The Commonwealth of Massachusetts
OFFICE OF THE
DISTRICT ATTORNEY
BRISTOL DISTRICT

888 Purchase Street
P.O. Box 973
New Bedford, MA 02740
(508) 997-0711

C. SAMUEL SUTTER
DISTRICT ATTORNEY

DISTRICT ATTORNEY'S FINDINGS AND CONCLUSIONS REGARDING THE DROWNING DEATH OF MARIE JOSEPH IN THE FALL RIVER, VIETNAM VETERANS MEMORIAL POOL

BACKGROUND

On Tuesday, June 28, 2011 at approximately 10 p.m., a group of Fall River youths entered the fenced in area of the Lafayette Park, Vietnam Veterans Memorial Pool in Fall River. As the group began an after-hours swim, they found the body of a woman floating in the pool. They quickly called 911 and removed the woman from the pool. Fall River Emergency Medical Services and police responded and determined that the woman was unresponsive. Nevertheless, attempts to resuscitate her were made and she was transferred to Charlton Hospital. At the Hospital, she was pronounced dead. At that time, police were unable to identify her.

An investigation by Fall River Police, Massachusetts State Police and the District Attorney's office, pursuant to the obligations of MGL ch. 38, sec. 4, followed. In the course of this investigation, the deceased was identified as Marie Joseph, DOB: 5/25/75, of 299 Quequechan Street, Fall River.

An autopsy was performed on Ms. Joseph by the Office of the Chief Medical Examiner. At autopsy, the medical examiner determined that the cause of death was drowning and that the manner of death was an accident. The medical examiner made findings that the condition of the body was consistent with having been submerged in the pool for two days.

THE INVESTIGATION

The Vietnam Veterans Memorial Pool (hereinafter, the pool) is located at Lafayette Park in the city of Fall River. The pool is a state-owned and state-run facility under the management of the Massachusetts Department of Conservation and Recreation (DCR).

In the course of this investigation, Fall River Police and Massachusetts State Police interviewed the civilian witnesses who found Ms. Joseph; the civilian witnesses who were with Ms. Joseph before and during her time at the pool; pool employees including lifeguards and pool supervisors, managers and supervisors of DCR, including the DCR Commissioner, and contractors for DCR. Investigators also consulted with the office of the Chief Medical Examiner and other experts retained by the District Attorney's Office to assist in this investigation.

In addition to the taking of witness statements and expert consultations, investigators conducted physical examinations of the pool and pool equipment, including testing of the pool and photographing of the pool and facility. Further, investigators took custody of physical evidence which was present at the pool, or which was in the possession of DCR. This physical evidence includes a recording made by video surveillance equipment located at the pool, pool logs, manuals and documents, and a sample of the pool water taken on June 29, 2011, the day after Ms. Joseph's body was discovered.

The investigation results are drawn from the sources listed above. Statements made by some of the witnesses during interviews conflict with statements of other witnesses or with the physical evidence. Where this occurs, efforts have been made to point out what other evidence exists to help resolve the conflict in recollected facts.

DCR AND THE POOL

DCR operates state-owned pools throughout the Commonwealth. The pool is the only deep-water swimming pool operated by DCR in the Southeast Region. In addition to the pool, DCR also operates swimming areas in the region. DCR employs seasonal staff to operate the pool during the approximately two month period of operation. This staff consists of nine lifeguards, including a lifeguard supervisor, two DCR park workers, an Assistant Pool Supervisor and a Pool Supervisor. Both the Assistant Pool Supervisor and the Pool Supervisor attended a course that led to them being certified as pool operators on June 20 and 21, 2011. This training was provided through DCR. Under normal operation, the pool is staffed by a minimum of one supervisor and six lifeguards.

When the pool was originally opened it was outfitted with two low-level diving boards and a high-diving platform. The installation of these devices dictated the twelve-foot maximum depth of the pool. The depth was necessary to safely accommodate divers. The shallower portions of the pool are opposite the diving area. There, patrons can descend stairs directly into the shallow end. The maximum depth of water in the area, outside of diving area, is six feet. Approximately ten years ago, the diving boards and platform were removed. Subsequently, two diving blocks and a slide were placed at the location of the twelve-foot deep end of the pool. Out of concerns

for safety in such deep-water pools, the twelve-foot deep ends are sometimes filled in and made shallower when diving apparatus are removed. Although the deep end of the pool has not been filled in, significant money has been spent to improve the facility. Recent expenditures have been made to install a new fence around the facility and install an outdoor shower.

During its seasonal operation, the pool is frequented by children of all ages. At the time of Ms. Joseph's death, the pool had no system of tracking patrons as they entered the facility and no method of tracking them as they left. Consequently, the pool staff had no way to determine if there was a discrepancy between the number of patrons who entered the facility and the number of patrons who departed. In prior years, pool staff kept track of the numbers of patrons entering and exiting by utilizing a hand tally device. This device, however, was stolen during a night-time break into the pool office in the 2010 season, and it was not replaced.

Further, the facility had no established method of determining whether any of the patrons, including unsupervised children, could swim. The pool had no policy requiring that child swimmers be accompanied by an adult. The pool staff had no policy of identifying the swimming proficiency of any of the patrons, such as issuing wristbands according to swimming ability. There were no formalized methods of limiting patrons to pool depths that are commensurate with their ability.

