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 20, 2023
Death of Inmate Todd Robert Whited
District Attorney Investigations Case # 23-000892
Orange County Sheriff's Department Case # 23-009937
Orange County Crime Laboratory Case # FR 23-42535
Orange County Coroner's Office Case # 23-01806-DS

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 20, 2023, custodial death of 47-year-old inmate Todd Robert Whited.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Whited. 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 20, 2023, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the Orange County Global Medical Center (OCGMC), where Whited died while in custody. During the course of their investigation of Whited's death, the OCDASAU interviewed five 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 March 17, 2023, at approximately 11:41 a.m., OCSD deputies arrested Whited for an Orange County Superior Court (OCSC) arrest warrant for possessing unlawful drug paraphernalia, domestic violence, and being a fugitive from justice. OCSD transported Whited to the Orange County Jail.

At approximately 2:43 p.m., Whited was booked into the Orange County Jail Intake Release Center (IRC).

A pre-booking medical screening was conducted at the IRC. During the screening, Whited was found to have a history of alcohol abuse with related seizures, drug abuse (amphetamines), Hepatitis C, and mental health issues.

On March 18, 2023, at approximately 6:28 a.m., Whited was transferred to the Orange County Central Men's Jail, where he was housed in Module A, Tank 5, Bunk 10.

Module A, Tank 5 is a large dormitory cell. It contains approximately 24 bunk beds. The module appeared to be housing approximately 50 inmates. Bunk 10 is located to the right of the cell entrance and is positioned up against the cell bars. Bunk 10 is the top bunk.

The Orange County Central Men's Jail is monitored by security cameras. There are cameras located outside of Module A, Tank 5. Video recordings from those cameras captured this incident.

Based on the video surveillance recordings, at approximately 11:05 a.m., Whited walked up to the foot of Bunk 10 and prepared the bedding. He then walked around the cell for approximately two

minutes before returning to the bunk. Whited then stood by the foot of the bed or by the cell bars at the head of the bed for approximately 15 minutes.

At approximately 11:22 a.m., Whited proceeded to get onto the top bunk and lie down.

Between 11:22 a.m. and approximately 4:34 p.m., Whited could be seen repeatedly getting in and out of the bunk bed and walking around the cell and leaving the cell for dinner. At that time, nothing unusual about Whited could be observed.

At approximately 4:34 p.m., Whited once again is observed getting onto the top bunk and lying down. For approximately the next three hours, Whited remained lying down on the bed. He occasionally moved around on the bed during this time.

At approximately 7:28 p.m., an unknown inmate approached the left side of the bunk and appeared to attempt to arouse Whited.

At approximately 7:28:43 p.m., the inmate was joined by another unknown inmate and they both tried to awaken Whited.

At approximately 7:29:20 p.m., several other inmates joined the effort to arouse Whited.

At approximately 7:29:33, one of the inmates ran to the cell door to notify OCSD deputies that Whited was unresponsive.

At approximately 7:30 p.m., OCSD Deputy Wes Lynd was working the Module A Guard Station when he heard a group of inmates housed in Module A, Tank 5 yelling "Man Down, Man Down." Deputy Lynd and several additional deputies responded to Tank 5 and saw Whited lying on his bunk. Whited had a pulse and was breathing, but was otherwise unresponsive to verbal and physical attempts to wake him up. OCSD Deputy Ryan Murray radioed a request for medical staff to respond.

At approximately 7:31 p.m., several OCSD deputies lifted Whited off his bunk and laid him on his mattress on the ground. He was then moved to the hallway outside his housing location to allow for medical staff to evaluate him in a secure environment.

At approximately 7:31:49 p.m., an OCSD Deputy administered one dose of Narcan to Whited's right nostril. At approximately 7:33 p.m., an additional dose of Narcan was administered to Whited's left nostril. Whited remained unresponsive.

At approximately 7:34 p.m., OCJ medical personnel responded and began evaluating Whited.

At approximately 7:34:37 p.m., OCFA paramedics were dispatched to the scene.

At approximately 7:35 p.m., a third dose of Narcan was administered to Whited's right nostril, followed by an intramuscular injection of Narcan to Whited's left deltoid.

At approximately 7:40 p.m., a second intramuscular injection of Narcan was administered to Whited's left deltoid. No change in condition was noted.

At approximately 7:49 p.m., OCFA paramedics arrived on the scene and assumed patient care of Whited. Paramedics confirmed Whited was unresponsive, with pinpointed pupils and a low

respiratory rate. A four-lead heart monitor revealed that Whited had a sinus tachycardia heart rhythm. Paramedics noted that Whited showed no signs of trauma.

OCFA personnel administered an intranasal dose of Narcan. At that time, Whited's respiratory rate accelerated, but his pupils remained pinpointed and fixed.

