verification of admission to another school has not been

³ Regulation of the Chancellor A-210 (6.3.1).

received within ten days.⁴ Obviously, there are numerous concerns underlying these rules which apply to all students, such as the protection of children from harm and the desire to prevent students from being truant from school.

The appropriate attendance bureau, upon receipt of a Form 407, will assign an attendance teacher to investigate the child's absence and to return that child to school. But an attendance bureau does this only when it receives the absentee paperwork, Form 407. Consequently, it is imperative that the attendance administrators at the child's school follow the rules and file the required form. Otherwise, no one searches for the missing child.

In addition to Form 407, which should be completed for any student in the school system, the Division of Special Education separately keeps track of its own students who have been absent for twenty consecutive days. The Division is supposed to do this by maintaining a list of pupils who have missed twenty days, or approximately four weeks of school. This list is called the "Special Attendance Register" or the "SAR." When a student is to be placed on the SAR, the student's teacher is supposed to inform the site's unit coordinator and the Committee of Special Education in charge of the absent student's educational evaluation and placement.

According to the 1990-91 School Attendance Manual, special education students who have been placed on the SAR will remain on this list until they return to the school or to a different special education program, are discharged from the school system, or have been decertified from the Division of Special Education. In Quentin's case, P.811 placed him on the SAR on

⁴ Regulation of the Chancellor A-210 (6.3.2).

December 2, 1994 and removed him from that list on January 5, 1995, with a notation that Quentin had been admitted to another school.

The SAR should serve as a further safeguard by reminding attendance personnel to prepare a Form 407 if they have not already done so, even though a Form 407 should previously have been prepared after the absent student missed ten consecutive days of school. As stated above, the 407, in turn, should trigger an investigation into the absence of the child. Thus, the rules provide two separate mechanisms -- Form 407 and, indirectly, the SAR -- that should have called attention to Quentin's prolonged absence.⁵ However, the people who should have initiated these mechanisms did not, because they did not fully understand how the system is supposed to work.

As a result, Quentin Magee missed thirty-seven consecutive days of school -- the entire months of November and December -- before appearing at the final school he attended, P.396, on January 3, 1995. At P.811, the school he had left, he was simply marked absent day after day. The administrators there did not prepare a Form 407 after his tenth consecutive unexplained day of absence. No calls were made to Quentin's family to find out why he was not in school.

Though Quentin's name was placed on an SAR, that paperwork accomplished nothing since it failed to generate a Form 407. Consequently, the attendance rules that, when taken together, are supposed to fashion a safety net, were not followed in this case. Quentin Magee, for all practical purposes, simply disappeared.

⁵ Jennifer Tunison, Coordinator of the Division of Special Education Attendance Improvement Office, stated that Division of Special Education schools and programs are not required to submit SAR lists to her office. According to Ms. Tunison, her office initiates attendance investigations only upon the receipt of Form 407.

DURING QUENTIN'S ABSENCE

Sometime during November, 1994, a second call was placed by someone in Quentin's family, this time to Community School District 29, where the P.811 program is located, to inform school personnel that the Magee family was moving to Brooklyn.

This meant that Quentin would be moving out of District 29. Rita Palley, the Division of Special Education employee who took the call, made no written notes about it, and remembers neither the date nor the name of the person who made the call to District 29. On November 28, 1994, Ms. Palley passed along information regarding the call she had received about Quentin to Steven Koch, Placement Officer of the Citywide Placement Office of the Division of Special Education. By this time, Quentin had been absent without explanation for one full month. That same day, Mr. Koch enrolled Quentin in a new special education program, P.396, by contacting the P.396 main site. The P.396 program was chosen for Quentin based on the location of his new home in Brooklyn. He was enrolled at the P.396 satellite site housed at P.S.9 because it had space available for a new student.

Mr. Koch also arranged for Quentin to be placed on a bus route to his new school, effective December 7, 1994. He recalls choosing December 7 as the start date for Quentin in order to allow time for Quentin's school records to be transferred to his new program and to provide time for the Office of Pupil Transportation to assign Quentin to the appropriate bus route, serviced by ABLE Bus, Incorporated.

Here again is one more instance in which attendance regulations were not followed. The P.396 main site, the

receiving school, should have noticed that a transferring student, Quentin Magee, had failed to report to his new school on December 7 -- the day he was due to arrive. After a student transferring within the Division of Special Education has failed to appear for five consecutive days, the rules require that the receiving school contact the sending school to alert them that the child is missing.⁶ The sending school, in turn, is supposed to file a Form 407, thereby initiating an investigation. Thus, here was another safeguard in place that should have resulted in an attendance investigation beginning December 13, weeks before Quentin finally returned to school.

On a date in early December 1994, ABLE bus driver Julius Tatum pulled up to Quentin Magee's new address in Brooklyn, ready to receive this new passenger. Mr. Tatum cannot recall the exact date that he made his first stop at Quentin's home.

A woman, presumed by Mr. Tatum to be Quentin's mother, appeared at the bus door and told the driver that Quentin was then or recently had been hospitalized -- Tatum cannot recall exactly what the woman said. He does remember her saying that she would call Quentin's new school when the child was able to attend. Mr. Tatum did not provide this information to ABLE Bus because he thought that he was merely required to fill out a daily bus attendance sheet which he gave his supervisor at the end of each day. Mr. Tatum added that when he dropped the children off at the school he would "...tell the school that Quentin didn't come, that's all. They'll see that the child didn't come when they, you know they got to come out and take him off the, the elevator so, they, they, you don't have to have no papers signed what they know."⁷

⁶ Regulation of the Chancellor A-210 (6.3.5). See also the 1990-91 School Attendance Manual.

⁷ Unfortunately, both the information on Mr. Tatum's attendance sheets and that provided to us by ABLE Bus

In fact, Quentin Magee was hospitalized on November 29 and 30, 1994, according to a home care attendant assigned to care for Quentin at that time. Denise Hytmiah, the attendant, recalls that Quentin was admitted to Brooklyn Hospital for treatment of a fever that reached 106 degrees. According to Ms. Hytmiah, Quentin's stay in the hospital was brief, and, in fact, he returned home on December 1. Dr. Julio Tardio, Quentin's pediatrician and primary physician, was unaware that Quentin needed to remain home from school for medical reasons or that Quentin had been hospitalized during this period. Indeed, Dr. Tardio was unaware that Quentin had not attended school between October 28, 1994 and January 3, 1995 and knew of no reason for his absence.

Even if it was necessary for Quentin to have a lengthy recuperation period at home due to this brief hospitalization, there was no need for his schooling to be disrupted for several weeks. Instead, Margie Magee could have arranged for his education to continue during that time. Home or hospital instruction is available to children within the Division of Special Education who cannot attend school because of a medical condition or a severe emotional disability. This educational service is considered temporary and is provided only until the disabling conditions have been corrected to the point at which the child can return to his regular school program. According to Division of Special Education records, Quentin's mother did not seek home instruction for her son during his two month absence from school. Instead, it appears that she made no attempt to maintain instruction for Quentin -

concerning Quentin's bus travel is inaccurate -- Quentin was marked present when actually absent and absent when actually present. ABLE Bus could provide no explanation for the inaccuracies other than to state that Mr. Tatum made some mistakes.

- either by bringing him to school or by bringing school to him -- between October 28 and January 3, when she finally appeared with Quentin at P.396.

Quentin's return to school on January 3, 1995 coincided exactly with the date on which Margie Magee was forced to make due with a reduction in home-care attendant services authorized for Quentin by Medicaid. Previously, Medicaid had approved payment for fifty hours of care per week. This was during the latter part of 1994, at approximately the same time that Quentin was absent from school. This meant that Quentin had full-time care at home, while Margie Magee held a full-time job.