The Pool Supervisor had been employed by DCR for approximately fourteen years. During this period of time, he started as a lifeguard and eventually became Assistant Pool Supervisor before becoming Pool Supervisor. The Assistant Pool Supervisor was employed by DCR for approximately nine years. He also started as a lifeguard before being promoted to Assistant Pool Supervisor. The 2011 season was his second year as Assistant Pool Supervisor. Finally, the

Lifeguard Supervisor had been employed as a DCR lifeguard for five years. The Pool Supervisor, Assistant Pool Supervisor and Lifeguard Supervisor are all seasonal employees of DCR

The first full time DCR employee with responsibility to supervise the operation of the pool was the SouthCoast District Manager. This individual (hereinafter, the District Manager) has been employed by DCR for five years. This is his first year as manager of the SouthCoast District, and he was serving in the position in June under the title of Acting Manager. Prior to this year, he was a manager of a DCR beach and the head of the Waterfront Safety Committee. As the head of the Waterfront Safety Committee, he was responsible for the screening, hiring and training of lifeguards and he had visited the Lafayette Park Pool in prior seasons in this capacity. The District Manager informed investigators that he took a course in practical pool management upon becoming employed by DCR, but stated that he was not a certified pool operator. According to the Pool Supervisor, however, this District Manager told the Pool Supervisor that he was a certified pool operator. The District Manager had no experience, prior to this summer, in running or managing a pool.

DCR's Southeast Regional Director oversees DCR operations in Southeastern Massachusetts. The Director was employed by DCR for more than thirty years. He also is not a certified pool operator. However, prior to becoming employed by DCR he had managed the operation of a swimming pool.

This DCR region employs a regional maintenance crew, overseen by the Regional Maintenance Supervisor, who reports to the Regional Director. The Maintenance Supervisor oversees maintenance of DCR facilities in the region. He is not a certified pool operator, nor is any member of his staff. His normal duties included filling the pool and putting it into operation. Once the pool is placed into operation, the responsibility for the day to day running of the pool shifts to the seasonal staff located at the pool.

In the fourteen years that the Pool Supervisor has been employed in various capacities at the pool, no inspection of the pool has ever been performed by the Massachusetts Department of Public Health. Instead, the Pool Supervisor, following the example of prior pool supervisors he worked under, annually called the Fall River Board of Health to arrange for them to inspect the facility. He also, notified the local Fall River newspaper, The Herald News, in an effort to publicize the opening of the pool for the summer season. Neither of these notifications was made prior to the opening of the pool in June, 2011. The Pool Supervisor informed investigators that he was told not to make these notifications by the District Manager.

DROWNING, SUNDAY, JUNE 26, 2011

Sunday, June 26, 2011 was the second day of operation of the pool during the 2011 season. That day, the staff consisted of six lifeguards and one park worker, all of whom were supervised by the Assistant Pool Supervisor. The pool was scheduled to open at 12:00 noon and close for "free swim" at 5:00 p.m. At 5:00 p.m. the pool was scheduled to be open for "family swim", which excluded children under the age of 12 who were present without a parent.

Marie Joseph went to the pool in the company of her neighbors. The group consisted of adult women, an adolescent child, and other, younger children. Investigators have learned from a number of sources that Joseph was not a swimmer and had not previously been to the pool. In fact, according to those closest to her, Joseph was actually unable to swim.

The group arrived at the pool between two and three p.m. Inside of the pool facility, the group, including Joseph and her neighbors' children, played in the shallow end of the pool. At approximately 3:00 p.m. Ms. Joseph was photographed on one of the women's cellular phones, in waist-deep water.

This photograph fairly and accurately depicts the condition of the water's clarity just fifteen minutes prior to Joseph's death. Witnesses, including lifeguards on duty at the pool, corroborate that this was the condition of the water on the afternoon of Sunday, June 26, 2011. Further, recordings taken from the pool's video surveillance equipment confirm that the photograph accurately depicts the water clarity. The water appears to be a cloudy white-blue in appearance. Portions of bathers below the water's surface cannot be distinguished in any meaningful way.

At approximately 3:18 p.m., Joseph walked to the twelve foot deep end of the pool. She informed one of the people she was with that she wanted to use the slide located at the deep end. She told this person she felt that if the neighbor's twelve year-old niece could go down this slide, she could as well. It is unknown whether Joseph observed the marking on the pool deck indicating that the water depth was twelve feet. It is certain, however, that Ms. Joseph would not have been able see the bottom of the pool or even past a few feet below the surface of the water. Because of this, Ms. Joseph would not have been able to visually discern the true depth of the water at this end of the pool.

Ms. Joseph followed a nine year-old boy, who was among the group she arrived with, up the ladder to the slide and then went quickly behind him into the pool. According to this person, upon entering the water, Ms. Joseph made contact with him and attempted to speak with him. Video surveillance footage of the incident shows that the two quickly separated, with the boy turning toward the slide-end of the pool and Ms. Joseph remaining behind him. As the boy swam away, Ms. Joseph went below the surface. She had shown no obvious signs of distress. Because of the extremely murky water clarity, Ms. Joseph was no longer visible when she went below the surface. From the moment she entered the water after coming down the

slide, until the moment she went underneath the water's surface, never to resurface, was a total of seven seconds. In our view, her inability to swim, along with what is termed the "instinctive drowning response,"[1] which is a lack of visible struggling by a drowning victim, and the lack of clarity in the water made it more likely that this brief incident would not be seen by either the lifeguards or other patrons.

