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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 unlicenced 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 unforseen 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;

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[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.

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[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).

Investigator Kimes did not begin his investigation until 4 months after Yoni's death, and did not issue his report until 9 months after Yoni's death. Yoni's parents, the complaining parties, were provided with a copy that had virtually all of the witnesses' names blacked out. This made much of the report meaningless and forced our firm to spend over 100 hours piecing together who said what.[4] Most of the key witnesses were not interviewed until six months after the Yoni's death, and most of those witnesses were not interviewed in person but by only by telephone. Worse, in many instances Investigator Kimes suggested facts to interviewees rather than letting them respond to non-leading questions uninfluenced by his suggestions. Many aspects of the report are vague as to time, place and dates. Many statements contained in it are conclusory and not based on established facts. Most important, the investigator failed to follow up on key pieces of evidence and witnesses.

A. The D.A. Failed to Follow Up on Key Evidence of Prior Incidents at COAC.

Our client's private investigator uncovered many witnesses who gave important evidence regarding prior incidents at COAC in which lifeguards and child care personnel were lax, procedures were inadequate, and/or facilities were dangerous. While Investigator Kimes interviewed many of these witnesses, he conducted no investigation into these prior incidents and the evidence seems to have been totally ignored in the prosecutorial decision.

Examples of the evidence apparently ignored, and for which little or no follow up investigation was conducted, can be found in Attachment I at:

DA00025 (reference to COAC's refusal to provide a parent with copy of release form signed, and identification of a parent who stated the swimming pool at COAC was "an accident waiting to happen" since the lifeguards did not carefully watch the pool);

DA00047 (lack of certification records for COAC staff involved in the incident);

DA00060 (children at the Camp were not properly supervised, and the staff was not properly trained);

DA00066 (misinformation given to paramedic by lifeguard regarding how long Yoni was under water);

DA00116-117 (Camp personnel encouraged a child who could not swim nevertheless to participate in the afternoon swim session; parent was "shocked and outraged");

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[4] Our office filed a request for an unredacted copy of the District Attorney Investigation Report, among other things, under the California Public Records Act. A copy of the unredacted report subsequently was provided to us, and is the version submitted herewith as Attachment I.

DA00128 (statement by the coroner's office, in response to evidence that Yoni was under water for a long time, that "kids bob up and down in the pool all the time, so it would be hard to tell who was dead and who was alive....");

DA00129 (one of the lifeguards was fired from the Montecito Country Club the week before the drowning);

DA00130-132 (former Camp director identifying numerous concerns about safety issues and prior incident of child's near-drowning at COAC);

DA00138-139 (additional prior incident of an child's near-drowning at COAC, as well as several other incidents of inattentive or absent lifeguards at COAC);

DA00140 (yet additional reference a child needing to be revived at COAC, information regarding inexperienced personnel at COAC, and a statement by a UCSB lifeguard reflecting unsafe conditions at COAC);

DA00141-143 (COAC misrepresented that it was licensed by the State and met all licensing requirements, when it was not and did not; the Camp was not safe and what the witness observed in the pool area of COAC was "irresponsible"; and the lifeguard who sat by while Yoni drowned was on duty at COAC the following day);

DA00146 (Camp was "hazardous" because counselors were inattentive to children in the pool);

DA00148-149 (no life guard on duty at affiliated club; conscious disregard of safety of children in pool area);

DA00150 (COAC lifeguards being inattentive or leaving the pool area completely).

B. The D.A. Ignored Evidence of Violation of License Requirements.

Despite tacit or explicit statements to the contrary, COAC's Camp was not a licensed facility. When it was cited by the Department of Social Services for this violation, COAC claimed that it was not required to be licensed. In denying each of COAC's three separate appeals of the citation, the Department of Social Services made it clear that: (1) the Camp was a "day care facility" as defined by Health & Safety Code section 1596.70; (2) that it therefore was required to be licensed; (3) that it was not licensed and therefore COAC violated Health and Security Code sections 1596.80, 1596.805 and California Code of Regulations, Title 22, Division 12, section 101157. Despite this fact, the District Attorney refused to consider COAC's violation of the law and its misrepresentations that it was licensed in his decision not to pursue charges.

