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June 4, 2009

Ms. Kathleen Pluchinsky
Mr. David Pluchinsky
2 Stonegate Drive
Houston, Texas 77024

Re: John Pluchinsky

I was originally retained in January 2008 regarding the investigation of the death of your son, John Pluchinsky. That representation terminated with the conclusion of the litigation in September 2008. In January 2009 you retained me again and asked that I provide a drowning accident reconstruction pertaining to the death of your son John Pluchinsky on July 18, 2007 at the Houston Racquet Club family pool. This reconstruction is based on my review of the documents attorney Matthew Pletcher again provided, my inspection of the Houston Racquet Club pools, and my expertise in drowning prevention, lifeguard training, and aquatic personnel supervision.

1.0 Qualifications, Training & Experience

1.1 Introduction

My expert qualifications were forwarded to your office. I hold a PhD in Philosophy with a concentration in psychology, human factors, and public health and several other academic degrees. I have become an internationally acknowledged authority in aquatic safety

who has conducted original research in drowning prevention and lifeguard training. I originated the Distress versus Drowning person water crisis categorical classification, formulated and developed the "Pia Carry," a non-equipment-based water rescue, conducted the original research on the Instinctive Drowning Response, and formulated the "RID Factor" framework for delineating the causes of swimming related drownings.

All of these works have been incorporated, relied upon or adopted by national and international organizations, including the American Red Cross. I have been an invited speaker of the World Congress on Drowning, the Task Force on Rescue – Rescue Techniques and have 21 years experience as a lifeguard and chief lifeguard at Orchard Beach, Bronx, New York where 2000 rescues occurred each summer; 35 years experience educating federal, state, county and local agencies on causes and solutions to drowning fatalities in swimming pools, lakes, rivers, streams and oceans; and 40 years experience in drowning accident causation and reconstruction for public and private aquatic agencies and individuals. Further details of my training, education, experience and qualifications can be found in the attached curriculum vitae.

2.0 Disclosure of Documents Reviewed

2.1 Documents

I reviewed the following documents:

1. Plaintiff's and Defendant's pleadings and document productions,
2. Written discovery responses, Houston Racquet Clubs (HRC) document production, related to HRC's Family Pool, Lifeguards, Camp Counselors and the 2007 Summer Camp John Pluchinsky was attending when he drowned,

3. Documents related to the training, education, experience, qualification and certification of all of the HRC managers, directors, supervisors, lifeguards, and camp counselors.
4. John Pluchinsky's medical records.
5. Documents related to pool side resuscitation attempts
6. HRC documents concerning training and certification in CPR and Emergency Response,
7. Medical records from the Village EMS, Memorial Hospital-Memorial City, and the Harris County Medical Examiner's Office.
8. Twelve Depositions of Houston Racquet Club Employees :

3.0 Summary of Significant Events

Based upon my review of these materials, the following information summarizes some of the more significant events that led to John Pluchinsky's foreseeable and avoidable drowning death. These failures to follow Texas laws for pool safety and childcare and many of the American Red Cross' lifeguard training and drowning prevention principles will be analyzed further in the discussion section of this report.

John Pluchinsky drowned during "swim time" in the HRC family pool on his second day of a Houston Racquet Club's 2007 four day summer day camp. This camp ran from July 17-20, 2007.

John was 42" tall, and he was found floating face down motionless in area of the pool marked 3'-6" or 42". At the time of my inspection I measured the estimated water depth where John's body was located and found it to be 43.2"deep. Clearly this depth was over John Pluchinsky's head.

At the time of John Pluchinsky's drowning, the family pool was described by multiple witnesses as being very crowded. When your four-year-old child was last seen alive

there were over 50 people in this pool which included 26 four year old campers and eight 7-year-old boys.