The weekly allotment of home care hours was a matter that Ms. Magee did not control. Instead, the number of home-care attendant hours provided to a patient is determined by the New York City Human Resources Administration/Department of Social Services (hereafter, "DSS"), which administers Medicaid services.

The process begins when a patient's doctor makes a recommendation to DSS citing how many hours and days the patient needs an attendant, according to Ms. Renette Damas, Assistant Field Director of the Central Civic Agency, which provided home-care attendants for Quentin from the summer of 1994 to the beginning of January, 1995. According to Ms. Damas, DSS then sends a case worker and a nurse to the patient's home to evaluate the patient and his needs. Subsequent to the evaluation, DSS contacts an agency, such as Central Civic, for a home attendant and tells the agency the number of hours and days of home care to provide. Ms. Damas stated that Central Civic then sends its own nurse to evaluate the patient. She further explained that in "special cases"

such as the Magees, when a student is not in school because of a holiday or school break, the parent can ask DSS to increase the number of home-care attendant hours. If DSS approves the request, Central Civic will increase the number of hours accordingly. DSS then pays Central Civic using Medicaid funds, and Central Civic, in turn, pays its home-care attendants.

Two of the home-care attendants who cared for Quentin from late November until early January, 1995 recall that Quentin did not attend school during this period. The two attendants, Denise Hytmiah and Yvonne Frazier, remember Quentin as being very thin and frail, frequently ill and malnourished.

Authorization for fifty hours of home care per week, which provided full-time care at home, ended on January 2, 1995. Thus, as of January 3, Medicaid would no longer cover the cost of a home care attendant for Quentin during school hours. On that day, Quentin finally returned to school, attending his new program at P.396 for the first time.

By the time Margie Magee took Quentin to his new school, he had been absent for over eight weeks. He remained on the P.811 attendance list until January 5, 1995; on the P.811 bus roster until December 7, 1994; he had been officially enrolled as a P.396 student since November 28, 1994; and had been scheduled for bus transportation to P.396 since December 7, 1994. He was enrolled in two different schools and yet was attending neither one. Nor was he receiving any instruction at home. Nevertheless, no one from the Board of Education made any effort -- not even that required by school regulations -- to find out why this child was missing.

THE FINAL WEEKS OF QUENTIN'S LIFE

On January 3, 1995, Margie Magee took Quentin to his new school, P.396, for orientation. Marva Henderson, the unit coordinator at the school, had been previously notified that a new student would be joining her program but was not told when to expect him. The P.396 main site pupil accounting secretary had merely provided Ms. Henderson with Quentin's name and nothing more. When Quentin and his mother appeared on January 3, Ms. Henderson recalls meeting them, interviewing Quentin's mother and taking her on a tour of the school. Along the way, Quentin and his mother were introduced to the unit's registered nurse, Wendy Walker. Nurse Walker recalls observing that Quentin required a wheelchair with a harness, was unable to talk, and could not feed himself. Quentin's mother told the nurse that she gave her son phenobarbital to control his seizures, but provided little other medical information regarding Quentin.

Following this day of orientation, Quentin returned to school the next day, January 4, and the day after that, January 5. He then dropped out of sight again and did not return to school until January 18.

This time Quentin's absence was noticed. Marva Henderson, the unit coordinator, contacted Margie Magee to find out what had happened to Quentin. Quentin's mother stated that she kept her son home from school because she, rather than Quentin, was sick. Ms. Magee also blamed one day of her son's absence on the fact that the bus driver refused to carry Quentin from his home to the bus.⁸

⁸ ABLE Bus driver Julius Tatum, who transported Quentin to and from the P.396 satellite site, responded that bus drivers are prohibited from lifting or carrying children, and it is the parents' sole responsibility to deliver the child to the bus stop. He told Quentin's mother this the first time he went to Quentin's home. P.396 teacher Laura Recchia

Margie Magee's claim that her own illness prevented her from sending Quentin to school is contradicted by one of the witnesses in this case who saw Ms. Magee during that period of time. The witness is Patricia Macklin, a home-care attendant employed by the L.B.J. Agency and assigned to provide part-time care for Quentin during what turned out to be the last few weeks of his life. According to Ms. Macklin, Margie Magee was not sick at the time she claimed to be ill, but was at home painting her apartment with the assistance of two men.

Apparently, it is Quentin who was sick for at least a portion of the lengthy January absence from school. According to Quentin's regular doctor, Julio Tardio, M.D., Margie Magee brought Quentin to see him on January 17, 1995 at the Central Brooklyn Medical Group P.C. offices. Ms. Magee complained that her son was constipated, and that he needed to be placed on high-protein liquids. Dr. Tardio agreed that Quentin was suffering from severe constipation after an x-ray revealed that the child's bowels were impacted. The doctor told Ms. Magee that Quentin needed a stool softener. He did not, however, prescribe one. Nor did he recommend a high-protein supplement, reasoning that this could worsen the constipation.

During Dr. Tardio's January 17 examination of Quentin, he observed that Quentin's ribs protruded but added that his ribs were always noticeable. In his opinion, Quentin was thin but not emaciated. Dr. Tardio noted no difference in Quentin's appearance on that date compared to previous examinations and

recalls Mr. Tatum, who is seventy-eight years old, complaining to her that Quentin's mother wanted him to carry Quentin out of the house and that he refused. The Board's Office of Pupil Transportation, 1982 School Bus Contractor's Manual of Procedures and Requirements, No. IV, section 5, states in part that "Escorts and drivers are not required to lift pupils." In cases where a child must be carried, a second escort or a porter will be assigned to the bus.

was not concerned about the child's frailty. Indeed, the doctor did not even weigh Quentin during this examination. Nor was he later surprised when he was informed that Quentin's weight had dropped from 35 pounds when the doctor last weighed him in August, 1994, to only 27 pounds at the time of his death. Concluding his examination, Dr. Tardio gave a note to Quentin's mother, to send back to school with Quentin, which stated that her son was well enough to attend. This was January 17, three days prior to Quentin's death.

QUENTIN'S DECLINE

In total, Quentin attended his new school for only four days: January 4 and 5, and January 18 and 19. On the fifth day, January 20, it is probable that he was dead by the time he arrived at school. Several of the teachers, administrators, and paraprofessionals who saw him during these final days give similar descriptions of Quentin's physical condition: his health declined dramatically between his first two days of school, January 4 and 5, and his last two days, January 18 and 19. While he was extremely thin in early January, according to some P.396 staff members, he was nevertheless alert and responsive. In contrast, they say, by January 18, he was "emaciated," "fragile," and "too weak and lethargic to participate in class," an opinion quite the opposite of that given by Dr. Tardio, Quentin's pediatrician, in his note to the school.

Quentin's teacher at his new school, Mary Kinsey, taught five children, including Quentin, all of whom she considered the lowest functioning students in the school. In Quentin's case, Ms. Kinsey's job was especially difficult because P.396 had not received his school records, despite several requests

to P.811 for these records.⁹ Because a student like Quentin, who is unable to speak, cannot be expected to communicate even his most basic educational and medical needs, his file is critical to the school personnel entrusted with his care. Quentin's school records contained his educational plan, and without it his new teachers had no idea where to pick up the prescribed course of speech and occupational therapy. Mary Kinsey never did receive Quentin's records -- the paperwork finally appeared three days after he died.

When she first met Quentin on January 3, his orientation day, Ms. Kinsey was impressed by the fact that he seemed alert and attentive. In contrast, on January 18, Ms. Kinsey was quite alarmed by Quentin's appearance and felt he was too weak to be in school. Consequently, she asked P.396 registered nurse Wendy Walker to examine him.