In fact, it is highly questionable whether COAC could have met licensing requirements given the unqualified personnel hired, the inadequate training of personnel, the lack of required certifications, and poor supervision and unsafe pool conditions.

C. The D.A. Ignored Evidence of A Delayed, Mishandled Emergency Response.

COAC employed young, inexperienced day care and water safety personnel who were inattentive, casual, and not properly trained, certified or supervised. What is most glaring is that COAC was aware of this situation long before this tragedy occurred. Had COAC taken seriously its responsibility to properly provide for the care and safety of the young children in the Camp, Yoni Gottesman would be alive today. Instead, COAC allowed lifeguards to be inattentive or completely absent from the pool area, counselors to have little or no knowledge of water safety and proper CPR techniques, and a general aura of malaise to exist among its employees. Had COAC been required to submit to State licensing review, these deficiencies could have been corrected before they resulted in a child's death.

The District Attorney seemingly was oblivious to the facts: Yoni floated prone and motionless in the water for **eight minutes** in plain view of lifeguards and counselors, yet no one took notice or intervened to save Yoni's life. Even after the lifeguard pulled Yoni from the pool, no one immediately called 911. When someone finally did call to 911, she erroneously reported that the child had a seizure. CPR was not properly administered to Yoni when he first was pulled from the pool. When the paramedics arrived and questioned how long the child had been in the water, the lifeguard misrepresented that Yoni had been under water for only 1 minute; this greatly affected (and misdirected) what medical response was required (see, Attachment I, DA00067-68).

D. The D.A. Failed to Conduct A Thorough, Timely Investigation.

Sheriff's Department and Coroner personnel conducted no real investigation at the time of Yoni's death, did not preserve evidence at the scene or interview percipient witnesses. Initially, they did not even know there were multiple video cameras that may have recorded the events. Witnesses who contacted the Coroner with evidence of prior unsafe conditions and incidents of near-drowning at COAC were ignored (see, e.g., DA00127-128; DA00138-139).

The D.A. investigator compounded these errors by interviewing witnesses long after the incident, conducting many interviews by telephone, and failing to follow up on some of the most incriminating allegations. For example, the investigator interviewed the COAC General Manager and the President of the Corporation that owned COAC *six months after the fact.* Perhaps worse, the investigator interviewed these two key witnesses *together* at their insistence (DA00071). The investigator ignored reported attempts by these same COAC personnel to discourage parent inquiries about Camp safety or subsequent intent to seek psychiatric help for their children, all of which seems to have been done in an effort to protect COAC and to cover up past incidents (see, e.g., Attachment I, DA00024-25 and DA00127-128).

E. Whitewash of Sheriff Council Connection With Club Owner.

The private investigator hired by the Gottesmans discovered that, soon after Yoni's death, the owner of COAC, Richard Berti, made a very substantial contribution to the Sheriff's Council. The Sheriff's Council is a local charity closely aligned with the Sheriff that raises money to assist the Sheriff's department in buying new equipment and paying its expenses. Berti had been on the Council's Executive Committee since 2004. At the annual fund raising gala in 2004, he bought a table for $10,000 and about $1000 in raffle tickets. Shortly after Yoni's death, Berti upped his contributions substantially, paying $15,000 for a table and buying over $3000 in raffle tickets – one of the largest ticket purchases. At the 2005 dinner, Berti also mysteriously won a lottery for $25,000 and immediately donated the money back to the Sheriff's Council. Unlike past years, where the lottery was randomly – and publicly – conducted by pulling a ticket from a drum in full view of the gathered audience, Berti was simply announced as the winner. Berti claims he was completely surprised by this occurrence, and that donating the money back was just "an immediate reaction to the situation." (Attachment I, DA00159.) Berti repeatedly denied news accounts in which he was accused of using his position on the Sheriff's Council to influence the Sheriff's department and its investigation of this drowning (Attachment I, DA00160), but the protestations only prompt a reaction that 'the gentlemen doth protest too much.' We understand that your office has been investigating Sheriff's Council fund-raising activities and finances; perhaps that investigation will shed some light on what went on here.

