



OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA

TODD SPITZER

August 14, 2026

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

Re: Custodial Death on February 1, 2025
Death of Inmate Christopher Joseph Donnelly
District Attorney Investigations Case # 25-000230
Orange County Sheriff's Department Case # 25-003909
Orange County Crime Laboratory Case # FR 25-41116
Orange County Coroner's Office Case # 25-00628-DE
Orange City Fire Authority # 25-017397

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 February 1, 2025, custodial death of 45-year-old inmate Christopher Joseph Donnelly.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Donnelly. 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 February 1, 2025, OCDA Special Assignments Unit (OCDASAU) investigators responded to the Orange County Jail (OCJ) - Intake Release Center (IRC), where Donnelly died while in custody. During the course of their investigation of Donnelly's death, the OCDASAU interviewed 11 witnesses and canvassed 28 jail inmates, and obtained police reports, incident scene photographs, jail surveillance footage, medical records, and other relevant materials from the OCSD, the Orange County Fire Authority (OCFA), the Orange County Coroner's Office (OCCO), and the Orange County Crime Laboratory (OCCL).

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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 the deaths of individuals while in custody within Orange County. 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 correspondence. 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.

FACTUAL SUMMARY

On July 9, 2024, at approximately 9:01 a.m., Christopher Donnelly was arrested by the Newport Beach Police Department (NBPD) on an outstanding warrant for a violation of California Vehicle Code Sections 23152 (a) and (b) – driving under the influence (DUI) and driving with a blood alcohol level in excess of .08%. Donnelly had an additional five outstanding warrants, mostly for DUI and traffic-related offenses.

At approximately 10:41 a.m., NBPD Officer Timothy Stewart completed an Orange County Health Care Agency (OCHCA)-Statement of Booking Officer Questionnaire on Donnelly, but Donnelly refused to answer any questions.

At approximately 2:40 p.m., an OCHCA Comprehensive Care Nurse (CCN) completed the Receiving Screening Refusal of Donnelly. Donnelly reported being previously incarcerated within the Orange County Jail and having a prior history of mental illness. He also reported consuming alcohol and smoking daily. Donnelly had a visible abrasion to the left side of his forehead, an injury he stated occurred two days earlier when he fell off his bike. He appeared unkempt but had

no other visible physical disabilities. Donnelly received additional OCHCA screenings throughout the day, and pending orders for medical blood lab screenings.

At approximately 7:11 p.m., NBPD Officer Stephen Buffington contacted Donnelly and completed a second OCHCA-Statement of Booking Officer Questionnaire on Donnelly. Donnelly answered routine questions but refused medical attention for his pre-existing head abrasion.

At approximately 7:35 p.m., an OCHCA Registered Nurse (RN) completed an additional Receiving Screening of Donnelly. At this time, Donnelly reported taking or being prescribed the following medications:

- Lexapro (anxiety medication)
- Vistaril (antihistamine/anxiety medication)
- Remeron (antidepressant)
- Rexulti (bipolar depression medication)

Donnelly reported having a depressive disorder and anxiety. He stated that a mental health doctor had seen him in the past and that he had attempted suicide about a year ago. Donnelly reported, "Sometimes I see things. Sometimes I hear things." He was noted to require medical follow-up for alcohol detox and mental health triage. A computed tomography (CT) scan was performed on Donnelly's head, which confirmed no major head injury. Donnelly had no physical disabilities but was placed on hold for additional mental health triage and mental health housing.

At approximately 7:48 p.m., Donnelly was officially booked into the OCJ/IRC.

At approximately 8:14 p.m., an OCHCA Clinical Care Nurse Practitioner (CCNP) documented withdrawal orders pertaining to Donnelly. Donnelly was cleared for regular housing and to receive detoxification medications with a medical follow-up in three days.