The nurse's log for January 18, 1995 contains an entry made by Nurse Walker describing Quentin as having puffiness to both eyes, a sore on his right hip, redness in the area of his pelvic bone and an emaciated appearance. The log notes his weight as approximately 31 pounds. Nurse Walker asked her colleague and office-mate Alenthia Robertson, a registered nurse assigned to the P.S.9 Modified Instructional Services program in the same building as P.396, to examine Quentin. Nurse Robertson noted many of the same problems: Quentin suffered from a bed sore on his right hip; his ribs were protruding and he showed visible signs of dehydration; he appeared emaciated and, in her opinion, in need of feeding by tube. Nurse Robertson advised Nurse Walker to contact

⁹ Regulations of the Chancellor A-701(5), A-725 and A-820(XI) instruct the sending school to send a student's medical and educational records to the receiving school upon a student's transfer. The regulations, however, fail to explain the methods by which the sending school will be notified as to when or where the records should be sent.

Quentin's doctor immediately.

Nurse Walker informed Nurse Robertson that Quentin had arrived at school that day, after a lengthy absence, with a doctor's note stating that the child was fit to attend school.

Nurse Robertson nevertheless counseled Walker to call the doctor. According to Nurse Walker, she tried, only to learn that Dr. Tardio was out of the office for the day. She then attempted to contact Margie Magee, whose telephone line at work was busy. Nurse Walker made no subsequent attempts that day to reach the doctor or a relative. Thus, Quentin remained at school even though he was apparently too weak and lethargic to participate.

That afternoon, Quentin was met at the home-bound school bus by Patricia Macklin, the home-care attendant mentioned earlier in this report. Ms. Macklin's job was to care for Quentin between the hours of 2:00 and 6:00 p.m. each weekday, taking him home from the school bus, bathing him, changing his clothes, and feeding him. According to Ms. Macklin, Margie Magee would leave food that had already been prepared and then call home at approximately 4:30 p.m. with instructions regarding what Ms. Macklin should feed her son. Ms. Macklin recalls that Quentin would clench the spoon when food was placed in his mouth, frustrating the process all the more. His afternoon diet consisted of a liquid nutrient supplement accompanied by foods such as pureed frankfurters, canned spaghetti, and canned ravioli. Ms. Macklin thought that the food provided by Quentin's mother was inappropriate -- too hard to digest and lacking in nutritional value. She also recalls remarking to Ms. Magee that Quentin had a cold during the entire time that he was under Ms. Macklin's care. Ms. Magee responded that Quentin always suffered from a cold -- it was part of his

medical condition. In fact, what Ms. Macklin may have observed was a case of pneumonia, which was detected later during the autopsy by the Office of the Medical Examiner.

Ms. Macklin provided care for Quentin from January 10 until January 19, 1995. Because she was with him on January 19, the eve of Quentin's death, she was one of the last people to see him alive.

JANUARY 19, THE DAY BEFORE QUENTIN'S DEATH

Quentin wept both on the way to school on the morning of January 19, and on the way back home, according to Wilda Smith, the school bus matron assigned to Quentin's route. His teacher, Mary Kinsey, recalls that Quentin's eyes were so swollen and puffy that day that he could scarcely open them. Educational Assistant Guillermo Rodriguez observed Quentin whimpering as though something was wrong. However, neither one of the two nurses who had examined Quentin the day before saw him on January 19. Wendy Walker, Quentin's school nurse, took the day off for a doctor's appointment and apparently left no instructions for her replacement to examine the child or to contact his mother or doctor. The other nurse, Alenthia Robertson, made no effort to check on Quentin either.

The nurse who did see Quentin was a replacement nurse, Agnes Aban, who was filling in for Wendy Walker that day. Ms. Aban recalls escorting children on a school field trip to the supermarket that day, but she does not remember Quentin or any of the other children. She does remember, however, that she was not alerted in any way, either orally or in writing, that there was a child whose health should have been monitored and his doctor or parent contacted. In fact, Ms. Aban says she was not provided with any information or records regarding any

of the children placed in her care. As a result, no effort was made by anyone to check to see that Quentin was well enough to be at school that day.¹⁰

On the way home from school, bus driver Julius Tatum observed that Quentin was gritting his teeth. When he was delivered to his home, Patricia Macklin, the home-care attendant, was waiting for him. She remembers that Quentin was asleep when he was removed from the bus. Ms. Macklin says that he later awoke during the process of her bathing and changing him and then went back to sleep. Also, Ms. Macklin recalls, Quentin's mother called and instructed Ms. Macklin not to wake Quentin in order to feed him. Instead, Ms. Magee stated that she would feed Quentin herself after she got home from work. When Quentin's mother came home, Ms. Macklin left, assuming that Quentin was sleeping. The next she heard, Quentin Magee was dead.

QUENTIN'S FINAL TRIP TO SCHOOL

It was raining on the morning of January 20 when he pulled up to the curb at Quentin's address, according to ABLE school bus driver Julius Tatum. By Mr. Tatum's account, the time was approximately 7:15 a.m. He recalls that on that morning, unlike others, Quentin's mother was standing at the front door of the Magee home waiting for the bus to arrive. This was in contrast to other mornings when he had to wait a few minutes for Quentin and his mother to appear.

Quentin was brought to the bus by his mother and placed on the wheelchair lift by Mr. Tatum. According to Mr. Tatum,

¹⁰ In contradiction to Agnes Aban, Wendy Walker testified that she did leave a list of instructions for the substitute nurse. She did not say, however, that any part of the instructions concerned Quentin Magee. This office was provided with the nurse's notes prepared by Wendy Walker. A copy of these instructions for the substitute nurse, if

he operated the lift, elevating Quentin in his wheelchair to the side entrance of the bus where escort Wilda Smith received the child. It was her job to secure Quentin's chair inside the bus.

Ms. Smith received Quentin on the bus that morning the way she receives all wheelchair-bound children -- by standing in the bus at the lift entrance and, as Quentin was elevated on the lift, grabbing the wheelchair from the back and wheeling it to an open space on the bus. Ms. Smith then secured Quentin, again from the back of his wheelchair, with a belt. According to Ms. Smith, she neither touched Quentin nor saw his face during this process. She could not say whether Quentin was alive or dead when he was on the bus.

WHAT SHOULD THE ESCORT HAVE OBSERVED?

Wilda Smith works as a bus escort, meaning that she is a bus company employee whose services are a cost passed on by her employer to the Board of Education. As an escort, it is her job to oversee the safety of school children while they are riding in a school bus. We asked Ms. Smith to describe her duties as she understands them. In her view, her responsibilities are quite limited, with an emphasis on never having contact with the children in her charge.

On January 19, for example, though Quentin wept both on the way to school and on the way home, Ms. Smith chose not to say anything to Quentin's mother, reasoning, "...you don't suppose to tell them if the kid is sick or not, just do what you have to do, just hook up the chair, that's it."

According to Ms. Smith, once all of the children are secured, either on seats or in their wheelchairs, she sits in

they in fact exist, was not among Walker's notes.

the middle of the bus where she can "check the kids." To Ms. Smith, however, checking the kids means doing virtually nothing; she seldom talks to the children or observes them once they have been secured on the bus. Ms. Smith claims she was instructed by her employer, ABLE Bus, to touch the wheelchair, not the child. She says no one ever told her to speak to the children or to look at them for any reason. According to Ms. Smith, she has not received any first aid training or instruction regarding medical emergencies. Furthermore, she claims that she was not provided with medical information concerning any of the children assigned to her bus.

Wilda Smith's understanding of her duties is shared, in some respects, by Ingrid Fray, a bus escort working for Consolidated Bus Company. Ms. Fray was the escort assigned to the bus that Quentin took to school when he attended P.811 in Queens. According to Ms. Fray, she constantly checks the children on her bus but is not permitted to touch them. She does not, therefore, unbutton their coats, take off their hats, or do anything to increase their comfort level if doing so requires physical contact with the child. Ms. Fray also claims that she has never received first aid training.