At this time the clarity of the water in the deep end of the pool was practically opaque. The Assistant Pool Supervisor, who observed the water within minutes of this incident described that he lost sight of swimmers just a few feet below the water's surface. The video surveillance shows the Assistant Pool Supervisor standing next to a diving block, observing the condition of the water, at 3:21 p.m. While he is standing there, a child jumps into the pool and disappears below the surface.

The video surveillance footage shows that after exiting the pool, the nine year old boy does not appear at the area of the deep end lifeguard for approximately one minute and forty seconds. When the boy first met with investigators at his home on June 29, 2001, he told investigators "that he exited the pool and told a life guard that his friend never came out of the water." The boy was brought to the Fall River Police Station later that same day. There, in the company of his mother, he told investigators that he went swimming and that eventually he went down the slide. He said Maria followed him down the slide. According to him, this was the first time she went down the slide. He stated that she hit him by accident, because she went down the slide too close behind him. She tried to say sorry, but she was mumbling. She then went down to the bottom. He tried to grab her hand, but she was too heavy. According to the boy, he then got out of the pool and told the lifeguard but she was not listening to him. He said he told a girl who was white and had blonde hair and was close to the slide. He said she wasn't listening to him, but when she finally did, she said that she would check, but then she didn't check because she was on break. According to the boy, she just left because she was on her break. In response to being asked if the lifeguard actually said that she was on break, the boy nodded his head affirmatively. He told investigators he spoke with another lifeguard, whom he recognized, in the five foot section of the pool. He described her as being short and having black skin. He said this lifeguard told him not to worry, it was almost pool check.

The surveillance video does not corroborate the description given by the boy. The lifeguard stationed at the slide was not blonde. The video shows that there was no possible interaction between the boy and this lifeguard until at least one minute and forty seconds after Joseph went under the surface. While it is not possible to determine from the video whether there was any interaction between the two after this one minute and forty seconds, it is clear that, if there was some interaction, it was exceedingly brief. The lifeguard had only recently taken up the station by the slide. The lifeguard did not walk away from the boy; in fact the boy can be seen walking away from the lifeguard. The boy then walked to the side of the pool where he stopped briefly. He appears to shrug while there and then he walked directly to the shallow end of the pool and jumped into the water. Further, none of the lifeguards fit the description of the second lifeguard given by the boy. All of the lifeguards on duty were Caucasian females. The video shows that there was no further interaction between the boy and any of the other lifeguards at that time.

[1] "'It Doesn't Look Like They're Drowning,' How To Recognize the Instinctive Drowning Response," By Aviation Survival Technician First Class Mario Vittone and Francesco A. Pia, Ph.D, On Scene, Fall 2006, p.14

All of the lifeguards who were on duty on June 26, 2011 were interviewed by investigators. The head lifeguard who was not on duty that day was also interviewed by investigators. None of the lifeguards, who were on duty that day, had a specific recollection of the purported conversation with the boy. One of those lifeguards does have a memory, however, of being approached by a boy, during the pool check which took place after 3:30 p.m., and being asked if the lifeguard had seen his aunt or mom. The boy gave no further information to the lifeguard.

At 3:30 p.m. all bathers were ordered out of the pool for a routine pool check. A pool check is designed to give both the lifeguards and the swimmers a break from the pool. It also provides an opportunity to rebalance the water chemistry without swimmers continuing to stress the system, and to address any concerns with swimmers or lifeguards. Because of the complete failure in the filtering/chemical system that began shortly after 12:00 p.m. that day, the pool's system of chlorinating and filtering the water had not been operating throughout the afternoon. Normal protocol required the Assistant Pool Supervisor to notify his superiors of the failure. He did this by leaving a voice message on the Pool Supervisor's cell phone. He did not notify any of his other superiors.

The Assistant Pool Supervisor determined that he would attempt to treat the pool by adding liquid chlorine to the pool by hand, during the 3:30 pool check. Consequently, the pool check lasted longer than normal. When it became apparent that the addition of chlorine was not effective, the deep end of the pool was shut down and only swimming in the shallow end was allowed. The pool closed operations for the day at 5 p.m. At that time the filter and pump were still not functioning and continued to be inoperable throughout the night and into the morning of June 27, 2011.

The adult neighbors who accompanied Joseph believed that Joseph had departed the facility without informing them. They could not locate her at the facility after making some attempts to find her. They believed they would see her back at her apartment. They left behind Joseph's belongings, including Joseph's cellular phone, which were recovered by pool staff. They informed investigators that over the next couple of days they tried, unsuccessfully to reach Joseph by telephone.