On July 10, 2024, at approximately 1:50 a.m., an OCHCA RN completed a Columbia-Suicide Severity Rating Scale on Donnelly. Donnelly reported previous thoughts of suicide and mental health problems. An OCHCA Medical Doctor spoke with Donnelly about his current mental condition and about the following medications being prescribed to him:

- Mirtazapine
- Lexapro
- Ativan
- Serax
- Hydroxyzine
- Gabapentin

Donnelly's mental condition was classified as acute and a danger to himself. Donnelly was issued a safety gown and placed under observation.

At approximately 4:12 a.m., an OCCA RN completed an additional mental health screening of Donnelly. Donnelly again reported mental health problems, approximately two years ago, while

incarcerated at the Orange County Jail. He stated he was diagnosed with depression and anxiety. Donnelly said he has been prescribed medications for his mental condition, but does not take the medication. Donnelly reported still feeling depressed, and hearing voices of people who aren't visible, "telling him to jump off the tier." Donnelly was placed on suicide watch, and a priority psychiatric evaluation was to be scheduled. Donnelly was determined to be mentally unstable, but did not meet the classification of 5150 at that time.¹

At approximately 4:48 a.m., OCHCA medical staff contacted Donnelly for his prescribed vital check and blood sugar check. Donnelly refused to be seen and treated.

At approximately 9:17 a.m., an OCHCA RN completed a Clinical Institute Withdrawal Assessment (CIWA) on Donnelly. Donnelly reported feeling slightly nauseated and having a mild headache.

At approximately 10:48 a.m., Donnelly was housed in Module J, Sector 7, Cell 2, in a lower bunk.

At approximately 2:56 p.m., an OCHCA physician completed a Psychiatric Evaluation of Donnelly. It noted that Donnelly had a history of mental health-related issues dating back to 2022. Donnelly was diagnosed as having major depressive disorder, anxiety disorder, and alcohol abuse. Donnelly was to remain in a safety gown with continued monitoring and continue with prescribed medications.

At approximately 8:38 p.m., Donnelly was contacted by OCHCA medical staff to review his detoxification withdrawal and was prescribed a blood sugar check. Donnelly refused to be seen and treated.

At approximately 10:11 p.m., OCHCA medical staff contacted Donnelly for a vital check and prescribed a blood sugar test. Again, Donnelly refused to be seen and treated.

Throughout the month of July, OCHCA medical staff members contacted Donnelly almost daily, but Donnelly continued to refuse medical treatment, vital checks, and follow-through with medical assessments.

On July 13, 2024, at approximately 3:44 p.m., an OCHCA Psychiatric Nurse Practitioner (PNP) contacted Donnelly and completed Psychiatric Progress Notes. Donnelly reported feeling suicidal, depressed, and hearing voices. Donnelly, however, indicated that he had no plan or intention of hurting himself. Donnelly refused to exit his cell for mental health counseling but was documented having a good appetite. Donnelly was also compliant with taking his medication.

At approximately 4:31 p.m., Donnelly was moved and housed in Module M, Sector 23, Cell 13, in a lower bunk.

Psychiatric evaluations and follow-up OCHCA medical visits continued through September 2, 2024. Progress notes indicated that Donnelly's mental condition remained unchanged; however, he continued to refuse to cooperate with OCHCA medical staff and declined medical treatment

¹ Section 5150 of the California Welfare and Institutions Code allows qualified officers or clinicians to involuntarily detain individuals for up to 72 hours for psychiatric evaluation if they are deemed a danger to themselves, a danger to others, or gravely disabled due to a mental health disorder.

and testing. Over time, Donnelly became increasingly withdrawn but denied having any medical concerns. His overall mental condition remained unchanged.

On October 1, 2024, at approximately 7:55 a.m., an OCHCA Clinical Care Nurse (CLCN) contacted Donnelly and determined his mental health to be reclassified as gravely disabled.

At approximately 12:33 p.m., Donnelly was moved and housed in Module L, Sector 17, Cell 16, in a lower bunk.