Approximately 10-15 minutes before John Pluchinsky was discovered floating face down motionless in the water, 4 of the 7 lifeguards on duty, including the lifeguard supervisor/head lifeguard and 3 other senior guards, went to lunch. The aquatic director and lifeguard manager, the lifeguards' direct supervisor, who was standing outside the fence surrounding the family resort pool, permitted the four lifeguards to leave the pool area for lunch. Shortly after these senior lifeguards went to lunch, the lifeguard manager also left the poolside so that he too could get lunch before it was no longer available. Abandoning the patron surveillance of this pool to the youngest and most inexperienced lifeguards on duty at a time when the youngest group, the 4 year old campers, who had not been given a swimming ability test, were in a "very crowded" family resort pool directly contributed to John Pluchinsky's drowning.

At the time of John Pluchinsky's drowning, two inexperienced lifeguards were on duty. The first was a 15 year-old lifeguard who was responsible for watching the slide area. The second lifeguard was also 15 years old and was in charge of watching the remainder of the pool. This was the area of the pool where most of the campers were playing a game prohibited by the Houston Racquet Club rules. Regrettably this was the specific area of the family pool where John Pluchinsky was discovered floating face down motionless in the water.

The combination of a young inexperienced lifeguard being assigned a patron surveillance area too large and too crowded for this 15-year-old lifeguard, lack of in-service training, and lack of a competent lifeguard supervisor's presence led to this lifeguard's failure to prevent John Pluchinsky from entering a dangerous water depth. Additionally, these factors led to the failure to recognize the surface struggle of a drowning four year old child,

and the inexperienced lifeguards not observing John Pluchinsky floating face down on the water for the extensive time needed for his respiratory and cardiac arrest to occur.

When John Pluchinsky was removed from the pool, he had no pulse and was not breathing. This means that John Pluchinsky went through the phases of a surface struggle of a drowning person before he lost consciousness, and floated face down on the surface of the water. This is a process that takes many minutes and was not recognized by either the 15-year-old lifeguard responsible for the main pool or children's summer camp counselors.

The 15 year old lifeguard, who finally noticed John Pluchinsky floating face down, did not immediately jump into the water to rescue him. Instead, the lifeguard continued to scan the pool and only after realizing that John Pluchinsky was still motionless initiated a rescue. Before the 15 year-old lifeguard reached John Pluchinsky, two camp counselors pulled him to the West end of the pool and placed him on the pool deck.

John Pluchinsky's face and lips were blue and his eyes were reported to be opened and glazed over. Neither the camp counselors that removed John Pluchinsky from the pool nor the 15 year-old lifeguard immediately performed CPR. Instead, it appears that the 15 year-old lifeguard ran by the pool emergency phone, which was approximately 6 feet away, looking for the head lifeguard.

Two camp counselors pushed on John Pluchinsky's stomach, rather than initiating CPR. Crucial minutes passed before the head lifeguard finally reached John Pluchinsky and started CPR.

Before CPR was attempted, John Pluchinsky was not properly positioned on the pool deck. Instead, part of his body remained in the water, with his legs, from his knees down, hanging over the pool edge. One of the counselors was in the water holding his legs up. John Pluchinsky had vomit and water coming from his mouth and his stomach was bloated. At

least three people, including the 2 counselors and the camp director, pushed on John Pluchinsky's stomach multiple times, hoping that your son had an obstructed airway.

However, there was no primary survey performed or other evidence gathered that John Pluchinsky's airway was obstructed. Chest compressions and rescue breathing were ultimately attempted, but John Pluchinsky never regained consciousness. Two of the 3 people who actually attempted CPR on John Pluchinsky had expired CPR credentials and were not currently certified in CPR.

During this failed resuscitation an Automatic Electronic Defibrillator (AED) was not immediately brought to John Pluchinsky's aid. In fact, the Houston Racquet Club's Camp Director, who actually certified many of the camp counselors in CPR/AED, testified that he did not even think about getting an AED even though he knew the importance of having an AED when treating a cardiac arrest. This is astounding since the Houston Racquet Club had at least 3 AEDs on site, including one that was only a 100 feet from the family resort pool.

Equally appalling is that nobody immediately used the pool side emergency phone to call 911. Instead, 2 different people went to the lifeguard office to call 911.

