OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA

TODD SPITZER

March 14, 2024

Sheriff Don Barnes
Orange County Sheriff's Department
550 N. Flower Street
Santa Ana, CA 92703

Re: Custodial Death on March 3, 2023
Death of Inmate Ryan William Barnette
District Attorney Investigations Case # 23-000719
Orange County Sheriff's Department Case # 23-007573
Orange County Crime Laboratory Case # FR 23-41909 and 23-42023
Orange County Coroner's Office Case # 23-01413-AY

Dear Sheriff Barnes,

Please accept this letter detailing the Orange County District Attorney's Office's (OCDA) investigation and legal conclusion in connection with the March 3, 2023, custodial death of 33-year-old inmate Ryan William Barnette.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Barnette. In this letter, the OCDA describes the criminal investigative methodology employed, evidence examined, witnesses interviewed, facts discovered, and the legal principles applied to review the conduct of all Orange County Sheriff's Department (OCSD) personnel as well as those under the supervision of the OCSD involved in this custodial death incident.

On March 3, 2023, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the Orange County Global Medical Center (OCGMC), where Barnette died while in custody. During the course of their investigation of Barnette's death, the OCDASAU interviewed three witnesses and obtained reports, incident scene photographs, jail surveillance footage, medical records, and other relevant materials from the OCSD, the Orange County Fire Authority (OCFA), and the Orange County Crime Laboratory (OCCL).

The OCDA conducted an independent and thorough investigation of the facts and circumstances of this event and impartially reviewed all evidence and applicable legal standards. The scope and findings of this review are expressly limited to determining whether any criminal conduct occurred on the part of OCSD personnel or any other person under the supervision of the OCSD. The OCDA will not be addressing policy, training, tactics, or civil liability.

INVESTIGATIVE METHODOLOGY

Among other duties, the OCDASAU is responsible for investigating custodial deaths within Orange County when an individual dies while in custody. An OCDASAU Investigator is assigned as a case agent and is supported by other OCDASAU Investigators, as well as investigators from other OCDA units.

Six investigators are assigned to the OCDASAU on a full-time basis. There are additional OCDA Investigators assigned to other units in the office trained to assist when needed. On average, eight investigators respond to an incident within an hour of being called. The investigators assigned to respond to an incident perform a variety of functions that include witness interviews, scene processing, evidence collection, and hospital investigative responsibilities as needed. The OCDASAU audio records all interviews, and the OCCL processes all physical evidence related to the investigation.

Deputy district attorneys from the Homicide, TARGET/Gangs, and Special Prosecutions Units review fatal and non-fatal, officer-involved shootings and custodial death cases and determine whether criminal charges are appropriate. Thus, when the OCDASAU Investigator has concluded the investigation, the file is turned over to an experienced deputy district attorney for legal review. If necessary, the reviewing prosecutor will send the case back for further investigation.

Throughout the review process, the assigned prosecutor will consult with the Assistant District Attorney supervising the Special Prosecutions Unit of the OCDA, who will eventually review any legal conclusions and resulting memos. It is also common for the case to be reviewed by several experienced prosecutors and their supervisors. Ultimately, the District Attorney personally reviews and approves all officer-involved shooting and custodial death letters.

FACTS

On Monday, February 27, 2023, at approximately 11:52 p.m., police officers from the Westminster Police Department (WPD) arrested Barnette for an Orange County Superior Court arrest warrant for receiving stolen property and unlawfully possessing firearm ammunition.

On Tuesday, February 28, 2023, at approximately 3:02 a.m., Barnette was transported to the Orange County Jail Intake & Release Center (IRC). He was examined by IRC medical staff outside the IRC and then taken into the Booking Loop. During his Receiving Screening, Barnette was asked if he currently used any street drugs. He admitted to methamphetamine and marijuana use. He also admitted to having been diagnosed with depression and psychosis and having received medication previously in the Orange County Jail. It was noted that Barnette appeared to be lethargic. He indicated that he was sleepy, and that it had been two days since he last slept.