In sharp contrast to the job descriptions given by Wilda Smith and Ingrid Fray is the job description actually stated by the Board. According to Board regulations, escorts are supposed to take a hands-on approach to assisting students. The escorts' duties are supposed to include all of the following: administering first aid in emergencies; executing a prescribed plan of action if an accident or serious illness occurs; maintaining an emergency medical data card for each student; walking through the bus aisle frequently to ensure

student safety; maintaining a good rapport with the students; and reporting any suspected incidents of child abuse to school administrative personnel.¹¹ Obviously, these duties were unknown to Wilda Smith on the morning of January 20. She did not touch Quentin and, in fact, did not even look at his face, which explains why she does not know if he was dead at pickup or by the time he arrived at school.

QUENTIN'S ARRIVAL AT P.396

When Quentin's bus arrived at P.S.9 at approximately 8:45 a.m., Ms. Smith unbuckled Quentin's belt from the back of the wheelchair, held the back of the chair and wheeled it to the lift. Mr. Tatum operated the lift and lowered Quentin to street level, where Quentin was received and taken into the school by a member of the school staff. Like Wilda Smith, Julius Tatum could not say with any certainty whether Quentin was alive when he was placed on the bus on the morning of January 20. Mr. Tatum recalls that Quentin was very quiet that morning, and, was "so restrained...he could be deceased or dead and you wouldn't even notice that 'cause how he got him tied in the chair."

Mr. Tatum later informed detectives at the 77th Precinct of the NYPD that when he placed Quentin on the bus that morning, the child's eyes were closed and he did not move. He also reported to the police that he noticed nothing unusual about the child that morning. That assessment is not surprising since, apparently, it was common for some of the children riding Quentin's bus to sleep during the long ride to school. Finally, Mr. Tatum stated to Jo Anne Masterson,

¹¹ Regulation of the Chancellor A-805 (IV); Office of Pupil Transportation, "An Escort's Guide to Clean, Safe and Reliable Transportation."

Secretary of ABLE Bus, that Quentin was asleep when placed on the bus that morning and remained asleep when received by the P.396 staff.

Wilda Smith gave differing accounts of the January 20 bus ride to everyone with whom she spoke. She informed NYPD detectives that Quentin Magee was alive when delivered to P.396 that morning but added that she never had contact with the children; she informed Dennis Harrington, an investigator for the Board's Office of Pupil Transportation, that when Quentin was brought to the bus that morning, she did not really notice whether he was conscious because it was hard to tell with him -- adding that Quentin looked the same as usual; she informed Jo Anne Masterson of ABLE Bus that when she received Quentin into the bus that morning, she pulled the wheelchair off the lift from behind and was therefore unable to see his face. Ms. Smith added that she did not look at Quentin, nor did she notice his condition even while securing his wheelchair in the bus. As a result, she did not know whether Quentin was awake, but could only say with certainty that he was very quiet; she told Doris Klueger, Director of Pupil Personnel Services for Community School District 13, within which the P.396 satellite site is located, that Quentin made noises on the bus that morning; and, finally, she told George Fornaci, principal of the P.396 special education program, that she did not know whether Quentin was dead or alive when placed on the bus that morning.

Quentin was met at the bus by Educational Assistant Guillermo Rodriguez, one of the staff members waiting for Quentin's bus that morning. Mr. Rodriguez received Quentin as his wheelchair was lowered from the bus. Because it was raining, Mr. Rodriguez hurriedly wheeled Quentin inside to the

cafeteria, where the children began their day each morning. To Mr. Rodriguez, Quentin appeared to be asleep.

But the situation looked much worse to Mary Kinsey, Quentin's teacher. As Rodriguez recalls it, Ms. Kinsey approached Quentin to remove his hat and coat and commented that he "did not look right," and that his lips were very pale. Ms. Kinsey then touched Quentin and asked Mr. Rodriguez to help her feel for a pulse. Not finding a pulse, Mr. Rodriguez placed his finger under Quentin's nose to see if he was breathing but did not feel any breath. By this time, other staff members surrounded Quentin and someone stated that the child was very cold. According to Mr. Rodriguez, the staff was very concerned and a call was placed to 911 immediately.

Mary Kinsey recalls that when Quentin was wheeled into the cafeteria that morning she removed his hat and observed that his eyes were closed, his lips were white and his hands were blue and cold to the touch. Laura Recchia, another teacher in the P.396 satellite program and one of the staff members responsible for meeting the school bus in the morning, walked over to Quentin and observed that he made no sound or movement, did not respond to being touched and had cold hands and sunken eyes. Ms. Recchia thought Quentin was dead. Because Wendy Walker, the P.396 program nurse, had not yet shown up for work, Alenthia Robertson, the P.S.9 nurse referred to earlier in this report, was summoned.

Alenthia Robertson remembers being approached by P.396 Educational Assistant Colette Wilson and told that a child in the cafeteria was not responsive. Nurse Robertson rushed to the cafeteria and, upon seeing Quentin, directed someone to call 911 immediately. According to Nurse Robertson, she then

checked Quentin's wrist and neck for a pulse but did not detect one. She detected no respiration and observed no movement of his body. Quentin's face was ashen, his lips were pale, his pupils were dilated, and he was cold to the touch. Nurse Robertson tried to pry his fingers open but was unable to do so because they were stiff and rigid. His jaw was also locked. She then checked Quentin for a heartbeat using a stethoscope but could not detect one. Nurse Robertson described Quentin's coloring as cyanotic, meaning that his skin was turning bluish or grayish because of an insufficient supply of oxygen to his blood.

Nurse Robertson stated that, based on her observation of Quentin coupled with her prior nursing experience, she knew that Quentin was already dead when she examined him. Nurse Robertson added that, in an attempt to keep the other children and school staff calm, she rubbed the child's chest around the area of his heart and patted his hand. She did not tell anyone that Quentin was dead and, in fact, acted as if Quentin was alive so as not to upset anyone. Nurse Robertson did not attempt to resuscitate Quentin, because, in her opinion, he was already dead.

According to Nurse Robertson, the years she spent working in a hospital emergency room prior to joining the Board of Education taught her how to recognize the signs of death. She says she is equally familiar with the criteria used to determine when CPR is effective. According to Nurse Robertson, it is futile to perform CPR once rigor mortis is observed. Signs of rigor mortis include, but are not limited to, stiffness and rigidity of the body, coldness to the touch, no vital signs, dilated pupils, an ashen color, no heartbeat or respiration and a lack of movement -- all of which were

exhibited by Quentin Magee. While she had no way of knowing how long the child had been dead, she believed that he died before he was brought into the school. By her assessment, Quentin had been dead for at least ten minutes by the time she was summoned to examine him.

OUTSIDE INTERVENTION: EMS AND THE POLICE

Four calls were made to 911 by staff members before an ambulance arrived approximately twenty-five minutes later. Each successive call was between two and three minutes in duration and provided 911 and EMS operators with insufficient or incorrect information.

P.S.9 school secretary Janet Scott made the first call at approximately 8:59 a.m., after teacher Laura Recchia ran into the P.S.9 office and instructed Scott to call 911 because, according to Ms. Recchia, "we have a sick child downstairs in the cafeteria." Having relayed this information, Ms. Recchia ran back to the cafeteria. In response to the call, Ms. Scott was told by an EMS operator who had been connected to the 911 call that, because she had no specific information about the emergency, the call would be entered as a "very low priority."

