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TRIAL LAWYERS

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November 10, 2006

File No. 06009.001

Via California Overnight

The Honorable William Lockyer
Attorney General of the State of California
1300 I Street, Suite 1740
Sacramento, California 95814

Re: Yoni Gottesman Drowning

Dear Attorney General Locker:

As you know, this office represents Anat and Oded Gottesman, parents of the deceased minor child Jonathan "Yoni" Gottesman. Yoni was 4 years old when he died on August 15, 2005. He drowned in the Cathedral Oaks Athletic Club ("COAC") swimming pool within a few feet of two lifeguards and three camp counselors while attending an unlicensed day care program at the facility.

A Santa Barbara County Sheriff's deputy was called to the scene that day, but conducted no investigation of the events leading to Yoni's death. After a cursory investigation, the Santa Barbara County Coroner's office pronounced Yoni's death to be an accidental drowning. Only after our clients hired legal counsel who engaged a private investigator to conduct an investigation into their child's death (a summary of which was provided to the District Attorney's office), did the District Attorney conduct any investigation at all. Even with all of the information provided by private counsel, the D.A.'s investigation was sloppy, inadequate and incomplete. Over our clients' strenuous objections, District Attorney Tom Sneddon announced at a July 13, 2006, press conference that he did not intend to pursue any criminal charges relating to Yoni's death.

We request that the Attorney General's office open an independent investigation into Yoni's death and convene a grand jury for the purpose of issuing indictments for child endangerment and involuntary manslaughter against those persons and entities found to be responsible for Yoni's death. We find it necessary to request your intervention as Attorney General to prevent a grave miscarriage of justice.

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First, as set forth herein, we believe that the laws of the State of California are not being equally enforced across the State. If certain conduct warrants prosecution for child endangerment or involuntary manslaughter in Riverside, Sonoma or San Jose counties (see cases below), that same conduct must also be prosecuted in Santa Barbara county. It is not. As Attorney General, we ask that you intervene to ensure the equal application and enforcement of State laws.

Second, it has become clear that the Santa Barbara County Sheriff and District Attorney failed to timely and adequately investigate Yoni's death. In doing so they ignored important evidence, and in some instances did not follow up on crucial evidence. The D.A. did not scrutinize the Sheriff's failure to investigate or his conflicts of interest with owners of the COAC. The D.A. did not act to prevent even the appearance of impropriety in the handling of the investigation. He did not consider that on lesser facts and evidence, other jurisdictions in California have found probable cause to charge child endangerment and involuntary manslaughter. The entirety of these events has resulted in discriminatory enforcement of the criminal laws.

I. Events Leading to Yoni's Death

The COAC operated a child day care program called the "Summer Activity Camp" ("Camp") for children ages four to ten at the Club's facility located at 5800 Cathedral Oaks Road in Santa Barbara, from 1999 to the date of Yoni's death on August 15, 2005. Regardless of its name, the State of California Department of Social Welfare has determined that the Camp was a day care program within the meaning of Health & Safety Code section 1596.70, requiring a license. Licensing ensures that day care programs will be inspected periodically by department personnel to insure compliance with, among other things, adequacy of staffing, staffing credential requirements, background checks and safety of facilities. Despite the licensing requirements, COAC had no license to conduct the Camp at the time of Yoni's death in August 2005, or at any other time.

In the two weeks before his death, Yoni attended another day camp in Santa Barbara. When it ended, Yoni's parents signed him up to attend the COAC Camp with two of his friends. The Camp involved art, games and sports, including tennis and swimming. In promotional materials for the Camp, COAC stated that it was "proud to introduce an exciting and educational program for children ages 4-10." Part of the educational experience offered in connection with the Camp was swim lessons. COAC's brochure for swim lessons touted its "solid reputation for providing the highest quality swim instruction available," and promised that participating children would have a "*safe experience*." Even today, COAC's website boasts that its aquatics instructors are "professionally trained to help you reach your goals safely," and that its child care program is a "fun and safe environment."