When Investigator Kimes interviewed law enforcement personnel and other witnesses, he did not ask questions to elicit facts about the witnesses' knowledge regarding any connection between COAC's owner and the Sheriff's Council. Rather, Kimes began his interviews by ***telling*** the witnesses about the allegations of favoritism and conflict of interest (see, e.g., Attachment I, DA00049). He then essentially invited witnesses to deny those allegations (see, e.g., Attachment I, DA00064; DA00074; DA00078; DA00079; DA00082).

Berti's notable financial contributions to the Sheriff's Council lead to an unavoidable appearance of impropriety. In spite of this, the D.A. never checked phone records between Berti and the Sheriff immediately following the incident. The conclusion is that the D.A., one small-town, good old boy to another, either didn't take the allegations seriously or didn't want to pursue a prosecution that might support the allegations against the Sheriff and/or the owner of COAC. This alone is grounds for an independent investigation and submission of the case to a grand jury.

IV. <u>The D.A. Ignored Precedent in His Own and Other Jurisdictions</u>

In declining to prosecute anyone for the death of Yoni Gottesman, District Attorney Sneddon ignored both previous prosecutions he pursued for child endangerment on far less

egregious facts not resulting in death, and previous prosecutions in multiple other jurisdictions on similar facts resulting in death. (Attachment II, pp. 1 to 26, contains several articles about California prosecutors who filed child endangerment and/or involuntary manslaughter charges.)

In California criminal negligence is described as "conduct that is such a departure from what would be conduct of an ordinarily prudent or careful person under the same circumstances as to be incompatible with a proper regard for human life or an indifference to consequences." *People v. Valdez* (2002) 27 Cal 4th 778 (mother convicted of child endangerment by leaving child with boyfriend whose abuse caused child's death). Without question, lifeguards and counselors allowing a child in their plain view to float face-down in a pool for eight minutes is a massive departure from what an ordinarily prudent or careful person would do. Given the known dangers of swimming pools, that conduct, whether caused by inattention, laziness or otherwise, is incompatible with a *proper regard for human life or an indifference to the consequences*. As Attorney General, we hope you will investigate this case and submit it to a grand jury for an unbiased review so that California's criminal laws are uniformly and fairly enforced.

A. District Attorney Sneddon's Prior Prosecutions Relating to Children.

Beginning in approximately June, 2003, District Attorney Sneddon undertook one of the most extensive – and expensive – investigations ever conducted in Santa Barbara County. In December, 2003, Mr. Sneddon charged entertainer Michael Jackson with numerous counts, including lewd conduct with a child younger than 14, attempted lewd conduct, administering alcohol to facilitate child molestation and conspiracy to commit child abduction. (Attachment II, pp. 27-35.) Mr. Sneddon very publicly and relentlessly pursued the prosecution of Michael Jackson, a prosecution predominately based upon the claims of a mother who indisputably was an unreliable complainant. The alleged victim and his brother gave contradictory testimony, apparently coached by the mother who had a financial motive. With little hard evidence, Mr. Sneddon personally tried the case (the first one he had tried in years), accompanied police on the service of search warrants of a private investigator's office, and threw all the resources of his department into the case. In June, 2005, two years after the case began, Mr. Jackson was acquitted on all counts. The County spent over $2.5 million on logistical and other costs related to the trial alone, as well as hundreds of thousands of dollars in court costs and over $1 million in investigation costs. (See e.g., Attachment II, pp. 36-38.) The District Attorney's office will not return our calls enquiring into the amount spent on the D.A.'s investigation, but knowledgeable estimates place it in the millions of dollars.

Is it possible that Mr. Sneddon thinks alleged child molestation is more serious and warrants more of his department's attention than conduct which, when viewed in the context of past incidents and violations of the law, constitutes gross criminal negligence that resulted in the death of a little boy? Perhaps not. In 2006, the Santa Barbara District Attorney's office filed

charges against a father who, while under the influence of methamphetamine, accidently rolled over onto his infant twin girls and killed them. The father was charged with two counts of involuntary manslaughter and two counts of child endangerment. (*People v. Gomez*, Attachment II, pp. 1-2.) Most recently, on October 23, 2006, Mr. Sneddon filed charges against the driver of a car who hit a teenage boy on a bicycle when the sun momentarily blinded him. The driver was charged with one count of vehicular manslaughter, and the complaint specifically states that the driver acted ***without*** *gross negligence*. (*People v. Botello*, Attachment II, pp.39-41.)