At approximately 3:28 a.m., OCSD Deputy Daniel Neuman conducted a booking search of Barnette.[1] During the search, Deputy Neuman discovered a small plastic baggie of white powder in Barnette's right shoe. Deputy Neuman suspected this powder to be a controlled substance, and Barnette was additionally charged with bringing a controlled substance into prison, possession of a controlled substance, and possession of unlawful paraphernalia under WPD Case #23-01740. The substance was later submitted to the OCCL for testing under FR# 23-46287.

[1] A booking search essentially consists of a pat down of the inmate as well as the removal and examination of his or her shoes. Per OCSD regulations, an extended search is not permitted on any arrestee during the intake process and prior to housing.

Between 3:28 a.m. and 10:47 a.m., Barnette was placed in and removed from various holding cells in the IRC Booking Loop as he went through the booking process. The IRC is monitored by security cameras outside the Booking Loop as well as inside the various holding cells. A review of the video recordings captured Barnette being moved and placed in the holding cells. Barnette was moving without assistance between the cells and while he appeared to be lethargic, there was nothing captured on video that would indicate that Barnette was in medical distress.

At approximately 10:47 a.m., Barnette was placed in Holding Cell PM9. The cell was monitored by security cameras located inside the cell and as well as outside Booking Loop. Barnette sat on a cement bench with his back to the security glass wall next to the cell door and appeared to nod off and sleep intermittently in a seated position. Four other inmates were initially present in the cell. Additional inmates were placed into and removed from the cell, but none appeared to interact with Barnette.

Between approximately 10:47 a.m. and 1:06 p.m., Barnette appeared to be sleeping in a seated position with his head forward. He awakened at various times and then appeared to go back to sleep. Other inmates were also placed in the cell and removed by deputies during this time period.

At approximately 1:06 p.m., Barnette appeared to stop significant movement. An inmate on the floor in front of Barnette and an inmate on the bench next to him appeared to notice something wrong. The inmates began banging on the glass and waving their arms.

At approximately 1:07 p.m., OCSD Deputy Garrett Scannell heard the inmates banging on the glass of Cell PM9. Deputy Scannell noticed the inmates pointing at Barnette and saying "he's turning purple." Deputy Scannell and his partner Deputy Kevin Tran removed the nine other inmates held in PM9.

At approximately 1:08 p.m., Deputies Scannell and Tran contacted Barnette. Barnette's face was purple, and he had saliva coming out of his mouth, along with mucus coming out of his nose. Barnette was non-responsive and was not breathing. Deputy Scannell removed Barnette from the bench and placed him on the floor in a recovery position. Deputy Tran radioed for the medical staff.

At approximately 1:09 p.m., Deputy Scannell administered a 4 milligram dose of Narcan. Barnette was then removed from the cell by Deputy Scannell, Deputy Kevin Tran, and Deputy Javier Torres. He was laid on the floor of the hallway of the Booking Loop.

At approximately 1:10 p.m., medical staff arrived and began rendering medical aid to Barnette.

At approximately 1:11 p.m., Deputies Scannell and Tran began administering cardiopulmonary resuscitation (CPR). The OCFA was summoned.

At approximately 1:17 p.m., Orange County Fire Authority (OCFA) paramedics arrived and took over treatment. Barnette was pulseless and apneic, while his heart displayed an asystolic rhythm. His pupils were fixed and dilated. Paramedics obtained the return of spontaneous circulation and CPR was discontinued.

At approximately 1:33 p.m., Barnette was removed from the IRC by OCFA.

At approximately 1:34 p.m., Barnette was placed into an ambulance and transported to OCGMC. He was accompanied by OCFA paramedics and OCSD Deputy Matthew Nguyen. Barnette went into cardiac arrest again while en route to the hospital and CPR was resumed.

At approximately 1:43 p.m., Barnette arrived at the hospital, and OCFA relinquished care of Barnette to OCGMC medical staff.

At approximately 2:25 p.m., an OCGMC student nurse located a small plastic baggie containing a white powder. This was discovered on the left side of the bed when Barnette's pants were cut off. The student nurse gave the baggie to Deputy Nguyen, who booked it into evidence.