On October 4, 2024, at approximately 4:36 p.m., an OCHCA CLCN contacted Donnelly to check on his welfare. Donnelly denied any discomfort or dizziness. Donnelly had a steady gait, had no visible injuries, and was determined to have no self-harming behavior.

Between October 11, 2024, and October 15, 2024, Donnelly complained about his medications, but no other information was noted.

On October 22, 2024, at approximately 2:24 p.m., Donnelly was moved and housed in Module J, Sector 1, Cell 2, a two-person cell with cellmate John Doe 1. Donnelly was assigned a lower bunk.

Module J has a guard station outside sector 1 and a surveillance camera mounted on the sector's ceiling. Sector 1 is separated from the guard station by a large metal-framed glass wall that extends from the floor to the ceiling. Module J, Sector 1, has two levels, each with eight two-person cells. The lower cells are numbered 1, 3, 5, 7, 9, 11, 13, and 15.

The upper cells are numbered 2, 4, 6, 8, 10, 12, 14, and 16. Each cell has a door that leads to a day room on the first floor. There is a staircase on the south side of the sector that leads to the upper level.

The upper level of sector 1 features a concrete walkway approximately six feet wide at the front of all upper-level cells. Each cell door is constructed of safety glass and a metal frame. Each cell door has its assigned number stenciled on the top. The surveillance camera has a limited view of Cell 2's interior.

The interior of Cell 2 had a concrete-and-metal bunk bed, connected lengthwise to the south wall. There was a fluorescent light fixture affixed to the ceiling of the cell. The cell also contained a sink, toilet, metal table, and metal stools.

Donnelly's overall medical condition remained the same throughout October. Toward the end of October, Donnelly became less forthcoming with OCHCA medical staff and continued to refuse requested blood draws for medical testing.

On November 19, 2024, at approximately 8:38 p.m., OCHCA medical staff contacted Donnelly to request a blood draw for a routine lab test. Again, Donnelly refused. At this time, Donnelly was documented as having no signs of distress or discomfort and as being compliant with taking his medication. He denied suicidal ideations, depression, or anxiety. He indicated he felt well and had no trouble sleeping.

On December 22, 2024, Donnelly reported not feeling well with signs of a cold (cough, congestion, sore throat). There were no other documented incidents involving Donnelly in December or January 2025.

On February 1, 2025, the OCJ security camera captured deputies making routine cell checks, passing by Cell 2 approximately every thirty minutes.

The following series of events was also captured on the OCJ security camera.

At approximately 3:52 a.m., food was delivered to Cell 2, and both Donnelly and John Doe 1 were captured seated at the cell's table, consuming their meal. Shortly afterward, Donnelly is captured walking around the cell, then returns to his lower bunk at approximately 4:10 a.m.

John Doe 1, in an interview with OCDASAU investigators, stated that, following breakfast, both he and Donnelly went back to sleep.

At approximately 4:31 a.m., deputies began collecting meal trays/trash from the sector and opened Cell 2. Donnelly was captured walking to the cell door and handing trash to the deputy without incident. Donnelly returned to his lower bunk and, shortly after, moved out of view of the camera. This was the last time the OCJ security camera captured Donnelly moving in the cell.

Safety checks by deputies continued approximately every 30 minutes.

At approximately 6:34 a.m., the OCJ security camera footage captured a deputy walking to the door of Cell 2 and providing an item to John Doe 1. Donnelly remained in his lower bunk.

At approximately 8:22:37 a.m., the OCJ security camera captured John Doe 1 looking down toward Donnelly, who was on the lower bunk. John Doe 1 stated that he recalled waking up from his sleep and hearing Donnelly making a "strange gurgle noise," a sound Donnelly had not made in the past. Security footage captured John Doe 1 moving closer toward Donnelly, and it appeared that John Doe 1 began checking on Donnelly.

At approximately 8:25:15 a.m., John Doe 1 stood up from the lower bunk and began pacing back and forth in the cell.