Despite the public representations that activities at COAC were safe, and the implication that the Camp was a properly licensed program that met all requirements of the State of California, in fact the Camp was an unsafe, illegal and unlicensed child care program. The deficiencies of the Camp included, but were not limited to:

- a) Improper hiring and training of lifeguards, resulting in incompetent lifeguard personnel being "on duty" when young children were in the pool;
- b) Lack of training of Camp counselors regarding the assignment of specific children to specific counselors, which would have required the counselors to observe, monitor and protect the children in their care;
- c) Failure to establish a procedure during the Camp's "recreational swim time" under which specific lifeguards and/or counselors were assigned to observe, monitor and protect specific children in the pool;
- d) Even after administering swim tests to determine the swimming skill level of all Camp participants, complete failure by the lifeguards and counselors to monitor the children and ensure they swam only in the section of the pool (e.g., the shallow end) for which their ability allowed, resulting in increased and potentially life-threatening danger to the children; and
- e) Improper and inadequate CPR and resuscitation training, procedures and equipment.

On August 15, 2005, the day he died, Yoni attended the Camp for the first time. Anat Gottesman took her four-year old son to the Camp believing it to be a safe facility and program to entrust with the care of her son. In the morning, Yoni participated in a separate swim lesson, during which time the swim instructor arrived at the opinion that Yoni was "overconfident in his swimming abilities," and that he needed to hold on to the side of the pool. This opinion was not conveyed to the Camp counselors or lifeguards.

Shortly after 2:00 p.m., thirteen children, including Yoni, went to the pool accompanied by the three counselors and a counselor-in-training. As part of the Camp swim session, the children were given a "swim test" that consisted of children swimming at the same time from the stairs to the lane line and back. Afterwards, the counselor who gave the test restricted Yoni to the shallow end of the pool. The counselors and lifeguards did nothing to enforce that restriction, however. Moreover, the shallow end of the 30' by 45' pool was 3'6" deep (the deeper end was 6' deep); little Yoni was only 3'5" tall. Thus, he would not be able to stand, and his head would be completely submerged, even in the shallowest portion of the pool.

The Camp had three counselors and a director. While at the pool, the children were supervised by two lifeguards and the three counselors. In addition, two swimming instructors were present periodically while giving swim lessons to other children. As the children began to

swim, two counselors remained on the pool deck; one was seated in such a position that she could not possibly monitor the pool, and the other was distracted by other children not in the pool. Only one counselor was in the pool with the children, but he did nothing to monitor the safety of the children; on the contrary, as explained below, he added to the danger faced by the children. One lifeguard was at each end of the pool. A total of approximately 12 to 14 people were in the swimming pool at the time.

During the first twenty minutes of the "recreational swim time," Yoni Gottesman drowned. Yoni drowned, not through some unforeseen or unstoppable cause, but through the negligence and wilful misconduct of Defendants. The COAC pools are monitored by closed circuit television which is recorded on a hard drive.¹ Of the five operable cameras on August 15, one was directed at the pool in which the Camp children swam. The final minutes of Yoni's life were captured by the surveillance camera focused on the COAC pool. The video shows:

- a) A COAC counselor aggressively "dunking" and otherwise "rough-housing" with several children in the pool, during which he repeatedly raises children in the air and then dunks them into the water with significant impact; Yoni Gottesman is believed to have been among those children;²
- b) Immediately after a round of dunking, all of the figures swimming away from the site except one: a single child's form is seen briefly struggling to stay afloat. Shortly thereafter, that form goes prone, floating in or atop the water.
- c) **Eight minutes** passing without any of the three counselors or two lifeguards taking any notice of the lifeless figure floating only feet away.
 - One lifeguard – *directly in front of and only a few feet away from* where little Yoni was dying – sits motionless and oblivious to Yoni's condition;

¹ Rather than review the original hard drive, the DA utilized lower-quality video CD's. This not only rendered the video less useful, it also apparently led to the DA's report referencing a slightly different time line (by approximately 8 to 10 seconds) than what is shown on the original hard drive.