Apparently then, the District Attorney is not adverse to filing charges – even against a parent – in a situation involving an "accident." The question is: In a situation as egregious as the facts of this case, where the conduct was ***so far beyond*** what any "ordinarily prudent or careful person" could possibly fathom, why were no charges filed? The answer is that no justifiable reason exists. We ask you to rectify that injustice.

B. Other Jurisdictions' Prosecutions Relating to Children.

A review of the child endangerment and involuntary manslaughter cases prosecuted in California and other jurisdictions leaves little uncertainty that the death of Yoni Gottesman should have resulted in the District Attorney filing criminal negligence charges. A sampling of such cases follows.

1. Cases Filed in California.

In a case with circumstances very similar to those leading up to Yoni's tragic death, the Riverside County District Attorney filed criminal child endangerment charges against the operators of a day care center, when a small child left in their care was not properly supervised and drowned in a hot tub. On March 29, 2004, twenty-month-old Aryanna Sanchez wandered into an uncovered spa and drowned at a child-care facility owned and operated by Debra and Fernando Gonzalez. Three other children were at the day care when the drowning occurred. While the Gonzalez Family Child Care was licensed by the state, the facility had been cited in past inspections and ordered to make improvements to the home; these citations included warnings to keep the spa enclosed and covered. The District Attorney charged the Gonzalez's with 3 counts of child endangerment and one count of child endangerment causing death. Debra Gonzalez also was charged with two counts of being under the influence of a controlled substance. State officials immediately suspended the Gonzalez's day care license, and the facility remained closed. The couple pleaded guilty to child endangerment. Fernando Gonzales was sentenced to six years in state prison in 2005, while Debra Gonzales was sentenced to two years in prison in February, 2006.

As a result of this incident, Assemblyman John Benoit, who represents Riverside, introduced AB 633 and AB 617, both bills named after Aryanna, both of which passed in January 2006. These bills establish a uniform grading system for child care facilities, and require disclosures to parents regarding serious or chronic health and safety violations discovered at child care facilities. (*People v. Gonzales*, Attachment II, pp.3-9.) Given that the COAC never bothered to obtain the required licence, and therefore never submitted to the requisite licensing inspections, it is difficult to say how many unsafe and dangerous conditions existed at the facility. One thing is certain, however: The lifeguards and counselors charged with the care and well-being of innocent children were criminally negligent in the performance of their duties.

Also in 2004, the Sonoma County District Attorney filed charges against a mother who left her children locked in a van; one of the children died. When Rena Corban returned to her home on August 19, 2004, at approximately 10:00 a.m., she left her two young sons locked in a van, with the windows rolled up, on a hot day. While the children were in the closed car, Corban went into the house and passed out drunk. The children's father found the boys in the van when he returned home from work at 6:00 p.m. Corban's two-year-old son, Liam, died from heat exposure in the van, in temperatures estimated in excess of 120 degrees. The District Attorney charged the mother with child endangerment and involuntary manslaughter in the death of her son. Corban pled no contest to involuntary manslaughter and two counts of felony child endangerment; she was sentenced to 7 years, 4 months in prison. The District Attorney had recommended a sentence of 11 years, 4 months. The DA offered no plea to Corban other than allowing her to admit all charges and face the maximum prison time at sentencing. (*People v. Corban*, Attachment II, pp. 24-26.)

In 2005, the San Jose District Attorney charged a third-party caretaker with child endangerment in the death of a toddler. On November 21, 2005, Katrina Hatton was caring for two brothers, Alexander and Elijah, ages two and four. She was on her way to a restaurant where she wanted to apply for a job. On the way, she led the brothers across railroad tracks, and then returned to bring across a stroller carrying her own infant daughter. When Hatton turned her back on the boys, Alexander followed her and was struck and killed by a speeding Amtrak train. Hatton simply had been asked to take care of the brothers by her roommate, who had been babysitting for Nicole Wilson, the boys' mother. Hatton had never met Wilson. Hatton pled no contest to one count of felony child endangerment, and was sentenced to four years of probation. (*People v. Hatton*, Attachment II, pp. 21-23.)

2. Cases Filed in Other States.

District Attorneys in other states repeatedly have charged third-party child care providers with child endangerment in the drowning deaths of toddlers or young children left in their care. Some examples follow.