The scene around this failed CPR attempt was described by various witnesses as frantic, panicked, and erratic. People were screaming, "call 911," "you're doing it wrong," "do you know what you're doing?," "go faster," "get the face mask," "has 911 been called?," etc. The EMS ultimately arrived on the scene and immediately took John Pluchinsky to the hospital, but they could not revive him.

4.0 Discussion

John Pluchinsky's death was a tragic and unnecessary fatality. His peril could have easily been detected or prevented by proper training in aquatic injury prevention, continual in-service drills, and written protocols and procedures for the detection of a drowning person. Aquatic injury prevention concepts were ignored, emergency response inadequate, proper

CPR procedures not followed and immediate AED usage absent. This young boy drowned because of multiple failures on the part of the Houston Racquet Club, its management, employees, and Board of Directors.

In my opinion this drowning was the result of the Houston Racquet Club's multiple failures to implement many Texas laws governing pool safety and child care. Additionally, many of the American Red Cross' lifeguard training and drowning prevention principles were not followed.

Rather than this fatality being an isolated instance of failing to comply with Texas law and American Red Cross requirements, this drowning, was in my opinion, a systemic failure by the management and employees of the Houston Racquet Club to follow established children's summer camp aquatic supervision principles, and basic preventive lifeguarding and patron surveillance concepts. The systemic failures were numerous and deplorable. The safety failures at the Houston Racquet Club that led to John Pluchinsky's drowning were some of the most horrible that I have seen in my 40 year career of aquatic injury prevention and control.

4.1 Patron Surveillance System Breakdown

4.1.1 Failure to Provide Adequate Lifeguard Surveillance

It is unfathomable to me how the aquatic director/lifeguard manager could have permitted 4 of the 7 lifeguards, which included the head lifeguard and 3 senior lifeguards to go jointly to lunch approximately 10-15 minutes before John was discovered floating face down motionless in the water. Shortly after watching these four lifeguards go to lunch, the lifeguard manager also left for lunch. His reasoning was that he and these four lifeguards wanted to get their lunch from the club before the food was no longer available.

The aquatic director/lifeguard manager easily could have and should have made arrangements to stagger the experienced and inexperienced lifeguards' lunch breaks.

Alternatively, arrangements could have been made to set lunch aside for the lifeguards. Staggering experienced and inexperienced lifeguards was a reasonable action rather than leaving two young and inexperienced 15-year-old lifeguards on duty at a time when the youngest group of non-swimmers, the 4 year old campers, were in a very crowded family pool.

The aquatic director/lifeguard manager knew these two young inexperienced lifeguards would be responsible for watching the entire family pool. One lifeguard was responsible for watching the slide area. The other was responsible for watching the remainder of the pool, including the area where many of the campers and counselors were playing a game prohibited by the Houston Racquet Club's rules and regulations. The area where the prohibited game was being played was very close to specific area where John Pluchinsky was discovered floating face down motionless in the water.

4.1.2 Failure to Provide Appropriate Number of Lifeguard Station

Incredibly, the management of the Houston Racquet Club permitted the removal of a third lifeguard stand from the patron surveillance system at their facility. Prior to John Pluchinsky's preventable drowning, a portable lifeguard stand had been positioned only a few feet away from the area where he was found floating face down motionless in the water.

If an attentive lifeguard were either stationed in this third lifeguard chair or assigned a walking patrol within this zone of responsibility, he/she would have noticed John Pluchinsky moving from waist high water into water over his head. Even if the lifeguard missed John Pluchinsky moving from a position of safety to a position of peril, he/she would have seen your four-year-old child either struggling on the surface of the water or floating face down motionless on the surface of the water before he went into respiratory and then cardiac arrest. In other words, having an additional lifeguard surveillance position would have provided the opportunity for a routine rescue rather than a needless fatality.

