Edward F. Stancik
Special Commissioner

NEWS RELEASE
September 19, 1995

REPORT RELEASED ON THE DEATH OF SPECIAL EDUCATION STUDENT

Special Commissioner Edward F. Stancik will release a report entitled *An Investigation into the Death of Eight-Year-Old Quentin Magee*, at 10 a.m. today. Quentin, a severely disabled Special Education student attending P.396 in Brooklyn, was brought into school without a pulse and not breathing on January 20, 1995. EMS technicians called to the scene were unable to revive him. The Office of the Medical Examiner found a primary cause of death to be an excessive dose of phenobarbital, a medication Quentin took for a seizure disorder. Quentin's mother refused to cooperate with our investigation without assurances that she would not be subject to criminal prosecution.

The Special Commissioner's report examines the complicated series of events leading to Quentin's death.

Many of the Board of Education employees who came in contact with Quentin were both compassionate and capable. While it is uncertain whether any Board employee could have saved Quentin, alarming individual and systemic failures eliminated any chance for the school system to intervene and prevent Quentin's death. These failures include:

• Prior to his death, Quentin transferred from P.811 in Queens to P.396. After he left P.811 in late October, 1994, he was absent from school for 37 consecutive days without Special Education officials taking notice. Though regulations require an investigation when a student is absent for 10 consecutive days, no investigation was conducted.

• School staff were concerned about Quentin's emaciated appearance two days before his death. A school nurse who examined him placed calls to his mother and doctor but left no messages and made no follow-up efforts.

• Quentin, who was wheelchair-bound, was secured in his school bus by an escort on the morning of his death. However, that escort is unable to say whether he was alive or dead at the time. In her misguided understanding of her duties, she claims that it is not her job to look at the children on the bus.

• Quentin's educational and medical records, which, according to Board rules, should have been at P.396 well before Quentin's own arrival on January 3, did not arrive there until three days after his death.
The report recommends both systemic reforms and personnel action. If enacted, these recommendations will ensure more effective delivery of Special Education services and may help prevent another tragedy from occurring.