Seeking more information about the emergency, Ms. Scott told parent volunteer Rosa Wright to run to the P.396 cafeteria. Seconds later, Ms. Wright returned, having just been told by Nurse Robertson that the child was not able to breathe and that his coloring was leaving his face. Ms. Scott then told the EMS operator, who had remained on the line, that "the child cannot hardly breathe."

When no ambulance arrived, Laura Recchia ran back to the school office and told Ms. Scott to call 911 again. Ms. Scott

made this second call at approximately 9:09 a.m., seven minutes after the first call was concluded. Once again the call was connected to an EMS operator, who stated that an ambulance was on its way. This operator also asked Ms. Scott whether the child's condition had changed, to which she responded "no."

When another few minutes had passed, at approximately 9:14 a.m., the third call to 911 was made, this time by Dr. Rosalie Schwartz, principal of P.S.9. Dr. Schwartz told both the 911 and EMS operators that there were two nurses with the child, that he had stopped breathing, and that the nurses could not find a pulse. The 911 operator, upon learning that the child had stopped breathing, informed the EMS operator that she had "changed the code," apparently indicating a heightened level of emergency. Dr. Schwartz was asked if anyone was performing CPR. Not knowing that the answer was "no," the principal answered "yes, the two nurses down there."

The EMS operator stated that EMS was on its way and commanded Dr. Schwartz to "tell them to keep doing it," referring to CPR.

Seconds later, a fourth call was made to 911 by Marva Henderson, the unit coordinator of Quentin's program at P.396.

Another EMS operator stated that EMS was trying its best to get there as soon as possible. Ms. Henderson stated "we have a child with respiratory problems" and that the child was neither awake nor breathing. She told the EMS operator that she did not know whether CPR was being administered by the nurse. The operator responded, "I'm pretty sure that she knows how to do CPR."

While the EMS operators apparently presumed that the school nurses were administering CPR, this was not the case.

Alenthia Robertson had already decided that CPR would be futile. And when Wendy Walker, who was thirty minutes late for work, finally arrived at approximately 9:00 a.m., she briefly examined Quentin and noted how rigid he seemed. In Nurse Walker's view, Quentin might have been dead for as long as an hour. She agreed that CPR was pointless.

Two police officers arrived at the school before the ambulance did. It was approximately 9:20 a.m., according to the report of Officer John Farrell of the 77th Precinct, when he entered the school and was told by the principal, "he is dead." EMS arrived minutes later, at approximately 9:24 a.m., followed by paramedics and fire fighters. EMS Emergency Medical Technician (hereafter, "EMT") Kim White recalls entering the room and observing a child strapped in a wheelchair surrounded by two police officers and two nurses who were doing nothing. According to EMT White, one of the nurses complained that EMS took too long to respond. EMT White removed Quentin from the wheelchair and immediately began administering CPR, attempting to pump air into his nose or mouth. Quentin's jaw was "clamped closed" which made CPR very difficult to perform. Nevertheless, EMT White and his partner, EMT DiPalmo, disagreeing with the judgment of the two school nurses who chose not to attempt CPR, and relying on EMS protocol, performed CPR on Quentin for approximately twenty minutes without response. CPR was continued in the ambulance and in the emergency room at Brooklyn Hospital, where Quentin was pronounced dead at approximately 10:00 a.m.

QUENTIN'S FAMILY LEARNS OF HIS DEATH

According to witnesses, Margie Magee was contacted and told to come immediately to the school. She arrived at P.396

accompanied by an unidentified man. By this time, Quentin had been taken to the hospital, and Ms. Magee and her companion were directed to go there.

At the hospital, Margie Magee wept at her son's bedside, according to P.396 speech improvement teacher Amaris James, the Board employee who was instructed to accompany Quentin to the hospital. In addition to Margie Magee, Ms. James also saw Quentin's grandmother, who was attempting to comfort Quentin's mother. Ms. James heard Quentin's mother saying, "I don't understand. I woke him up this morning and he went back to sleep." Also, at the hospital, EMT White overheard Quentin's grandmother telling someone on the telephone that the family was going to sue. In fact, Margie Magee has since filed notice of her intent to sue the City of New York, the Board of Education, and the New York City Department of Health in connection with the death of her son.

Later that day, Maddie Magee went to P.396 and requested the return of all of Quentin's belongings, including his wheelchair and the items stored in a bag that usually hung on the chair. However, one of those items, a notebook, was no longer in the bag. Earlier that day, the notebook had been taken as possible evidence by a detective from the 77th precinct.

QUENTIN'S NOTEBOOK

Quentin's teacher, Mary Kinsey, required each of her P.396 students to carry a notebook which was to be kept in a book bag attached to the child's wheelchair. The notebook was to be the means of daily communication between Ms. Kinsey and the parents. As a student in Mary Kinsey's class, Quentin had the required notebook in his book bag.

Guillermo Rodriguez recalls that on the day of Quentin's death, police detectives came to the school and examined Quentin's wheelchair and other belongings. Mr. Rodriguez showed a detective the January 20 notebook entry written by Margie Magee. According to Mr. Rodriguez, Ms. Magee wrote that Quentin had slept after he returned home from school on January 19, that her son was up that night as a result, and that he might therefore be asleep on the bus on January 20. Mr. Rodriguez, Ms. Kinsey and others at P.396 considered the January 20 entry quite odd since many of the children, including Quentin, normally slept on the bus, and because Quentin's mother chose only January 20, the date of his death, to mention that Quentin would be sleeping on the bus.

Guillermo Rodriguez observed a detective take Quentin's notebook, and Mr. Rodriguez assumed that the police found the final entry to be significant. However, the police apparently discounted any significance because they gave the notebook back to Margie Magee without maintaining any copy of the book's content. When our office sought to examine the notebook, we were informed that it was no longer in police custody. According to a detective, Quentin's mother had come to the precinct shortly after her son's death and had asked to be given the notebook. This detective recalls that the notebook was returned to Ms. Magee, and no copies were made of the January 20 entry. When asked why, the detective responded that the notebook contained only a child's scribbles and drawings, and there was no need to retain it or copy its pages. Our office subsequently served Ms. Magee with a subpoena for the notebook. In response to the subpoena, we were informed by her attorney that Ms. Magee had given the notebook to her seven-year-old daughter, who later lost it.

Because Margie Magee declined to answer our questions, we have been unable to determine why she sought the return of the notebook. Also unexplained is the contradiction in her account of Quentin's condition the morning he died. After Quentin's death she told Derrick Stanley, Quentin's father, that their son was awake and his eyes were open when she brought him to the bus. However, Ms. Magee said the opposite to the Office of the Medical Examiner, claiming that Quentin fell asleep prior to boarding the bus and was asleep when he was put on the bus. This version is consistent with the observations of Julius Tatum, the bus driver, who told the police that Quentin had his eyes closed and did not move at the time Tatum placed him on the bus.

While Ms. Magee has chosen not to cooperate with this investigation, she did give a statement to the Office of the Medical Examiner. In addition, in her notice of claim indicating her intention to sue, Ms. Magee states, through her attorney, that Quentin died sometime after he arrived at school. However, the Medical Examiner's findings regarding the time of death differ from Ms. Magee's version. The Medical Examiner has determined that Quentin died sometime between 4:00 a.m. and 8:45 a.m., the time at which Quentin first arrived at school.

THE AUTOPSY RESULTS

An autopsy was performed on Quentin Magee that included toxicology testing. The results revealed that Quentin suffered from an excessive amount of phenobarbital. The amount of phenobarbital discovered in Quentin's blood was more than twice the amount that should have appeared in his system, given his prescribed dosage. Dr. Thomas Andrew, who performed

the autopsy and reviewed all the test results, has stated that the level of phenobarbital found in Quentin's blood was of a "dangerously toxic level." According to Dr. Andrew, that level could easily cause someone to be extremely drowsy or lethargic at the very least, and could cause a child in Quentin's condition to become so lethargic that he could not be aroused.