On July 18, 2007 the Houston Racquet Club had an insufficient number of lifeguards on duty at the family resort pool at the time of John Pluchinsky's drowning. The number of people in the pool most likely was greater than 50 patrons. The vast majority of these patrons were children, and the majority of whom were under the age of five. At the time John Pluchinsky was in the pool the Houston Racquet Club placed the responsibility for patron surveillance of the entire family resort pool in the hands of two inexperienced 15-year-old lifeguards.

One of these inexperienced lifeguards was primarily responsible for watching the slide at the family resort pool. The other lifeguard was responsible for watching the entire family resort pool which included the area where John Pluchinsky was found floating face down motionless in the water. This lifeguard had 4-5 days of lifeguarding experience. In my expert opinion these two 15-year-old lifeguards were not, because of their lack of training and supervision experienced enough to safely handle their patron surveillance duties at the time of John Pluchinsky's drowning. Because of their inexperience John Pluchinsky was not recognized as a drowning person.

Further the testimony and information provided by the counselors suggested to me that John Pluchinsky was most likely unsupervised for approximately 9 minutes while he was in the pool. Clearly no action was taken by these inexperienced lifeguards to see that John Pluchinsky was safely supervised because they did not receive pre-service and in-service training and were not properly supervised.

The Houston Racquet Club required three lifeguards were to be present at the family resort pool when the bather load exceeded a certain lifeguard to patron ratio. The management of the Houston Racquet Club testified that for every 25 pool users in the family resort pool there would be a lifeguard provided. They noted a minimum of two lifeguards would always be on duty at the family pool. When the number of bathers exceeded 50 at the

family resort pool, a third lifeguard was required to scan the pool. Yet the management of the Houston Racquet Club did not enforce this standard. Approximately 10 minutes before John Pluchinsky was discovered, floating face down motionless in the water, the aquatic director and lifeguard manager, observed a pool crowded with four-year-old non-swimmer campers. Yet he allowed the supervising lifeguard and three senior lifeguards to leave the pool area for lunch, instead of stationing another lifeguard at the pool. Incredibly the lifeguard manager also decided at this time to also take a lunch break.

The lifeguard stationed at the slide at the east end of the family resort pool was required to give his complete attention to the slide users on July 18, 2007. This lifeguard was required to give the okay signal to each user of the slide, watch the user enter the water, observe the user swim to the side of the pool, ensure that no one else was swimming in the area in which the slide users entered pool, and then start the surveillance slide cycle over again. Thus this lifeguard would be monitoring users less than the one lifeguard per 25 patron ratios.

The lifeguard responsible for watching bathers in the family resort pool was responsible for watching substantially more than 25 pool users. Clearly the bather load in the family pool exceeded the 1 -- 25 ratio. At the time immediately prior to John Pluchinsky's drowning it should have been obvious to lifeguard manager that a third lifeguard station was needed. The typical placement of this additional lifeguard station would have been a few feet away from the location where John Pluchinsky was discovered floating face down in the water.

4.1.3 Failure to Prevent John Pluchinsky from Entering an Unsafe Water Depth

John Pluchinsky was 42" tall and was found floating face down in approximately 42 inches of water. This water depth was extremely dangerous for a four-year-old non-swimmer. The Houston Racquet Club's removal of the layers of protection that permitted a child of this

height to venture undiscovered into water that was above his mouth, struggle on the surface of the water, and then float face down motionless on the water for the time necessary to cause respiratory and cardiac arrest was irresponsible and was neglectful supervision.

A buoyed safety line coupled with appropriate lifeguard and counselor supervision should have been in place to keep youngsters of John Pluchinsky's age, height, and non-swimming ability, in mid-chest high water. The camp counselors testified that they were never told to restrict the four-year-old campers to any part of the pool.

During my site inspection of the Houston Racquet Club family resort pool, I found there was a very limited area where the four-year-old non-swimmers could safely play. Given the number of four-year-old campers this area of the family pool would easily become overcrowded. This could have the effect of inducing small children to move towards deeper water that was unsafe for them.