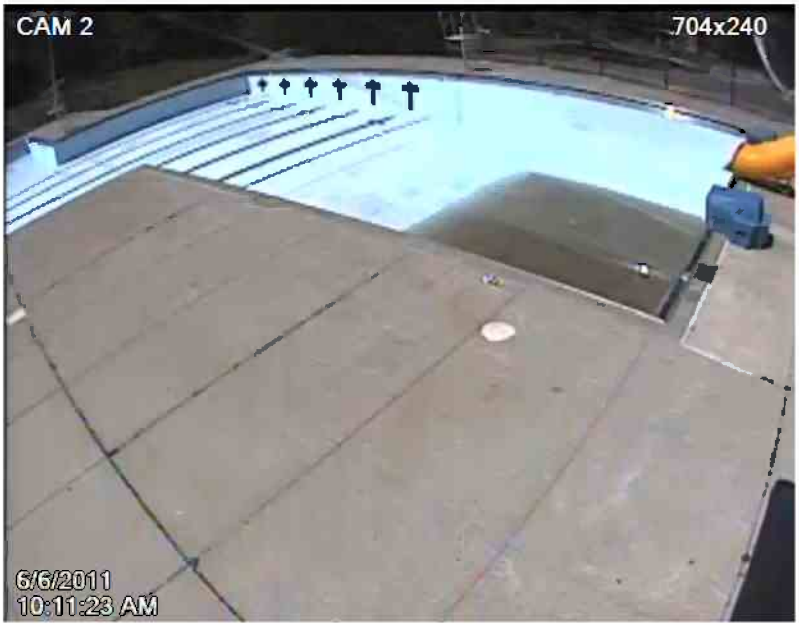
The nine year old boy apparently made no mention of the incident at the slide to any of the adult neighbors who brought him to the pool along with Marie Joseph. The boy's mother told investigators that when she heard about a body being recovered on the morning of June 29, 2011, she told her kids not to go back to the pool. At that time, her son told her "watch it be Maria."

OPENING AND OPERATING THE POOL, JUNE 2011

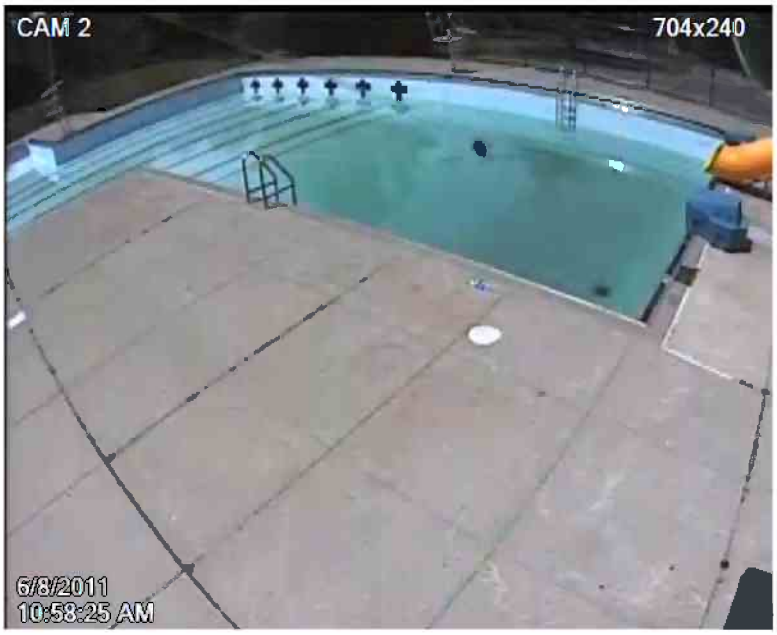
It was well known that all of the deep-water DCR pools were going to open on June 25, 2011. DCR printed pool log books, which included the operating dates for the entire pool season, and distributed them to the pools. In order for the pool to open on time, DCR seasonal staff, and permanent DCR staff were required to take preparatory steps to return the pool, which had been closed following the 2010 pool season, to operational condition.

The Pool has a capacity of approximately 240,000 gallons of water and it is drained at the end of each season in preparation for winter. Prior to filling the pool with water, witnesses reported that there was a pool of dark colored liquid and solids covering the bottom of the deep end of the pool. These reports are corroborated by surveillance video of the pool's deep end.

Members of the maintenance staff discussed removing this material before adding water to the pool and were told by the Pool Supervisor not to bother doing so, because the volume of water being added to the pool was so great that this material would be insignificant. The pool was filled between June 6, 2001 and June 10, 2011. This was the time period historically used to allow proper preparation of the pool and pool water in advance of the public opening.



The effect of this material on the initial condition of the pool is obvious in the surveillance video. As clean water is introduced into the pool it mixes with the debris-filled water and diffuses throughout the pool. As the water fills the pool, the area of black, soiled water residue continues to be visible in the deep end.


CAM 2
704x240
6/8/2011
10:58:25 AM


CAM 2
704x240
6/10/2011
10:06:18 AM

On June 29, 2011, the day after the recovery of Marie Joseph's body, a Fall River Police diver dove to the bottom of the deep end of the pool. The diver's report recounts his observations: "a lot of debris such as hair, band aids, hair ribbons and hair bands, newspaper, earrings, coins, lea[ves] and dirt that looked to be left from the past winter and spring, small pieces of broken glass and other unknown papers and tissues. Over the two drains was a larger amount of debris making it hard to locate them at first without sweeping my hand to clear the debris from that portion of the pool in which I was looking for the drains." On July 19, 2011 investigators, including Massachusetts State Police Crime Scene Services, were present as the pool was drained in its entirety. Material consistent with the diver's description was recovered from the pool. This material including an eyeglass lens, sunglasses, broken eyeglass, hair bands, jewelry, and dead leaves (indicating that they had been in the pool prior to its opening) were recovered from the bottom of the pool. Pool staff informed investigators that the pool vacuum available to them was not functioning and, therefore, at no time while the pool was being readied for operation, or in operation, was the bottom of the pool vacuumed. When the vacuum could not be fixed, a replacement vacuum was located at the DCR facility in Freetown. However no arrangements were made to transfer the vacuum to the pool and the vacuum was never brought to Fall River.