While Dr. Andrew could not conclude whether the phenobarbital intoxication was committed intentionally or accidentally, he did state that the cause of death was largely attributed to the excessive amount of phenobarbital.

In addition, Quentin Magee was also severely dehydrated. He suffered from a seizure disorder. He weighed a mere 27 pounds at the time of death -- the same amount he weighed at age four. No food was found in his stomach. His bowels were extremely impacted. He suffered from acute pneumonia. Because of Quentin's cerebral palsy, and because his body was emaciated, containing little muscle tone and virtually no fat, Dr. Andrew could not accurately determine the exact time of death or rigor mortis. He was, however, able to state a range of the time of death based upon his observations of Quentin's body and internal organs coupled with information he learned about the case: from approximately 4:00 a.m. on January 20, 1995 until approximately 8:45 a.m., the time Quentin arrived at P.396 that morning. Dr. Andrew added that he was more comfortable stating that the time of death occurred on the earlier end of the time frame rather than the later.

As stated earlier in this report, the Office of the Medical Examiner initially determined that Quentin died of natural causes. However, as a result of Dr. Andrew's autopsy and a review of the test results, the death certificate lists

the manner of death as "undetermined" and states that the injury occurred from "excessive phenobarbital administered to decedent."

THE AFTERMATH

Not surprisingly, Quentin's death came to the attention of a number of supervisory personnel within the Board of Education. Some of these individuals were asked to examine the role their subordinates played in the case of Quentin Magee. The reports prepared by two such supervisors are described here because those assessments were deficient, and the performances of those supervisors inept.

The first of the two is Peter Smergut, who was at that time the Supervising Principal of the Division of Special Education. Smergut has since left the Board, taking a job in the private sector. At the time of Quentin's death, however, it was Smergut who wrote a memorandum to the Executive Director of the Division, Howard Tames, addressing whether school regulations had been followed in Quentin's case. With respect to attendance regulations, Mr. Smergut reported the following:

First, he wrote that Quentin's last day of attendance at P.811 was October 26, 1994. This is incorrect -- Quentin's last day was October 28. Mr. Smergut went on to say that, "At that time, the school followed SOPM [Standard Operating Procedures Manual] attendance procedures and filed a 407 placing the student on the LTA [Long Term Absentee] register."

This is also incorrect. As noted earlier in this report, no Form 407 was ever filed, even though Quentin was absent for two months.

By stating that a Form 407 had been filed, Mr. Smergut

implies that the appropriate attendance investigation was conducted. This too is incorrect. No such investigation was undertaken, because no one prepared a Form 407. At best, Mr. Smergut submitted his memo after receiving incorrect information by someone within the Division who erroneously reported to him that the requisite Form 407 had been filed. Regardless, Mr. Smergut's report neglects to address the confusion regarding attendance rules and regulations.

Mr. Smergut also fails to criticize his subordinates at P.811 and P.396 who were unacceptably slow in transferring Quentin's school records from the former school to the latter.

Given the fact that Quentin's grandmother reported on October 28, 1994 that Quentin was leaving P. 811, and given the fact that ten school days passed during which time no other school contacted P.811 to request Quentin's records, P.811 was required¹² to file a Form 407. That should have been done on November 11, 1994. If P.811 had filed a Form 407 at that time, an attendance investigation into Quentin's whereabouts would have begun shortly thereafter.

P.811 is not alone in this failure: the P.396 main site learned on December 7, 1994 that Quentin had been enrolled in their program. Yet they failed to request his records until January 5, 1995, nearly a month later. Had P.396 requested Quentin's records earlier, his new teachers could have familiarized themselves with Quentin's educational and medical needs and prepared to teach Quentin from the moment he appeared at their school. Instead, Quentin's records were not requested until January 5, two days after he appeared with his mother for orientation. Then, to make matters worse, delivery

¹² Regulation of the Chancellor A-210 (6.3.2), which is also referred to in footnote 4.

of the records by P.811 was also slow. As stated earlier in this report, Quentin's records were not at his new school the day he died, and, indeed, did not arrive until three days after his death.

Mr. Smergut notes the absence of the records but does not explain the failures on the part of those responsible. Nor does he comment on the apparent ambiguities and confusion in the regulations regarding the transfer of records. In view of his misstatements and omissions, Mr. Smergut's report reflects poorly on his ability to perform his supervisory duties.

What is commendable about Mr. Smergut's report is his recommendation that in the future all medical alerts be sent by fax to the transferring student's new school, rather than being routed through the Citywide Placement Office. This measure should ensure that vital medical information is passed expeditiously. Oddly enough, this recommendation, laudable as it is, essentially counsels one administrative unit to bypass another -- the Citywide Placement Office -- hardly a vote of confidence in the efficiency of the system.

The other supervisor who warrants mention here for mediocre performance is Nursing Supervisor Carole Marchese, who was asked to review the actions of nurses Wendy Walker and Alenthia Robertson. Ms. Marchese is one of two nursing supervisors employed by the Board to supervise the 173 nurses assigned to public schools throughout New York City. Ms. Marchese states in her written review that she interviewed both Nurse Robertson and Nurse Walker in order to ascertain the facts regarding the death of Quentin Magee. Her report appears accurate insofar as it describes the events that took place the morning that Quentin died, when Nurse Robertson and,

later, Nurse Walker arrived on the scene.

What is notable about Ms. Marchese's report, however, is the omission of several critical pieces of information. First, she makes no mention whatsoever of the fact that both Alenthia Robertson and Wendy Walker had been very concerned about Quentin's deteriorating condition two days before he died. Nowhere does Ms. Marchese mention that both Nurse Walker and Nurse Robertson examined Quentin on January 18, 1995. Nor does Ms. Marchese discuss the fact that, even though Nurse Walker accepted the responsibility of alerting either Quentin's doctor or his mother that Quentin needed medical assistance, Nurse Walker never followed through. As mentioned earlier in this report, after making one attempt to reach the doctor and one to reach Ms. Magee, Nurse Walker simply gave up. She made no further attempts that day and the evidence suggests that she left no instructions for her replacement to make another attempt the following day.

Ms. Marchese's report describes the events of the days preceding Quentin's death as this: "He [Quentin] returned to school on Wednesday, January 18, 1995 [after being absent for several days] with a doctor's note stating that he had been seen by the doctor on the 17th of January. Nurse Walker had been absent on Thursday the 19th of January and had not yet spoken to Quentin's mother regarding his doctor's visit." In other words, Ms. Marchese never mentions the fact that Nurse Walker failed in her responsibility to contact either Quentin's mother or his doctor. Ms. Marchese did not take notes during her meeting with Nurse Walker and cannot remember whether Nurse Walker told her about the telephone calls. By the time Nurse Walker next turned her attention to Quentin, on January 20, 1995, he apparently was already dead in his

wheelchair in the cafeteria of P.396. On that day, Walker did not get to school on time, a fact that is noted in Ms. Marchese's report. Ms. Marchese states that, according to Nurse Robertson, Walker's tardiness was due to inclement weather, a claim that is credible because it was raining the morning that Quentin died. Yet, the fact that Nurse Walker was not at her post on time meant that Alenthia Robertson had to assume the responsibility for Quentin, a child under Walker's direct care. Ms. Marchese does not comment on this fact either.

Another notable omission in Ms. Marchese's report is her failure to ascertain why Alenthia Robertson did not administer CPR to Quentin. Nurse Robertson was the first medical professional to reach Quentin on the morning of his death and it was she who had the earliest opportunity to perform CPR. Yet she did not.