4.1.4 Failure to Provide Camper Swimming Ability Testing

The management of the Houston Racquet Club did not have in place a swimming ability test requirement for the four year old campers during week five of their summer camp. While the summer camp director, stated all the campers were to be viewed as "non-swimmers", this policy was not made known to the 15-year-old lifeguard who found John Pluchinsky floating face down in the water. The lifeguard mistakenly believed that all the four year old campers were swimming ability tested.

Sadly, the materials I reviewed indicated that a swimming ability test was not given to the campers enrolled in week 5 of the Houston Racquet Club's children's summer camp. The 2007 Summer Camp registration form for the Houston Racquet Club's children's summer camp, a document given to the parents, specifically noted that children would be grouped by age and ability. Additionally, even if a 4 year old passes a swim test that does not mean that the child may not still need the assistance of a lifeguard or counselor.

The summer camp counselors indicated their concern for the safety of the four year old campers. Several of the counselors testified they would not permit a non-swimmer to enter the pool in an area that was unsafe for them.

4.1.5 Failure to Have Specific Counselor to Camper Assignments

Camper supervision is one of the many layers of protection needed to prevent drownings and other summer camp injuries. There were 6 camp counselors assigned to watch the 4 year old boy campers (and 4 camp counselors assigned to the 4 year old girl campers) while these youngsters were in the pool. However, there was no specific counselor to camper assignments. Further, some of the 4 year old counselors did not focus exclusively on the 4 year old campers, but also played with the 7 year old campers.

A general, rather than a specific, camper supervision policy was in place on the day of John Pluchinsky's drowning. Under the general supervision practice all counselors were responsible for watching all children at all times.

Contrary to the specific supervision model, which is the preferred counselor to camper accountability model, John Pluchinsky did not have a specific counselor assigned to watch him while he was in the water. In my opinion, the general supervision policy, rather than the specific supervision policy was one of the reasons why none of the 6 camp counselors neither remember seeing John Pluchinsky in the water shortly before he was found floating face down in water over his head, nor prevented him from entering into and unsafe water depth.

In addition to the removal of the third lifeguard chair and the lack of specific counselor to camper supervision, there were additional preventive lifeguarding and camper supervision breakdowns. In my expert opinion, these factors significantly contributed to the failure to quickly recognize John Pluchinsky's peril.

4.1.6 Failure to Prevent Horseplay

Minutes before John Pluchinsky was discovered floating face down in the water, several 4 year old camp counselors were playing a water game with the 7 year old campers and counselors and at least two or three of the 4 year old campers. The object of the game was to catch a tennis ball thrown in the air before the ball hit the water. When the ball was thrown up, the campers and counselors jumped from the fountain deck and whoever caught the ball won points or the jackpot.

Sadly, this game was being played in the same area where John was found floating motionless. Further, while counselors were playing this game with the campers, no counselor was specifically assigned to supervise John Pluchinsky. In fact, the 4 year old counselor that ultimately pulled John from the water was within 10 feet of him, but had his back to John during the Jackpot game. When asked by the 15 year old lifeguard if John was alright while he floated motionless, the counselor responded "I think so" because children would play like that in the pool.

The young inexperienced 15-year-old lifeguard on duty saw this game being played, but did not stop it. On the day of this unfortunate and unnecessary drowning at least one lifeguard also saw campers being thrown or launched into the pool from the fountain deck by the camp counselors.

4.2 Failure to Have a Written and Practiced Emergency Action Plan

After the 15-year-old lifeguard noticed your son floating face down in the water the lifeguard ran towards him and asked camp counselors if he was okay or playing. Two summer camp counselors placed John Pluchinsky on the pool deck. His face and lips were described as blue, his eyes were reported to be open and glazed over, and he was neither breathing nor had a pulse.

The American Red Cross recommends and Texas state law requires that aquatic facilities have and practice an emergency action plan. When an emergency occurs trained lifeguards are clear about their individual responsibilities and are trained to respond appropriately. However, the Houston Racquet Club did not have a clear and practiced emergency action plan for either the lifeguards or camp counselors. Further, there was conflicting testimony regarding what constituted emergency whistle blast signals necessary to summon help.