According to DCR staff, filling and placing the pool into operation was the responsibility of the Regional maintenance crew. None of the members of this crew were certified pool operators, but the function of filling the pool and starting the filtering, chlorinating and pH regulating equipment was, historically, a job that they performed. Once the system was restarted, further operation of the pool and preparation for the opening of the pool reverted to the Pool staff under supervision of the Pool Supervisor and the District Manager.

For the fourteen years prior to June, 2011, the normal operation for preparing the pool was to immediately begin chlorinating the water drawn from the Fall River water supply and constantly

filter the water.[2] Chlorinating and filtering the pool water is required to prevent the water from becoming stagnant, leading to the growth of algae and bacteria in the pool. Instructions to do this were given by the Regional Maintenance Supervisor. This supervisor then left on a week-long vacation which began on June 11, 2011, and in his absence his instructions were countermanded by the District Manager.

The District Manager instructed pool personnel not to add chlorine to the pool and not to turn on the pump to filter the water. According to the pool staff, the District Manager informed them that there was a "big thing" about money for chlorine in the state and that the District Manager decided that he could save money by not putting chlorine into the pool so far in advance of the opening. As a result, the pool water sat untreated and unfiltered beginning on June 11, 2011. Although the shallow end lane lines are initially visible on the video surveillance, they can barely be observed beginning on June 13, 2011.

Two members of the pool staff informed the District Manager that this was not an appropriate approach to take, but he refused to reconsider his decision. As the pool water sat in this condition, it became populated with algae. The condition of the water in the pool deteriorated, becoming green and opaque over the ensuing days. According to the DCR pool consultant, the pool, left untreated, essentially became a swamp. During the week of June 13, 2011, pool staff again brought the condition of the pool to the attention of the District Manager and asked if they could begin to chlorinate and filter the water. The District Manager refused their request. He

[2] The pool is filled from the Fall River Water supply which is under the control of the City of Fall River, Department of Community Utilities, Water Division. The water is under constant monitoring for, among other things, water clarity. Water clarity or turbidity is quantitatively measured in NTUs (Nephelometric Turbidity Units). Monitoring data shows that water clarity in Fall River is .08 NTUs or better. Fall River water clarity exceeds any and all Massachusetts Department of Environmental Protection and United States Environmental Protection Agency requirements for water clarity. City of Fall River, Department of Community Utilities Water Division 2010 Consumer Confidence Report.

informed the Pool Supervisor that they would begin chlorinating and filtering the water on Wednesday, June 22, 2011.

The District Manager's plan was changed by the return of the Regional Maintenance Supervisor from vacation on Monday June 20, 2011. The Maintenance Supervisor arrived at the pool in the morning and observed, as he described it to investigators, "pea-soup green" water filling the pool. He was angry about the condition of the pool and immediately called the District Manager to voice his opposition to the pool's condition. At that point the District Manager relented and agreed the water could be treated and filtered. The Maintenance Supervisor later told investigators that the approach had been penny-wise and pound foolish, since staff then needed to add chlorine in large quantities to try to "shock" the pool water to clarity. He opined that at a minimum no money was saved.

When investigators met with the District Manager he acknowledged that he told staff not to chlorinate or filter the water. Although a number of witnesses, who reported being in different conversations with the District Manager, told investigators that he had explicitly stated that the decision was made to save money, the District Manager denied that money was the primary factor in his decision making. He said he had consulted with the Regional Director and determined there was no need to pump chemicals into the pool while it was not under constant supervision. He said it was his decision and he did not know whether this was normal or not. He said mainly that he did not feel it was necessary to pump the pool full of chemicals and have it run unattended for an extra week. He said some of it was money and some of it was that the pool was not being monitored every day and people jump the fence. Although he had no operational experience with pools, he did not think there would be a problem getting the pool ready for the June 25, 2011 opening. He told investigators he could not remember what he told the Maintenance Supervisor when he was questioned by him about not starting the pump, filter and chemicals upon the filling of the pool. The District Manager indicated he was worried about complications in the event that someone trespassed at the pool. When investigators asked him

how this concern was different than the possibility of trespassers during the period of the year when the pool was fully operational, but unattended during the hours it was closed, the District Manager could not articulate any reason for his decision. He said that they were going to start the chemical feed on Monday, June 20, 2011, but because the Pool Supervisor and Assistant Pool Supervisor were going to the pool operator class on Monday, he actually instructed them to start the chlorine and filter on Sunday, June 19, 2011. He informed investigators he did not believe they did what he had asked and he does not believe the filtration and treatment was started on Sunday, June 19, 2011. Further, he believes that the maintenance crew came in on Monday and began pumping in chlorine, but he cannot say for sure. He said he was present at the pool on Tuesday morning, June 21, 2011 at 9:00 a.m. but could not picture the pool in his head, and could not describe the condition of the water. Additionally, although he was present at the pool on Thursday, June 23, 2011, again he could not describe the water clarity.