At approximately 2:40 p.m., a urine blood screen sample was collected from Barnette. The sample tested positive for amphetamine and benzodiazepine.

OCGMC physicians performed a computerized tomography (CT) scan which revealed a subarachnoid hemorrhage with significant cerebral edema. Barnette was found to suffer from acute acidosis, renal and respiratory failure, and shock. A neurosurgeon was consulted and noted that Barnette's findings were consistent with anoxic brain injury and death. Nevertheless, Barnette was admitted to the Intensive Care Unit and placed on life support. Barnette was classified as having a poor prognosis. OneLegacy was recommended in order to explore organ harvesting options.

On March 2, 2023, at approximately 2:27 p.m., Barnette was declared brain dead by an OCGMC neurosurgeon.

On March 3, 2023, at approximately 9:18 a.m., an OCGMC internal medicine physician gave Barnette a second brain death diagnosis and declared him deceased. At approximately 11:40 a.m., Barnette was released from the custody of the OCSD to the OCGMC where he remained on life support for purposes of organ donation.

AUTOPSY

On March 17, 2023, at approximately 8:00 a.m., Forensic Pathologist Scott Luzi conducted a postmortem examination of Barnette at the Orange County Sheriff-Coroner Forensic Science Center.

An OCCL Forensic Specialist took 47 color digital photographs and an OCCL Forensic Scientist collected deep muscle tissue standard.

After the autopsy, Dr. Luzi stated the cause and manner of death were pending.

On July 27, 2023, Dr. Luzi issued an amendment to the initial autopsy report. Dr. Luzi identified Barnette's cause of death as acute fentanyl intoxication and the manner of death as accidental.

EVIDENCE COLLECTED

IRC

An OCCL Forensic Specialist took 15 digital color photographs

- One baggie containing an off-white crystalline substance booked under FR# 23-46287
- One baggie containing an off-white crystalline substance booked under FR# 23-41909
- One plastic bag containing a black cell phone and two shoelaces.

OCGMC
An OCCL Forensic Specialist took 37 digital color photographs of the scene and body.

EVIDENCE ANALYSIS
Toxicological Examination
A sample of Barnette's antemortem blood was collected and examined for the presence of drugs and alcohol. The following results and interpretations were documented:

Drug/Alcohol	Antemortem Blood
Fentanyl	0.0165 ± 0.00130mg/L
4-ANPP	Detected
Amphetamine	Detected
Methamphetamine	Detected
Ethanol/Volatiles	Not Detected
Barbiturates	Negative
Cannabinoids	Negative

A sample of the off-white crystalline substance from the IRC Booking Loop submitted under FR# 23-46287 contained methamphetamine.

A sample of the off-white crystalline substance from the OCGMC submitted under FR# 23-41909 contained methamphetamine.

BACKGROUND INFORMATION
Barnette had a State of California criminal history record that revealed prior arrests for the following violations:

- Obstructing or Resisting a Public Officer
- Burglary
- Making a Fictitious Check
- Grand Theft
- Petty Theft
- Auto Theft
- Possession of a Stolen Vehicle
- Receiving of Stolen Property
- Possession of Burglary Tools
- Possession of Ammunition When Prohibited
- Identity Theft
- Conspiracy to Commit a Crime
- Vandalism
- Possession of a Unlawful Paraphernalia
- Under the Influence of Drugs
- Possession of a Narcotic / Controlled Substance
- Probation Violation
- Driving While License is Suspended or Revoked

THE LAW

Homicide is the killing of one human being by another. Murder, voluntary manslaughter, and involuntary manslaughter are types of homicide. To prove that a person is guilty of murder, the following must be proven:

a. The person committed an act that caused the death of another person;
b. When the person acted he/she had a state of mind called malice aforethought; and
c. He/she killed without lawful excuse or justification.

There are two kinds of malice aforethought, express malice and implied malice. Express malice is when the person unlawfully intended to kill. Implied malice requires that a person intentionally committed an act, the natural and probable consequences of the act were dangerous to human life, at the time he acted he knew his act was dangerous to human life, and he/she deliberately acted with conscious disregard for human life.