Clearly the events surrounding the drowning of John Pluchinsky of July 18, 2007 at the Houston Racquet Club pool demonstrated the need for emergency action plan and for practicing the plan. When an emergency action plan is either absent or not practiced, the pool emergency phone may not be used, emergency whistle blasts may not occur, CPR and administration will be delayed, and inexperienced lifeguards will try to find experienced lifeguards.

4.2.1. Failure to Promptly Call 911

Another of failure of the emergency action plan was that the pool side emergency phone for calling 911 was not used. Rather several different people attempted to call 911 from the lifeguard office rather than from poolside. Witness statements indicate that bystanders were screaming, "call 911," "you are doing it wrong," "do you know what you're doing?" "go faster," "get the face mask," "has 911 been called?" If CPR was indeed delayed and being performed incorrectly then these witnesses statements are indicative of another failure of the emergency action plan.

When John Pluchinsky was placed on the pool deck his lower legs were hanging over the pool edge into the water. This four-year-old child had vomit and water coming from his mouth and his stomach was described as distended or bloated. Fluid, vomitus, and a distended stomach are not unusual findings in a drowned person.

Rather than immediately starting cardiopulmonary resuscitation, reports indicate that at least three people including the camp director pressed down on John Pluchinsky's stomach multiple times. The testimony of these rescuers indicated that they pressed down on the stomach in the hope that John had an obstructed airway and that the outcome of thrusts would clear the airway.

4.2.3. Failure to Have Current CPR Certifications.

Texas state law required that each member of the lifeguard staff be certified in CPR. However, the supervising lifeguard who attempted CPR on John Pluchinsky, plus 3 of the 6 lifeguards working on July 18, 2007 when John Pluchinsky drowned, were not currently certified in CPR. The aquatics director was well aware that these lifeguards were not currently certified in CPR. Nevertheless he hired and retained these lifeguards during the 2007 Summer Camp. Likewise, the children's summer camp director also should have been aware that certain lifeguards were not currently certified in CPR because he shared the lifeguards hiring responsibility with the aquatic director.

The Houston Racquet Club's board president's, testimony suggested that current CPR certification was preferred, but not necessary. His analogy that an expired certification for performing CPR is essentially the same as having an expired driver's license for driving a car is absolutely wrong. His opinion regarding yearly CPR recertification shows a complete lack of understanding of the necessity to practice CPR skills and the research studies that document the CPR skills decrements in emergency and non-emergency situations. The failure to have current CPR certification directly contributed to the improper CPR that was performed poolside by the lifeguards, counselors, and supervisors on John Pluchinsky.

4.2.4 Failure to Properly Administer CPR

All the major CPR training agencies in the United States specifically note that water and vomitus in a person's airway is not to be considered a solid body airway obstruction. In

the absence of a documented airway obstruction, the first step in the resuscitation of a drowned person is to initiate rescue breathing and cardiac compressions. While chest compressions and rescue breaths were ultimately attempted, John Pluchinsky never regained consciousness. Two of the 3 people who attempted CPR had expired CPR certifications.

4.2.5 Failure to Bring AED to Poolside

The failure to immediately bring an AED to poolside demonstrates the absence of a documented and practiced emergency action plan. There were at least three AED's at the Houston Racquet Club, one of which was approximately 100 feet from the pool. The camp director, who certified many of the camp counselors in CPR/AED, testified that he didn't even think about getting an AED.

4.3 Failure to Provide Integrated Lifeguard and Counselor In-Service Training

Another failure that led to John Pluchinsky's death was that the lifeguards were unaware of the Camp Counselor Rules, the camp counselors were unaware of the Lifeguard/Pool Rules, and both groups were unaware how the rules, procedures and policies counselor/lifeguard communication applied to each other. For example, the Summer Camp Counselor Rules specifically indicate that there will be "Absolutely No Horseplay" and the Lifeguard/Pool Rules prohibit "horseplay" and "pushing", but the "Jackpot" tennis ball game was being played without interruption just moments before John was noticed floating face down in the water. The lifeguards and camp counselors were seemingly unaware that the Houston Racquet Club's rules specifically prohibit tennis balls in the pool area. Incredibly, the same person was in charge of both the camp counselors and the lifeguards, but failed to coordinate their activities.