This description of events does not comport with the information gathered from other witnesses. Furthermore, it is, at a minimum, a reflection of the District Manager's inexperience in view of the fact that the District Manager believed that the DCR Commissioner would be at the pool on June 25, 2011 for the DCR Commissioner's opening day event. Investigators learned that DCR had initially planned to hold this event at the Fall River pool, and as a result, had placed emphasis on the physical appearance of the facility. The decision to hold the event elsewhere was made approximately one week prior to the June 25, 2011 opening day. Apparently, this decision was not communicated to the staff as their preparations continued during the week of June 20, 2011 in preparation for the event. According to the Pool Supervisor, he was informed, as part of this preparation to not notify The Herald News about the opening and to not call the Fall River Board of Health to arrange for an inspection. Instead, he was told that DCR public relations staff would handle the notification and that the Massachusetts Department of Public Health (DPH) would conduct an appropriate inspection of the facility.

The District Manager said that efforts were made to comply with DPH guidelines because DPH would be inspecting at some time. He said that DPH flags their violations, but was uncertain as to whether they were bound to follow them to the letter. He described that the DCR waterfront manual follows DPH guidelines.

He said he was present at the pool on Saturday, June 25, 2011, the first day of operation, and went through the whole checklist with the Pool Supervisor and Assistant Pool Supervisor and everything was fine. He told them they should call him if they had any problems. The pool was a little bit cloudy, he stated, but you could see the bottom on both ends. There was never a concern about the water quality on Saturday that he was aware of. He stated he could see the black lines at the deep end of the pool.[3] When questioned about that, he reiterated that he thought there were lines on the bottom of the pool. The water was not crystal clear, but he could see the whole pool. He denied that anyone had told him to not open the pool. After he left the facility in the afternoon, the District Manager sent an e-mail that described that the facility looked "great."

[3] There are no black lane lines in the deep end of the pool.

On Monday June 27, 2011 the Maintenance Supervisor was at the pool early in the morning and determined that all of the pool water was cloudy, the pump and chemical controller were shut off and he could not figure out what was going on at that time. The Maintenance Supervisor made appropriate notifications to those responsible for the operation of the pool. After a meeting at the pool, it was determined that the pool would open for operations that day. However, the deep end would not be opened and patrons would be limited to swimming in the "shallow end" of the pool. The "shallow end" of the pool was demarcated from the "deep end" of the pool by a line of floats at the depth of six and one-half feet.

This decision was made, investigators were informed, because supervisory staff viewed the shallow end and the deep end as separate pool entities which could be operated independent from each other.

The Regional Director informed investigators that he learned that the filtration system was not running during the week of June 12, 2011 only when the Maintenance Supervisor came back from vacation. However, the District Manager stated that he informed the Regional Director that no treatment of the pool would happen during the week the Maintenance Supervisor was on vacation. The Regional Director was concerned that the pool might not be ready in time, but the Maintenance Supervisor told him that it would be ready. After that conversation the Regional Director was no longer concerned about the pool water being ready for opening day. He was never told that there was any problem with the water being cloudy on Saturday; instead he believed all was well because he received the District Manager's e-mail describing the pool as "great." The Regional Director stated that the pool operation relied on past practice in determining when to close the deep end of the pool. The Regional Director was aware that DPH had not inspected the pool and he believed it was because of a mistake by DPH. He was not aware of any requirement for a safety certificate. He did not think it was his job or responsibility to get DPH to inspect the pool. He dismissed the utility of any DPH inspection. Instead, he likened his approach to driving a car without a current inspection—you drive the car and wait to be pulled over; only then do you get an inspection sticker. When he spoke to the investigators the Regional Director conceded, in retrospect, he did not think safety at the pool was up to par at the time of the drowning.

Surveillance video of the pool corroborates the observations of witnesses and shows the change in the appearance of the water as it stagnated in the pool. The Maintenance Supervisor returned to the pool on June 20, 2011. He described the condition of the water as "pea-soup green." The pool was scheduled to open to the public in five days. Under normal operation, the water chemistry (which ensures safe and clear pool water) is maintained by balancing the pH and chlorine levels and filtering out solids. The pool has an automated system which does all of this. However this system requires human monitoring and operation of some functions as a fail-safe, and adjustment in the case of a malfunction. A component of this system is a controller which monitors the system operation, controls additions of chemicals, and is capable of automatically reporting malfunctions to a DCR pool consultant. The automatic reporting function of the controller has never been operational. However, investigators in conjunction with the DCR pool consultant were able to download information contained in the memory of the controller and reconstruct the water chemistry and system operation from the beginning of the operation of the controller at approximately 2 p.m. on June 21, 2011 through June 30, 2011. This data, together with eyewitness observations and surveillance video of the pool provides a complete picture of the pool leading up to, during and following the death of Marie Joseph.