² Our office currently is in the process of locating an expert technician capable of enhancing the video, but it appears from the entirety of the video that Yoni was one of the children dunked. As part of an investigation by your office, we would like to submit the hard drive of the video to the State crime lab to see if it is able to enhance the video.

one of the few times the lifeguard moves is to turn his back to the pool and adjust his umbrella for better shade protection.

- The second lifeguard (from the far end of the pool) similarly does nothing to save Yoni for the first *six minutes* Yoni is floating in the water; he then *walks right past where Yoni is floating face-down and motionless in the pool and leaves the pool deck to get a soda*. He does not return to the pool area until after Yoni is pulled from the pool.
 - The counselor in the pool repeatedly returns to within a couple of feet of where Yoni is floating face-down in the pool, and continues to “dunk” other children, but takes no notice of Yoni’s motionless body right next to him.
- d) It is only after a *Camper* notices Yoni floating in the pool and calls for help that anything happens. Even that call for help elicits no reaction from the nearest lifeguard; it is not until a counselor on the pool deck – who hears the call from the little boy – goes to the lifeguard and points out the lifeless figure that the lifeguard finally jumps in to pull Yoni from the pool. Not surprisingly, when he finally was pulled out of the water, Yoni was non-responsive, limp, blue in coloring and had white foam seeping from his mouth.

Thereafter, improper resuscitation and CPR techniques and equipment were used on Yoni. Even after Yoni was pulled from the pool, it took nearly another two minutes for a call to be placed to 911. Without any basis, the dispatcher was told it was “a seizure.” The paramedics arrived approximately eight minutes after Yoni was pulled from the pool and found that Yoni had no pulse. They immediately questioned the lifeguard about how long the child had been submerged in the pool; the lifeguard responded: “No more than a minute.” A Deputy Sheriff, Tom Green, arrived approximately six minutes after the paramedics. At 2:48 p.m., twenty-one minutes after he was pulled from the pool, Yoni was transported to Goleta Valley Cottage Hospital. He was pronounced dead an hour later.

We have contacted several renowned experts in the field of aquatics safety and the pathology and stages of drowning. Uniformly, they all state that: (1) The “10/20 Rule” advocated within the ANSI/NSPI Standards for Public Swimming Pools, as well as other organizations, should be implemented and adhered to by lifeguard personnel at all public and semi-public swimming pools; (2) At a minimum, lifeguards must scan their zone of responsibility twice within each 30-second period (the “30-Second Rule”); and (3) The American Red Cross advocates the need for a lifeguard to be vigilant and to constantly scan his/her zone of

responsibility.³ Had any of these actions occurred, Yoni's distress would have been recognized with appropriate intervention occurring before he deteriorated into respiratory arrest, and then further into cardiac arrest. Furthermore, (4) COAC was responsible for developing and implementing its own operational protocols and was responsible for guaranteeing that lifeguard and counselor personnel were able to adhere to these protocols; (5) Anytime a child is allowed to swim in water above his shoulders, he is at a heightened risk for drowning; (6) It is medically impossible for a child to drown in the 20 - 30 seconds it should have taken for the lifeguards to recognize Yoni's distress, and time is critical as there is a limit on full recovery (e.g. brain damage occurs after 3 - 4 minutes under water); and (7) After COAC and its employees assumed the responsibility to care for Yoni, they abandoned him and breached their duty of care to properly supervise him. The experts we have spoken with have called what happened to Yoni Gottesman "outrageous," "deplorable" and "horrific."