Next, while the Houston Racquet Club did have an initial lifeguard orientation meeting, there was no formal, structured preseason or in-service training program or any

emergency alertness/response drills for its lifeguards. This training was not provided despite being required by Texas law and a specific recommendation of the American Red Cross.

The Houston Racquet Club did not train its lifeguards about the drowning process, effective pool surveillance, effective scanning, drowning recognition, or the "RID factor" for drowning. Once the lifeguards were certified they were employed without further training. Additionally, the Houston Racquet Club did not give any training regarding the surveillance challenges presented by the unusual shape of the family resort pool, the many water features, or how the pool would suddenly drop in the sun deck area from a depth of 6 inches to a depth of 3 feet 6 inches opposite of the zero depth entry that also sloped to a depth of 3 feet 6 inches.

Counselor training involved only two pages of written rules and a four hour orientation meeting. It did not appear to me that aquatic safety issues and the handling of emergencies were adequately addressed. For example, the camp director did not believe it was necessary for counselors to be instructed about the location of the AED's.

From my review of the materials it did not appear that any of the counselors received any training in recognizing swimmers in distress or drowning persons. One counselor noted after John Pluchinsky's preventable drowning that because no one was either flailing their arms are calling for help that this counselor was unaware that anything was wrong. Further, the camp counselor supervisor who attempted CPR on John Pluchinsky was not certified in CPR. Yet the 2007 children's summer camp registration form noted "all counselors will be CPR certified."

4.4 Failure to Heed Prior Warnings about Patron Surveillance Inadequacies.

The Houston Racquet Club received multiple warnings and complaints about the inadequacies of its lifeguard and summer camp programs before John Pluchinsky's drowning death. This included concerns from board members that the lifeguard coverage at the pool

was inadequate, that the club was not licensed as a daycare facility; the summer camp enrollment was too high, the circumstances at the pool were an accident to happen, and the aquatic director and the lifeguards were not doing their jobs. Further, one mother noted that 10 minutes before John Pluchinsky's drowning there was chaotic horseplay and overcrowding at the pool.

5.0 SUMMARY OF OPINIONS AND CONCLUSIONS

John Pluchinsky's drowning death was avoidable and the result of multiple systemic failures on the part of the Houston Racquet Club's management, employees, agents and Board of Directors.

1. The Houston Racquet Club failed to provide basic in-service training and supervision to the lifeguards and camp counselors they hired to provide protection to the pool users.
2. The Houston Racquet Club permitted the family pool on July 18, 2007 to be supervised by two inexperienced 15-year-olds while the head lifeguard and three other more experienced lifeguards, as well as the lifeguard manager/aquatic director left the pool area to eat lunch, at the busiest time of summer camp with the maximum number of the youngest campers in the pool.
3. The Houston Racquet Club failed to have an adequate number of lifeguards at the Family Pool on July 18, 2007 to provide sufficient supervision, continuous surveillance, and close observation of pool users in all areas of the pool and at all times.
4. The Houston Racquet Club failed to prohibit horseplay in and around the Family Pool such as the "Jackpot" tennis ball game, the "Launching" game, where summer campers were thrown in and around the pool, and other unsafe games and activities.