At approximately 8:00 p.m., Whited was loaded into an awaiting ambulance and transported to OCGMC. At approximately 8:09 p.m., OCFA paramedics established an intravenous (IV) line and administered another dose of Narcan via IV, which increased his heart rate and respiration.

At approximately 8:10 p.m., Whited arrived at the hospital and OCFA relinquished care to OCGMC emergency medical staff at approximately 8:21 p.m.

During diagnostic testing, which included x-rays and computerized tomography (CT) scans, it was discovered that Whited had sustained an intracranial bleed/aneurysm that resulted in a catastrophic brain injury.

On March 19, 2023. At approximately 12:05 pm., Whited was moved from the Emergency Department to the Intensive Care Unit, where standard tests for brain death confirmation were completed.

On March 20, 2023, at approximately 1:49 p.m., Whited was pronounced brain dead by an OCGMC Internal Medicine Physician and an OCMGC Neurologist. Whited was kept on life-support pending next of kin notification and organ/tissue procurement efforts by the One Legacy Foundation.

On March 28, 2023, at approximately 4:00 p.m., Whited was taken to an OCGMC operating room, where One Legacy Foundation conducted organ/tissue procurement.

AUTOPSY

On March 31, 2023, at approximately 8:00 a.m., Forensic Pathologist Scott Luzi conducted a post-mortem examination of Whited at the Orange County Sheriff-Coroner Forensic Science Center.

An OCCL Forensic Specialist took 52 color digital photographs and an OCCL Forensic Scientist collected deep muscle tissue standard.

After the autopsy, Dr. Luzi confirmed that Whited had sustained a brain aneurysm, but identified the cause and manner of Whited's death as "pending" until toxicological and microscopic testing results were obtained and evaluated.

On August 1, 2023, Dr. Luzi issued an amendment to the initial autopsy report. Dr. Luzi identified Whited's cause of death as a subarachnoid hemorrhage due to a ruptured intracranial aneurysm. Dr. Luzi classified the manner of death as natural.

EVIDENCE COLLECTED

An OCCL Forensic Specialist took 53 digital color photographs of the scene and body, located at OCGMC. No evidence was collected

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Whited's antemortem and postmortem blood was collected and examined for the presence of drugs and alcohol.

The following results and interpretations were documented:

Drug/Alcohol	Antemortem Blood	Postmortem Blood
Ethanol/Volatiles	Not Detected	Not Detected
Barbiturates	Not Detected	Not Detected
Cannabinoids	Not Detected	Not Detected
Phenethylamines	Not Detected	Not Detected
Cannabinoids	Not Detected	Not Detected

BACKGROUND INFORMATION

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

- Fugitive from Justice
- Terrorist Threats
- Exhibit Deadly Weapon, Not Firearm
- Possess/Manufacture/Sell Dangerous Weapon
- Dissuading a Witness
- Drunk in Public
- Petty Theft
- Carry a Concealed Dirk or Dagger
- Possession of a Controlled Substance
- Possession of Drug Paraphernalia
- Battery of Spouse/Cohabitant/Dating Relationship
- Violation of Domestic Violence-Related Court Order

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 Whited 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). Whited was evaluated by medical personnel upon admittance to the IRC on March 17, 2023. It was noted that he had a history of drug and alcohol abuse, Hepatitis C, and mental health issues. He was subsequently housed in a general population module. There were no indications of illness or physical distress. A review of the jail video shows Whited acting normally and showing no signs of distress. He was continually in and out of his bunk, moving around the tank, and leaving the tank for dinner. He ultimately laid down in his bunk and showed no signs of distress.

When Whited was observed by fellow inmates to be unresponsive, they alerted OCSD deputies who immediately came to Whited's aid. OCSD personnel responded promptly and appropriately. Suspecting a possible overdose, OCSD administered multiple doses of Narcan. Within four minutes, medical personnel had been summoned and arrived on the scene. Narcan was again administered and emergency services were called. Lifesaving efforts continued until OCFA paramedics arrived.

Ultimately, it was not an overdose that caused Whited's death, but rather a sudden medical incident, namely a brain aneurysm.

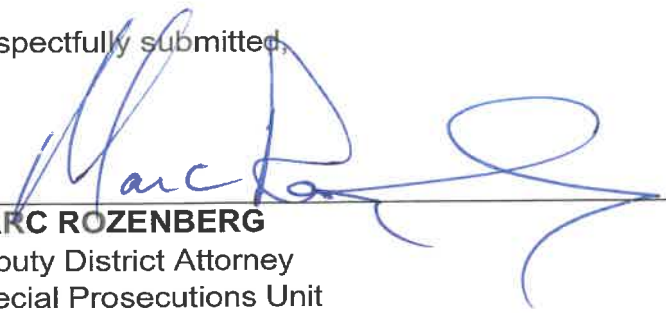
There is nothing to indicate that Whited's death was the result of inaction or improper action of OCSD personnel or those under the supervision of OCSD.

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 Todd Whited.

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

Respectfully submitted,



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