II. Events Immediately After Yoni's Death

Deputy Sheriff Green left the scene a mere **twelve minutes** after he arrived. Although he briefly chatted with the lifeguard who pulled Yoni from the pool, Deputy Green left without conducting any formal interviews, without pursuing any kind of investigation, and without apparently taking any notice of the video cameras or attempting to secure the video recordings. (See, Santa Barbara County District Attorney's Office Investigation Report, Attachment I, DA00064.) Deputy Green did nothing to designate the pool area as a crime scene and took no action to preserve the integrity of the scene until a full investigation could be conducted. Instead, because Deputy Green left the scene, COAC employees immediately hosed down the pool deck and nearby objects, and removed all soiled towels. Deputy Green did not write a report until sometime later when asked to do so by his Supervisor.

Another Deputy Sheriff, Kelly Moore, who was on duty that afternoon, left his shift and went to the COAC at 3:30 p.m. after receiving a call from his wife. His wife reported that his niece, who worked at COAC, had called and was distraught. Although he was not there in an official capacity, Deputy Moore noticed the cameras and discussed with his niece telling the management to save the tapes. He also noticed that the staff had been sequestered and asked to write statements of what had occurred. (Attachment I, DA00077-78.) Through this process, COAC was able to control and monitor the preparation of written statements by its employees. No one from law enforcement intervened in this questionable procedure.

³ This latter protocol essentially is codified in California Code of Regulations, Title 22, Chapter 20, Section 65539(b), which provides that the number of lifeguards "shall be adequate to maintain *continuous surveillance* over the bathers."

When the Coroner was notified of Yoni's death, the Sergeant in charge of the Coroner Bureau, Deputy Court Williams, and Sheriff Coroner Investigator Deputy John Kolbert, conducted a cursory investigation and summarily concluded Yoni's death was an accidental drowning. (Attachment I, DA00079-82.) Until Mr. and Mrs. Gottesman retained legal counsel who hired a private investigator to conduct an investigation and undertake extensive witness interviews, no real inquiry was made into how a four-year-old child – otherwise completely healthy – possibly could have died in plain view of numerous adults who were charged with his care and safety.

Following the tragic death of Yoni Gottesman, the State of California, Department of Social Services, fully investigated the Camp and determined that: (1) COAC provided child care when it operated the Camp; (2) the Camp did not have a license to provide child care; and (3) the Camp did not meet the criteria to be license exempt. On October 11, 2005, the Department of Social Services sent COAC a letter notifying it that it was operating a child care facility without a license in violation of California Health and Safety Code Sections 1596.80 and 1596.805. COAC appealed that ruling three separate times, all of which were rejected by the Department of Social Services. To Plaintiffs' knowledge, COAC never attempted to rectify its violation of law by obtaining the requisite license. Even more astounding, prior to the third rejection of COAC's appeals, the President and Oversight Manager of COAC stated that she didn't know what would happen if the third appeal failed because, in her opinion, "what is needed for child care licensing is not appropriate for a camp-type situation."

The drowning of Yoni Gottesman was not the first, or last, water safety incident at COAC or its sister organization, SBAC. As early as mid-2000, to only a week prior to Yoni's death, a number of near drownings occurred at COAC that were attributable to negligent supervision. As late as two days prior to Yoni's death, parents observed COAC lifeguards paying little or no attention to the children in the pool. Within weeks following Yoni's death, a parent observed children swimming *completely unattended by a lifeguard* at the SBAC pool. COAC did nothing to inform parents of these incidents and/or the lack of supervision prior to enrolling their children in the Camp.

III. The District Attorney's Inadequate Investigation and Baseless Refusal to Prosecute

On November 2, 2005, the Gottesmans' former counsel wrote to District Attorney Sneddon requesting a formal investigation be opened into whether the death of their son was the result of criminally culpable conduct. That request included a copy of our clients' private investigator's report and the witness statements he gathered. The District Attorney's office assigned D.A. Investigator Paul Kimes to conduct an investigation. Mr. Kimes' report, dated May 25, 2006, is attached hereto as Attachment I (pages DA 00001 to 00160).