At approximately 8:26:30 a.m., John Doe 1 is seen standing at the cell door, moving his arms, and requesting assistance.

At approximately 8:26:33 a.m., OCSD Custody Service Assistant (CSA) John Doe 2 entered the sector to clean and observed John Doe 1 waving his arms. John Doe 2 contacted John Doe 1, who reported that Donnelly was not breathing or having difficulty breathing. John Doe 2 saw Donnelly on the lower bunk and then called deputies for assistance.

At approximately 8:27:48 a.m., Deputies Spencer Ned and Jeremy Dutra responded to Cell 2. The deputies entered the cell and discovered Donnelly unconscious, unresponsive, and exhibiting a slight gurgling sound, as if he were choking. Deputy Ned found that Donnelly was pulseless. Deputy Dutra attempted to wake Donnelly and administered a sternum rub, but there was no response.

At approximately 8:28:35 a.m., Deputies Ned and Dutra removed Donnelly from the cell to provide medical aid. Deputy Stephen Guzman responded to the sector to assist deputies and broadcast a “man down” to jail medical staff. Deputy Ned initiated chest compressions on Donnelly and continued compressions until medical assistance arrived.

At approximately 8:30:48 a.m., OCHCA RNs arrived in Sector 1, responding to the “man down” call. RN Jane Doe 1 observed deputies performing chest compressions on Donnelly, while outside the cell on the top tier.

Jane Doe 1 told OCDASAU investigators that she contacted Donnelly and saw he was pale, clammy, vomitous, and had a distended abdomen. Jane Doe 1 affixed an automated external defibrillator (AED) to Donnelly. The AED went through several cycles, each time it recommended no shock. Jane Doe 1 administered two rounds of Narcan (0.4 mg) but saw no change in Donnelly’s condition.

RN Jane Doe 2 told OCDASAU investigators that Donnelly was pulseless and did not react to pain stimuli (a pinch).

At approximately 8:32:16 a.m., OCFA paramedics were dispatched to the OCJ.

At approximately 8:34:04 a.m., additional OCHCA jail medical staff arrived to assist with lifesaving efforts. Medical staff never saw any movement or positive response from Donnelly as cardiopulmonary resuscitation (CPR) was continuous.

At approximately 8:38:27 a.m., OCFA paramedics arrived at Mod J, Sector 1, Cell 2. The paramedics found Donnelly pulseless, unresponsive, with pale skin and cyanotic. Donnelly remained in asystole upon contact with the base hospital (Orange County Global Medical Center). After 20 minutes of advanced lifesaving efforts, Donnelly’s condition did not change.

At approximately 8:58 a.m., an OCFA captain pronounced Donnelly deceased at the scene.

AUTOPSY

On February 12, 2025, at approximately 10:00 a.m., Forensic Pathologist Scott Luzi performed a post-mortem examination of Donnelly at the Orange County Coroner’s facility.

During the examination, an OCCL Forensic Scientist (FS) collected bloodstain and muscle standards from Donnelly, and an OCCL Forensic Specialist (FSP) took 47 color digital photographs.

Following the post-mortem examination, Dr. Luzi noted Donnelly had a swollen brain and heart irregularities/blockage. Dr. Luzi stated the final cause and manner of death were pending review of medical records, toxicology results, and examination of microbiological slides.

On September 11, 2025, Dr. Luzi amended his report, identifying the cause and manner of Donnelly's death. Dr. Luzi identified the cause of Donnelly's death as "Acute buprenorphine intoxication" and the classification as "Accident."²

On March 16, 2026, an OCDASAU investigator interviewed an OCHCA physician who stated that a review of Donnelly's medical records showed that he was not prescribed buprenorphine or any medications that contained buprenorphine during his time in the OCJ.