A person can also commit murder by his/her failure to perform a legal duty, if the following conditions exist:

a. The killing is unlawful (*i.e.*, without lawful excuse or justification);
b. The death is caused by an intentional failure to act in a situation where a person is under a duty to act;
c. The failure to act is dangerous to human life; and
d. The failure to act is deliberately performed with knowledge of the danger to, and with conscious disregard for, human life.

A person can also commit involuntary manslaughter by failing to perform a legal duty, if the following conditions exist:

a. The person had a legal duty to the decedent;
b. The person failed to perform that legal duty;
c. The person's failure was criminally negligent; and
d. The person's failure caused the death of the decedent.

In *Giraldo v. California Dept. of Corrections and Rehabilitation* (2008) 168 Cal.App.4th 231, 250-251, the court held that there is a "special relationship" between jailer and prisoner:

> "[T]he most important consideration 'in establishing duty is foreseeability.' [citation] It is manifestly foreseeable than an inmate may be at risk of harm.... Prisoners are vulnerable. And dependent. Moreover, the relationship between them is protective by nature, such that the jailer has control over the prisoner, who is deprived of the normal opportunity to protect himself from harm inflicted by others. This, we conclude, is the epitome of a special relationship, imposing a duty of care on a jailer owed to a prisoner, and we today add California to the list of jurisdictions recognizing a special relationship between jailer and prisoner."

California Government Code 845.6 codifies that the special relationship that exists in a custodial setting gives rise to a legal duty, as follows:

> "[A] public employee, and the public entity where the employee is acting within the scope of his employment, is liable if the employee knows or has reason to know that the

prisoner is in need of immediate medical care and he fails to take reasonable action to summon such medical care."

Criminal negligence involves more than ordinary carelessness, inattention, or mistake in judgment. A person acts with criminal negligence when he acts in a reckless way that creates a high risk of death or great bodily injury and a reasonable person would have known that acting in that way would create such a risk. In other words, a person acts with criminal negligence when the way he acts is so different from how an ordinarily careful person would act in the same situation that his or her act amounts to disregard for human life or indifference to the consequences of that act.

An act causes death if the death is the direct, natural, and probable consequence of the act and the death would not have happened without the act. A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes.

There may be more than one cause of death. An act causes death only if it is a substantial factor in causing the death. A substantial factor is more than a trivial or remote factor; however, it does not need to be the only factor that causes the death.

LEGAL ANALYSIS

There is no evidence of express or implied malice on the part of any OCSD personnel or any inmates or other individuals under the supervision of the OCSD. Accordingly, the only possible type of homicide to analyze in this situation is murder or manslaughter under the theory of failure to perform a legal duty.

Although the OCSD owed Barnette a duty of care, the evidence does not support a finding that this duty was in any way breached -- either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter). Barnette was evaluated by medical personnel upon admittance to the IRC on February 28, 2023. It was noted that he had a history of drug usage and mental health issues; however, he was not viewed as a suicide risk. While he was lethargic, he indicated that he had not slept in two days. He was not showing any objective symptoms of being under the influence. During the subsequent seven-hour period, Barnette did not display any concerning behavior. After being placed in Holding Cell PM9, he spent the next several hours appearing to fall asleep in a seated position, wake up, and then fall back asleep.

When Barnette was observed by fellow inmates not to be moving and turning purple, they alerted OCSD deputies who immediately came to Barnette's aid. OCSD personnel responded promptly and appropriately. Within four minutes, medical personnel had been summoned, Narcan was administered, emergency services were called, and CPR was performed. Lifesaving efforts continued until the OCFA arrived.

There is nothing to indicate that Barnette's death was the result of inaction or improper action of OCSD personnel or those under the supervision of OCSD.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that there is no evidence to support a finding that any OCSD

personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Ryan Barnette.

Accordingly, the OCDA is closing its inquiry into this incident.

Respectfully submitted,

MARC ROZENBERG
Deputy District Attorney
Special Prosecutions Unit

Read and Reviewed by **BRETT BRIAN**
Assistant District Attorney
Special Prosecutions Unit

Read and Approved by District Attorney **TODD SPITZER**