So tentative is the Marchese report that it states the following: "I asked Ms. Robertson if CPR had been initiated and she reiterated her previously mentioned assessment [of Quentin's medical condition]. She did not directly answer my question."

Apparently, Ms. Marchese allowed Nurse Robertson to avoid explaining why she failed to perform CPR. This could be considered a calculated omission, if Ms. Marchese was contemplating the possibility that someone might later try to hold Robertson accountable for Quentin's death. Nevertheless, it is Ms. Marchese's responsibility to evaluate the nurse's performance, rather than to try to avoid addressing what actually happened on the morning that Quentin died.

Ms. Marchese states in her report that she made a follow-up visit to the school to discuss the events surrounding

Quentin's death. About this meeting she states that "Emergency procedures were reviewed and discussions were held regarding appropriate nursing practices and protocols." Again, it appears as though Ms. Marchese is trying to be as vague as she possibly can.

That Ms. Marchese sought to defend both nurses is demonstrated by the final paragraph of her evaluation of the Magee case. She concludes with a commendation of both Nurse Walker's and Nurse Robertson's responses to a different medical emergency involving a child other than Quentin. Notably absent are any conclusions about the performance of the nurses in Quentin's case.

Ms. Marchese's report is no more useful than is Peter Smergut's. It avoids fully stating the facts and evaluating them in any critical way. As a nursing supervisor, Marchese is supposed to carefully monitor the performance of the nurses she oversees, and offer corrective advice when necessary. Her two-page report serves neither purpose.

WHAT WENT WRONG/RECOMMENDATIONS

Here, in brief summary, is a listing of the various ways in which school personnel failed Quentin Magee and our recommendations for systemic change and personnel actions. These recommendations, if implemented, can assure better services for special education students and may help prevent a future tragedy.

1. ATTENDANCE:

Quentin Magee missed 37 consecutive days of school, yet Board employees charged with his care failed to make the requisite efforts to find him. The many attendance rules in place -- whether in the Regulations of the Chancellor or in one of the several Board documents addressing attendance -- provided not one but two mechanisms that should have triggered an investigation into Quentin's absence. Those regulations were not followed and Quentin's absence was never questioned until after his death.

The Board's failure to investigate Quentin's disappearance undermined all aspects of his educational plan.

The Board's own Committee on Special Education had determined that Quentin needed to attend school year-round to ensure that he maintained his progress. So concerned is the Board for the education and well-being of special education students that not only is twelve-month schooling provided at considerable cost to the Board, but also procedures are in place to provide home-bound or hospitalized students with educational instruction.

Furthermore, the Board has various bureaus of attendance whose primary purpose is tracking children who are missing

from school. In Quentin's case, however, the attendance bureau for special education students was never provided with the information needed to trigger an attendance investigation.

Obviously, the many regulations and procedures in place to educate and care for children like Quentin are only beneficial if enforced. In this case, the individuals who misunderstood or ignored the regulations failed Quentin Magee, the type of student who needed them most.

It is important to note, however, that this failure of Board personnel to enforce attendance regulations in no way lessens the responsibility borne by Margie Magee for the education of her son. The Board of Education necessarily relies on parents to help ensure that students come to school when possible, or receive home instruction if appropriate.

RECOMMENDATION: The current attendance monitoring rules would be adequate to ensure that no child's prolonged absence goes unnoticed, if only they were better explained. The rules as written are in many instances needlessly confusing, resulting in an attendance system that seems more complicated than it really is. Some regulations fail to state whose responsibility it is to perform particular attendance tasks. Still others fail to clarify the particular event from which to begin counting days to determine when enough days have elapsed (ten, for example, in the case of Form 407) to trigger an attendance investigation. Furthermore, the Attendance Manual should be clarified, and also updated to reflect new regulations as they take effect. The manual must remain current if it is to be a guide relied on by attendance administrators.

It is clear that those charged with the responsibility of

monitoring attendance in this case did not fully understand the regulations. While it cannot be determined whether the outcome of this case would have been different had all of the attendance regulations been followed correctly, it is clear that the intervention that should have occurred in response to Quentin's absence did not. Because the regulations were misunderstood, no one within the Board was given the opportunity to intervene. Though Quentin was missing, an attendance investigation was not initiated, the possibility of home instruction was not addressed, and the individuals who should have made inquiries about Quentin's well-being did not.

In our view, what happened to Quentin must provide a warning to all attendance administrators that no child should go unnoticed for so many days because a missing child may be a child in distress.

To avoid similar attendance problems in the future, we therefore recommend that the attendance bureaus for both general and special education students review the regulations and simplify them where possible. Finally, and of critical import, the Board must make sufficient efforts to see that administrators understand the rules and comply with them. The Board must see to it that its directives regarding training of attendance personnel are enforced.

2. FAILURE TO DELIVER SCHOOL/MEDICAL RECORDS:

Quentin Magee had been dead for three days by the time his educational records finally arrived at P.396, his new school. His medical records were requested by, and hand delivered to, P.396 on the day he died, but only after P.396 school administrators learned of Quentin's death. Obviously, the death of a new student should not be the catalyst that

prompts school administrators to acquire that student's records.

Placing a child with Quentin's needs in a new program without providing his educational and medical records was senseless. Indeed, Quentin could not express his needs and certainly could not explain his educational plan to his new teachers. By not delivering Quentin's records to P.396 in a timely manner, an unfair burden was placed on the educators at P.396. Without his records, Quentin's new teachers had no way of knowing his instructional plan, and could not possibly know where to pick up his course of occupational and speech therapy. Perhaps even more significantly, those persons entrusted with Quentin's care were lacking a complete set of medical records regarding a child who could not voice his needs.

RECOMMENDATION: In all cases of a special education student transferring from one school to another, administrators receiving notice of the transfer (usually the Citywide Placement Office) must be required to see that a copy of the student's medical and educational records are delivered to the child's new school prior to his arrival. Additionally, in the case of special education students who have special medical needs, a verbal exchange of critical information from the sending teacher and nurse to the receiving teacher and nurse should occur before or on the date of transfer.

3. SCHOOL-BASED MEDICAL CARE:

School nurses Alenthia Robertson and Wendy Walker were alerted to Quentin Magee's medical condition by worried teachers on January 18. Nurse Robertson, though not directly

responsible for children in Quentin's program, examined him, as did her office-mate Nurse Walker. Both were concerned that Quentin needed immediate medical attention. Wendy Walker, who was directly responsible for Quentin, made two telephone calls, both uncompleted, to Quentin's doctor and mother. She did nothing more.

Although Nurse Walker knew she would not be at work the following day, she apparently left no instructions for the substitute nurse to contact Quentin's mother or doctor. Nor did she alert the substitute nurse that Quentin should be checked. Alenthia Robertson did not examine Quentin during Nurse Walker's one day absence, leaving Walker's duties to the substitute nurse.

Having observed Quentin's condition on January 18, it is inexcusable that Nurse Walker made so meager an effort to reach Quentin's doctor or mother. When her efforts failed, she could have called EMS for assistance, as a last resort. Instead, Quentin was merely sent home on January 18 and his health ignored on January 19, belying the concern expressed by Alenthia Robertson and Wendy Walker. He died the following morning.

RECOMMENDATION: We recommend that Wendy Walker receive severe disciplinary action which could appropriately include termination of her employment with the Board. While it can never be determined whether Quentin's life might have been saved if Nurse Walker had obtained medical assistance for Quentin on January 18, it is clear that Nurse Walker observed his distress that day, yet failed to carry out her responsibility to Quentin. By failing to notify his parent or doctor regarding her assessment of Quentin's condition, she

failed not only Quentin, but also her colleague, Alenthia Robertson, as well as the teachers who were relying on Nurse Walker to get help for the child. By her own admission, Wendy Walker made only two calls, both uncompleted, and, because it was then the end of the day, merely placed Quentin on the bus and sent him home. Though Nurse Walker was aware of the notebook used by P.396 to communicate with Margie Magee, she did not make an entry about her concern for Quentin. She simply sent him home on the bus without communicating her concern, and did nothing more.