EVIDENCE COLLECTED

An OCCL FS collected the following evidence:

- Swabs of Donnelly's face, neck, hands, palms, and fingernails
- Donnelly's clothing

An OCCL FSP took 102 digital color photographs documenting the scene.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Donnelly's postmortem blood was collected and examined for the presence of drugs and alcohol. The following results and interpretations were documented:

Drug	Postmortem Blood	Peripheral Blood	Brain
Buprenorphine (Free)	Detected	0.0037 $\pm$ 0.0006 mg/L	0.0111 $\pm$ 0.0018 mg/kg
Citalopram	Detected		
Norcitalopram	Detected		
Mirtazapine	Detected		
N-desmethylmirtazapine	Detected		
Olanzapine	Detected		
Caffeine	Detected		

BACKGROUND INFORMATION

Donnelly had a State of California criminal history record dating from 2013 that revealed prior arrests for the following violations:

- Delay/Obstruct Public Officer
- Terrorist Threats
- False Information to a Public Officer
- Rape

² A review of Donnelly's prescribed medication throughout his time in the OCJ, found that none of the medicines contained Buprenorphine. It is unknown how Donnelly came into possession of the Buprenorphine.

- Domestic Battery
- Hit and Run
- Driving Under the Influence
- Assault with a Deadly Weapon
- Battery
- Disobey Court Order
- Public Intoxication
- Driving with a Suspended License

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 a 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 section 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.

The OCSD owed Donnelly a duty of care. There is no evidence, however, that the duty was breached- either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter).

Donnelly was identified as needing psychiatric help during the booking process. During his time in custody, he was housed in a psychiatric module and received ongoing psychiatric evaluations and follow-ups. He was also seen by medical professionals for his other medical issues and was monitored and prescribed medications.

On the date of the incident, OCSD deputies conducted safety checks, per protocol, every 30 minutes. They did not notice anything unusual during these checks. Donnelly's own cellmate also did not notice anything unusual until Donnelly woke him with gurgling noises.

Once OCSD deputies were made aware of Donnelly's situation, they acted promptly and appropriately. Medical and emergency personnel were summoned immediately, and Deputies Ned and Dutra began lifesaving measures. OCSD medical personnel responded promptly and administered multiple doses of NARCAN and provided life-saving emergency treatment. The OCSD also attempted emergency lifesaving measures, but, unfortunately, Donnelly could not be revived.

To the extent Donnelly's death was caused by an overdose of buprenorphine, there is no evidence that OCSD was aware of the presence of the drug, and it was not a drug that he had been prescribed.

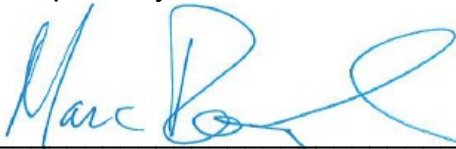
There is nothing to indicate that Donnelly's death was the result of inaction or improper action of OCSD personnel or those under the supervision of OCSD.

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 Christopher Donnelly.

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

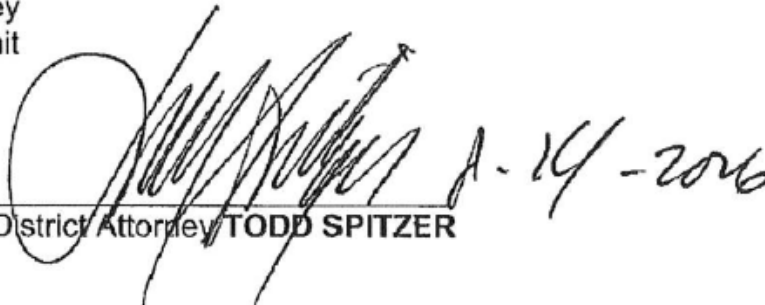
Respectfully submitted,



MARC ROZENBERG
Senior Deputy District Attorney
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Read and Reviewed by **STEVEN SCHRIVER**
Assistant District Attorney
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Read and Approved by District Attorney **TODD SPITZER**