5. The Houston Racquet Club failed to assign specific counselors to watch specific campers while the four-year-old campers were in the pool.
6. The Houston Racquet Club failed to provide adequate adult supervision for the inappropriate number of children it allowed to enter the pool on that tragic day.
7. The Houston Racquet Club failed to have appropriate and documented areas of responsibility for lifeguard surveillance of the Family Pool.
8. The Houston Racquet Club failed to have all lifeguards and counselors certified in CPR;
9. The Houston Racquet Club failed to ensure that the lifeguards and camp counselors appropriately scanned the pool for swimmers in distress and drowning persons, and to quickly and appropriately employ correct cardio pulmonary resuscitation techniques;
10. The Houston Racquet Club failed to have an adequate number, type and location of lifeguard chairs;
11. The Houston Racquet Club failed to have and practice Emergency Action Plan (EAP) setting forth the roles and responsibilities of all lifeguards, camp counselors, and supervisors with appropriate communication technique between themselves and external emergency responders including the EMS;
12. The Houston Racquet Club failed to have appropriate orientation and coordination between HRC's Lifeguard Team which included the Lifeguard Manager/Aquatic Director, Head/Supervising Lifeguards, and other Lifeguards, and the HRC's Summer Camp 2007 staff which included the Camp Director, Assistant Camp Director, Camp Counselor/Pool Supervisors, and Camp Counselors including, so that their respective roles, rules, regulations, requirements, responsibilities as related to the Houston Racquet Club's Summer Camp 2007 were followed when the summer campers were in the Family Pool.

13. The Houston Racquet Club failed to have adequate procedures in place to hire, manage, supervise and assess lifeguard candidates and lifeguard employees.

14. The Houston Racquet Club failed to exercise the necessary care to adequately supervise, monitor, and protect John Pluchinsky, a little boy that could not protect himself when he was entrusted to its care.

15. The Houston Racquet Club failed to adequately hire, train, supervise, place, and educate lifeguards, counselors, and supervisors who were responsible for the control and supervision of John Pluchinsky.

16. The Houston Racquet Club failed to implement adequate safety and supervisory rules and guidelines to ensure the safety of John Pluchinsky and the other children placed their care.

17. The Houston Racquet Club failed to assign surveillance areas commensurate with the lifeguard's ability to ensure the safety of John Pluchinsky and the other children entrusted to its care.

18. The Houston Racquet Club failed to promptly use appropriate life saving treatment in attempting to save John Pluchinsky's life.

19. The Houston Racquet Club failed to provide a safe pool environment.

20. The Houston Racquet Club failed to provide an additional lifeguard to monitor the Family Pool at the time John Pluchinsky was in the family pool,

21. The Houston Racquet Club failed to have alertness/response drills and other training, including a preseason training program, a minimum of 60 minutes per week of continual in-service training for all lifeguards and other aquatic personnel, performance audits and a written and practiced emergency action plan which are required by Texas law.

22. The Houston Racquet Club failed to test the swimming skills and abilities of all campers, to group the summer campers by age and swimming ability, to provide specific assigned areas for the campers based upon the results of their swimming test classification, to have procedures to ensure the campers remained in these areas in which they are assigned, to have a specific area in the family pool designated for non-swimmers, to have a floating line demarking the "wading area" of the family pool, and to have a continuous barrier, such as floating line, preventing campers, whose swimming abilities were not tested, from venturing into water that was unsafe for them.

23. The Houston Racquet Club failed to have mock emergency response drills and to have a written emergency action plan that delineated effective communications, the use of appropriate life saving equipment, such as an AED which could be routinely practiced, as well as having emergency responders who were not certified in CPR and AED.

24. The Houston Racquet Club failed to call 911 at the earliest opportunity;

25. The Houston Racquet Club failures and omissions set up these teenagers and young adults to fail in their responsibility to prevent John Pluchinsky's drowning, and to possibly experience the emotional trauma of trying to save a drowning person when they were ill-prepared to do so.

26. The Houston Racquet Club violated Texas Health & Safety Code: 42.041(a) by failing to have the required Child-Care Center Operation license.

27. The Houston Racquet Club violated Texas Family Code: 261.401(3) by failing to supervise the children while they were in the pool.

28. The Houston Racquet Club violated Texas Family Code 25 TAC 265.199 (g) (1) which required all lifeguards to have current CPR certifications.