Parents have a right to expect that a school nurse will carry out nursing responsibilities to the children in his or her care. Nurse Walker's actions did not meet the standard of care that Board nurses owe to the students in their charge. Given her observations regarding his medical condition, Nurse Walker's two incomplete attempts at seeking assistance for Quentin were plainly insufficient.

4. CALLS TO 911:

Of the four calls placed to 911, each contained incorrect or insufficient information. We place no blame on the callers -- all of whom showed much concern for Quentin.

RECOMMENDATION: Because critical information about Quentin and his medical condition was poorly communicated, the seriousness of the emergency was not immediately realized. We recommend that the Board carefully review the procedures followed in emergencies to ensure that those procedures are adequate and understood by all employees.

5. BUS ESCORTS:

Bus escort Wilda Smith cannot say whether Quentin Magee was alive or dead during his one-and-a-half hour bus trip to school on January 20. She did not look at his face and did not touch him. Indeed, Ms. Smith believes that she is not supposed to touch the children entrusted to her or interact with them in any way. To some, it may seem unfathomable that Ms. Smith did not know whether this child in her care was dead. Yet it is highly likely that Ms. Smith did not know, given her understanding of her duties as a matron.

In our view, it is imperative that bus escorts follow existing Board regulations and guidelines. An escort who performs a role as limited as Ms. Smith's is all but useless to the children entrusted to her care. In contrast, if the guidelines are followed, escorts will ensure that children are secured on the bus, perform first aid if needed, report suspected child abuse when it is observed, and maintain a good rapport with the children.

Frequent monitoring of the children on the bus is especially important to a student such as Quentin, who cannot voice his needs. By observing a child's demeanor or facial expressions, an escort should be able to tell if the child is in distress. What's more, simple compassion dictates that escorts ought to be permitted to unzip a heavy jacket or remove a hat, for example, if such actions would prevent a child from sweltering during what can be a long and tiresome bus ride to school. To allow a matron to merely stand by and ignore obvious human needs seems unwise and unnecessarily cruel.

Had Wilda Smith interacted with Quentin on the morning of his death, either by trying to speak with him, or by simply looking at him, she might have assumed that he was sleeping,

as many of the children tend to do during the bus ride. On the other hand, she might have determined that Quentin needed immediate medical attention. In turn, bus driver Julius Tatum could have used the bus radio to contact EMS or otherwise seek immediate medical assistance.

Wilda Smith is paid \$8.32 an hour for the limited work she performs, and the Board of Education spends upwards of 50 million dollars per year to provide escorts on every special education vehicle. Clearly, if the Board spends 50 million dollars a year on escorts who cannot tell whether a child is dead or alive because the escort failed to look at the child, something is drastically wrong. The Board must work to ensure that it is getting the quality of service it is paying for.

RECOMMENDATION: The Board should examine the quality of escort services provided by ABLE Bus, Inc. and review the training provided by ABLE to its escorts to determine whether ABLE is in compliance with existing Board regulations and procedures. Upon a finding of non-compliance, ABLE must correct its deficiencies or be held in default for a breach of its contract with the Board, serial number 0070, dated June 22, 1993. Likewise, a warning should be issued to Consolidated Bus Company that its escort training and supervision may be inadequate based on the statements of escort Ingrid Fray. Finally, we recommend that the Board reiterate its standards of professional conduct for bus escorts and ensure that all school bus contractors comply with these standards. This should include requiring that contractors certify that all escorts have received proper training regarding these standards.

6. SUPERVISORY FAILURES:

Senior Board administrators Peter Smergut and Carole Marchese were both called upon to report the facts regarding their subordinates' involvement in the case of Quentin Magee.

Peter Smergut submitted a report that contained false information, while Ms. Marchese's report, in a different fashion, appears to emphasize favorable facts about Nurse Robertson and Nurse Walker while avoiding the unfavorable facts. Both reports were inadequate, and both administrators failed in their responsibilities to provide guidance and supervision to their employees. They also failed to take action that might prevent similar errors in the future.

RECOMMENDATION: Due to their supervisory failures, we recommend that letters of reprimand be placed in the personnel files of both Mr. Smergut and Ms. Marchese. In spite of the fact that Mr. Smergut no longer works for the Board, his permanent file should reflect his failure to perform in the event that he seeks future employment with the Board.

7. EMS:

EMS medical technicians did not arrive at Quentin's school until approximately 25 minutes after they were first called for assistance. It was not until the third call for help that EMS upgraded the code of the emergency to a more serious level.

RECOMMENDATION: EMS has conducted its own internal investigation regarding the emergency response of its employees. We are referring our evidence to EMS for their analysis and review.

8. DR. JULIO TARDIO AND MARGIE MAGEE:

An examination of what went wrong in this case would be incomplete without acknowledging that the two individuals who were in the best position to help Quentin Magee were his mother, Margie Magee, and his pediatrician, Dr. Julio Tardio.

Margie Magee, Quentin's mother and caretaker, entrusted her son's education to the New York City Board of Education, and yet she kept him out of school for lengthy periods of time. Indeed, New York State Social Services Law section 371 includes in its definition of "neglected child" a child "whose physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his parent or other person legally responsible for his care to exercise a minimum degree of care in supplying the child with adequate...education..." In addition, Regulation of the Chancellor A-750 instructs all Board employees to file a report of suspected child abuse or maltreatment with the New York State Central Register upon the belief that a child is suffering from educational neglect. Ms. Magee, therefore, as Quentin's parent and guardian, was required by law to ensure that her son received adequate education. Clearly, she was in a better position than anyone to ensure that Quentin attended school or received medical care for his declining health. Ultimately, primary responsibility for his education and welfare rested with her.

Ms. Magee now claims through her attorney that the Board of Education, among others, is to blame for the death of her son. However, the findings of the Medical Examiner's Office

regarding the time of Quentin's death make it seem more likely that Quentin Magee died before he arrived at school on the morning of January 20, 1995. Indeed, he may have died as early as 4:00 a.m. that morning. Additionally, Quentin's death was in part caused by "excessive phenobarbital administered to decedent," medication provided to Quentin by Ms. Magee. Exactly when Quentin died, and on whose watch, is a question that can probably never be answered with certainty. And although Ms. Magee was in a position to provide this investigation with important and helpful information about her son, she chose not to.

As for Quentin's physician, Dr. Julio Tardio, he was primarily responsible for Quentin's medical care, and it is difficult to understand how Dr. Tardio could have found Quentin fit to attend school when the child's physical condition appeared to be deteriorating so dramatically.

RECOMMENDATION: It is not the mandate of this office to reprimand or make recommendations regarding health care providers who are in no way connected to the Board of Education. With that in mind, we are referring our findings regarding Dr. Tardio to the New York State Department of Health, Office of Professional Medical Conduct, whose responsibility it is to evaluate physicians licensed to practice medicine in New York State.

ENDNOTE

It is unusual, perhaps, to end a report such as this with a commendation. However, it appears that a commendation is warranted in this case. The teachers, unit coordinators, and paraprofessionals who actually provided education to Quentin

Magee represented to us the highest level of dedicated and caring professionals. These Board employees include: Carol Brady, Marva Henderson, Mary Kinsey, Guillermo Rodriguez, Laura Recchia, Amaris James, Marlene Alexander, Rosemary Tranchant, and Colette Wilson, among others. Their desire to help Quentin and provide him with a comfortable, positive, and dignified learning environment is exemplary.