All of this evidence shows that water in the pool never became clear. When the controller came on line on June 21, 2011 the pool water was at a pH level of approximately 9.00. At this pH level, the controller will not allow chlorine to be introduced automatically into the pool. Chlorine is not automatically added, because at high pH levels it is not effective. Instead, the system automatically pumps Carbon Dioxide into the pool which is designed to lower the pH level of the water. Evidence establishes, however, that pool staff made manual additions of chlorine to the pool. The automated additions of Carbon Dioxide ended when the unmonitored computer controller turned off the pump at approximately 8 p.m. The software that runs the controller is designed to turn off the chlorine and carbon dioxide pumps after predetermined

periods of time in order to prevent the continual addition of chemicals in case of a malfunction. When the pump stops because of the programmed time-out, the pump could be returned to operation by the operator. Because the remote monitor was never used, the only way this could happen during the hours that the pool was closed was by having an operator stationed at the pool. Water was continually filtered through two sand filled filters beginning at approximately 2:00 p.m.

On Wednesday, June 22, 2011 the carbon dioxide pump was returned to operation at approximately 8 a.m. By approximately 10:00 a.m. the pH level had been lowered to a point that the controller began to automatically add chlorine to the water. The software that controls the automatic addition of chlorine allows it to operate for much shorter periods than the carbon dioxide pump. The chlorine pump shutoff was reset throughout the day. At approximately 12:00 p.m., the water chemistry came into balance and the chlorine could then begin to operate in order to clean the pool. Water was pumped and filtered throughout the day. The pool was scheduled to open in 72 hours.

The water chemistry remained relatively balanced from this point leading up to the opening on June 25, 2011. Video surveillance of the pool shows that the water was not clear at the time the pool opened at 12:00 p.m. on June 25, 2011. Video Surveillance shows that the pool had not become clear at any point since June 21, 2011. This corroborates the statements provided to investigators by the pool staff. The video surveillance conflicts with the statement of the District Manager. According to the District Manager, he had no difficulty seeing the bottom of the pool. He informed investigators that he could see the black lines at the deep end of the pool. Video surveillance of the pool when it was unfilled, observation of the pool after it was drained, and other witness statements establish that there are no black lines at the bottom of the deep end of the pool. Further, as described above, a police diver went to the bottom of the pool and could only find the grates covering the drain by feeling them and sweeping away debris. When the pool was drained, material covering the grates was also observed. The DCR pool log also shows that when the pool water was tested throughout Saturday, June 25, 2011, it was observed to be cloudy.

On Sunday June 26, 2011, the automated chlorine and CO2 pumps shut down at approximately 12:00 and 1:00 p.m. Neither feed was restored for the remainder of the day. The Controller then registered low water flow. The filter pump then shut off and repeated attempts by the Assistant Pool Supervisor were not successful in restarting the system. At that point, chlorine was no longer automatically being fed into the pool. No records show that any testing was done on the pool water. The Assistant Supervisor did not know what was wrong with the equipment. He made one unsuccessful attempt to contact the Pool Supervisor. The pool continued to be open and in use. What had been a cloudy pool became, according to witness statements, worse.

On Sunday June 26, 2011 at the conclusion of the 3:30 pool check, the Assistant Supervisor determined that he would close the deep end of the pool. Patrons were allowed to return to swimming in the shallow end of the pool.

The pumps for the filter and chlorine remained inoperable until Monday morning, June 27, 2011. At that time, the entire system was shut down and restarted. At the time the system was

shut down, the ORP level of the water was 287, which according to the DCR pool consultant is akin to having no chlorine in the water. Following the hard shut down, the system resumed operation. The pool, with the deep end closed to patrons was reopened. Pool staff advised investigators that, in their experience, they did not have the authority to close the pool in such a circumstance. These witnesses told investigators that they were informed that DCR full time employees did not want people complaining that the pool was not in operation and that they had to open the pool. Surveillance video shows the pool gates being opened to patrons at just after 12:00 p.m. Investigators were told that the DPH regulations mandating that the pool be closed had always been interpreted to allow for the deep end of the pool to be closed separately from the non-deep end of the pool. The regulations allow for no such interpretation.

On July 1, 2011, after the continual running of the filter and chlorinating systems, in the absence of patrons swimming in the pool, the pool water became clear. A Fall River Police photographer took photos of the pool in that condition.

This photograph shows the bottom of the deep end of the pool on July 1, 2011. Debris and other material can be seen covering areas on the bottom and the drains.

DEPARTMENT OF PUBLIC HEALTH SWIMMING POOL REGULATIONS AND THE STANDARD FOR WATER CLARITY

The Department of Public Health regulates the minimum standards for swimming pools in 105 CMR 435. According to DPH regulation, no swimming pool shall be operated without a permit issued by the Board of Health. The permit must contain, among other things the method of water treatment. The operator of the pool is required to maintain detailed records of the pool's operation which include: daily attendance, amounts and types of chemicals used daily, results of chemical and bacteriological tests, dates and times of emptying and cleaning the pool and backwashing of filters, and the daily number of hours of operation of purification equipment.

DPH regulations further require that at all times the water in the swimming pool must be sufficiently clear to permit a black disc, six inches in diameter on a white field, to be clearly visible when that black disc is placed on the bottom of the pool at the deepest point. The regulations require that operators immediately close the pool whenever water quality diminishes to the point that this disc is not visible.

In a 2001 opinion, the Attorney General determined that these regulations did not apply to state owned and state operated pool facilities such as the Fall River Vietnam Veterans Memorial Pool. The effect of this opinion was to make state run facilities exempt from public health regulation while a privately owned pool, open to the public, or a municipally owned pool was subject to the full monitoring and permitting regimen. In May, 2011 DCR and DPH entered into an agreement whereby DCR would submit DCR owned and operated pools to inspection by DPH. However, the authority of DPH at the pool was limited by the agreement, unlike DPH's authority at other pools that are subject to DPH regulation.

The DCR Waterfront Operations Manual contained a copy of the relevant DPH regulation. An excerpt of this manual titled Section VI Management of DCR Pools, Issue April 1, 2007, was recovered by investigators from the pool office. This manual adopts the Department of Public Health Regulation, 105 CMR 435.00, as the minimum standard for the operation of DCR swimming pools. According to this DCR manual, "At all times any swimming…pool…is in use, the water shall be sufficiently clear to permit a black disc six inches in diameter on a white field, when placed on the bottom of the pool at the deepest point, to be clearly visible from the sidewalks of the pool at all distances up to ten yards measured from a line drawn across the pool through said disc." This disc is commonly referred to as a Secchi disc. The DCR manual, again quoting the DPH regulation, further requires that "If at any time, the swimming…pool water does not conform with the requirements set forth…, the operator shall immediately close the pool until the pool water conforms with those standards."

Neither the Pool Supervisor nor the Assistant Pool Supervisor was familiar with the DCR manual, or the DPH regulations. No Secchi disc was available for use at the pool. No Secchi disc was ever used to determine water clarity at the pool. Instead, DCR staff purported to use their own standard for water clarity. During interviews with DCR staff, from lifeguards through the Regional Director, they variously referenced being able to see the lane lines or the drains as the standard for clarity. None of these standards comports with DCR's own manual. The lane lines were measured while the pool was drained. They measure 12 inches across. They begin within inches of the side of the pool and they are all located in less than six and one-half feet of water and as little as three and one-half feet of water. Using the lane lines as a substitute for a six inch disc in the deepest part of the pool does not provide a water clarity standard similar to the DPH standard embodied in the DCR Waterfront Operations Manual.

The pool has two drains located at the deepest end of the pool. However, they are square and are 18 inches on a side. If the water had been clear enough for the drains to have been actually observed, the observer would have seen that the drains were covered in debris. No person made this report. The District Manager told investigators that he used the standard of being able to see lane lines in the deep end of the pool to make his assessment to open the pool. The pool has no lane lines in the deep end.

The water sample taken from the pool following the recovery of Joseph's body was analyzed for water clarity by New England Testing Laboratory, Inc. of North Providence, RI on July 18, 2011. This analysis determined that the water clarity was 3.6 NTU. According to research studies done by scientists and engineers in other contexts, such as pond and lake water clarity testing, a water sample measuring 3.6 NTU correlates to an observed visibility of three to five feet using a Secchi disc.[4]

CONCLUSION

The investigation into Marie Joseph's death revealed a systemic failure in the operation of the Vietnam Veterans Memorial Pool. A series of poor decisions, with errors compounding errors, a disregard for regulatory requirements, and a disregard for the proper standard for operating the pool pervaded multiple levels of DCR supervision and management. The investigation revealed a repeated willingness to diminish minimum safety standards by re-interpreting the applicable regulation and substituting self-generated standards. This resulted in an environment where the minimum DPH regulatory standard was no longer seen as a prerequisite condition that ensured a minimally acceptable level of safety. Instead, the minimum standard became a sliding scale which could be satisfied in other, less safe ways, and, which, when satisfied, justified the continued operation of the pool. The combination of this approach and the acts and omissions of pool staff and DCR managers and DCR supervisors led directly to the unsafe condition of the water at the time of Ms. Joseph's drowning.

A prosecution for the unintentional death of Marie Joseph can only be brought where the conduct that led to her death was reckless and wanton. In order for such a prosecution to be brought in this instance, the Commonwealth would be required to prove that the acts of one particular person were performed with a conscious disregard that those acts would create a high degree of likelihood that substantial harm would result to another as a natural and continuous consequence of those acts and that without those particular acts this specific death would not have occurred. We have concluded that no individual act in the chain of events leading to Ms. Joseph's death, was wanton and reckless, in and of itself. As a consequence, no charges, directly related to the drowning of Marie Joseph on June 26, 2011 will be sought.

However, our full consideration of all the events in this investigation revealed individual acts and decisions made subsequent to Ms. Joseph's death concerning the opening of the pool on Monday, June 27, 2011 and Tuesday, June 28, 2011. We believe these acts and decisions constituted crimes and, therefore, today the Massachusetts State Police have filed applications for complaints, in the Fall River District Court, seeking criminal complaints against Brian Shanahan, the DCR Regional Director, and Jeff Carter, the SouthCoast District Manager, for their actions related to opening the Fall River Lafayette Park Pool on Monday, June 27, 2011 and Tuesday, June 28, 2011. In both of these applications, the Commonwealth alleges that these two individuals committed the offense of Reckless Endangerment of a Child.

[4] E.g. The Brooks Deep and Shallow Wet Detention Ponds Water Quality Monitoring Report, June 2005.