An Analysis of a Sample of Title 15 Safety Checks at Men's Central Jail and Twin Towers Correctional Facility

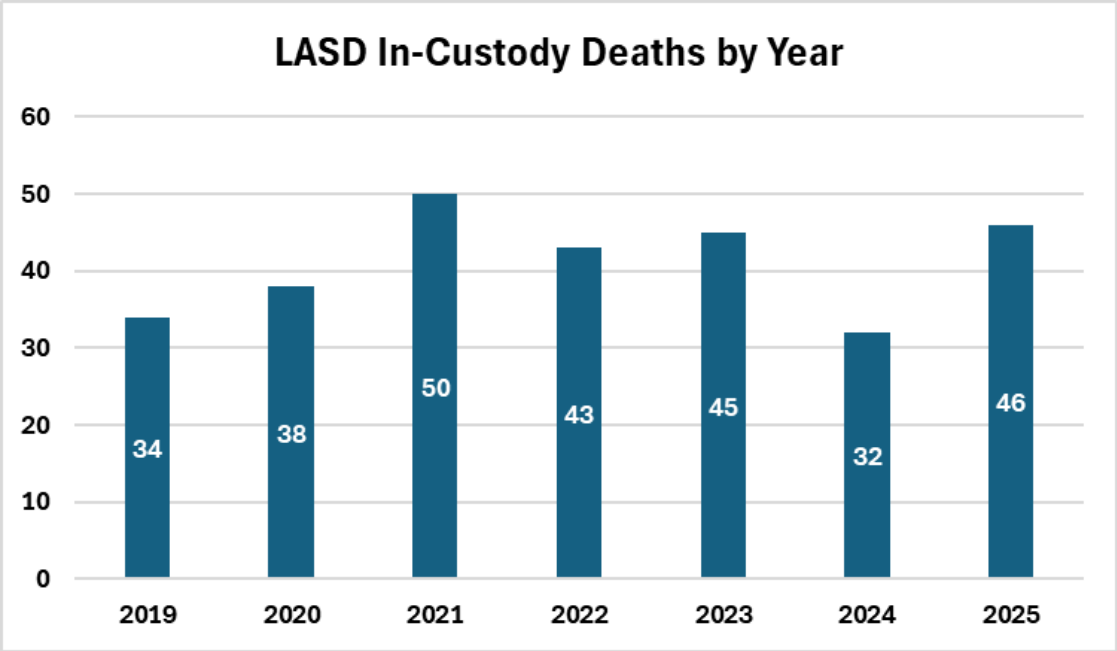
August 11, 2026

Table of Contents

INTRODUCTION

State law and Los Angeles County Sheriff's Department (Sheriff's Department) policy require that custody staff conduct safety checks to ensure the safety and security of people in custody.[1] In its monitoring, reviewing, and reporting on in-custody deaths, the Office of Inspector General has routinely identified concerns with safety checks.[2] This report is a result of OIG's identifying concerns with adherence to the laws on safety checks and the quality of the checks.

Between January 1, 2020, and December 31, 2025, 253 people died while incarcerated in Los Angeles County Jails. The Office of Inspector General identified concerns regarding the quality and/or timeliness of safety checks in approximately 40% of these in-custody deaths.



[1] This report refers to the Sheriff's Department, the Department, or LASD when referencing the Los Angeles County Sheriff's Department. The Office of Inspector General is also referred to as OIG in some places throughout the report.

[2] *See* *Reform and Oversight Efforts: Los Angeles County Sheriff's Department – October through December 2025* (February 26, 2026) at page 38.

The California Department of Justice raised similar concerns. On September 8, 2025, the California Attorney General's Office filed a lawsuit against the Sheriff's Department alleging the people in custody in Los Angeles County jails are subject to unconstitutional conditions of confinement.[3] Noting the "shocking rate of deaths inside the jails,"[4] the California Attorney General's Office asserted that "by failing to perform required safety checks and otherwise engaging in a pattern and practice of deliberate indifference to the substantial risk of serious harm to persons confined in [Los Angeles County] jails, [the Department has] failed to maintain the safety and security of persons in [its] custody, to whom they owe a constitutional duty to protect from both self-harm and violence."[5]

On March 2, 2026, the Los Angeles County Board of Supervisors passed a motion aimed at improving conditions of confinement in Los Angeles County jails and reducing the number of in-custody deaths.[6] The motion requested that the Sheriff's Department improve the quality and timeliness of safety checks and report back on their policies and practices concerning safety check quality and timeliness.

The Office of Inspector General conducted a review of a sample of safety checks in two Los Angeles County jail facilities to ascertain whether the Department has been able to improve the quality and timeliness of safety checks. This report discusses legal requirements for safety checks, reviews the Department's policies and practices related to safety checks, utilizes mixed methods to analyze safety checks in Men's Central Jail (MCJ) and Twin Towers Correctional Facility (TTCF), reviews the Department's safety-check audits, and makes recommendations for improvement.

Safety Checks

Safety checks are required by California State law and Department policy. In addition to statutory requirements, the Department prioritizes training custody staff on how to

---

[3] Complaint, Sept. 8, 2026, - *The People of the State of California ex rel. Rob Bonta, Attorney General of the State of California v. County of Los Angeles et. al.*, 2:25-cv-09765 (L.A. Super. Ct.).

[4] Complaint, at 2, Sept. 8, 2026, - *The People of the State of California ex rel. Rob Bonta, Attorney General of the State of California v. County of Los Angeles et. al.*, 2:25-cv-09765 (L.A. Super. Ct.).

[5] Complaint, at 24-5, Sept. 8, 2026, - *The People of the State of California ex rel. Rob Bonta, Attorney General of the State of California v. County of Los Angeles et. al.*, 2:25-cv-09765 (L.A. Super. Ct.).

[6] Los Angeles Board of Supervisors, (March 3, 2026) *Strengthening Accounting to Significantly Decrease Jail Deaths in the Los Angeles County Jails*.

conduct safety checks, and each facility re-enforces individualized expectations for custody staff who conduct safety checks.

Title 15 of the California Code of Regulations

Title 15 of the California Code of Regulations, entitled *Crime Prevention and Corrections*, is the administrative code establishing mandatory minimum standards for secure detention facilities in California. In addition to governing custody operation standards pertaining to use of force, search procedures, classification, housing, and staff training requirements, Title 15 governs safety procedures, including standards for conducting safety checks.

Title 15 safety checks refer to how and with what frequency custody staff shall observe people in custody to ensure their welfare.[7] Safety checks must be conducted "at least hourly through direct visual observation" and at random or varied intervals so that people in custody cannot predict when a safety check will occur.[8] Title 15 also outlines circumstances where, based on the classification of a person in custody, safety checks must be conducted more frequently than every hour. For people in heightened observation due to their mental health classification and/or people who are at risk of harming themselves or others, safety checks must be conducted every 15 minutes."[9] For people in detox housing, safety checks must be conducted at least every thirty minutes.[10]

Title 15 requires custodial facilities to document the employee who conducted each safety check in addition to the time and specific location (cell, module, etc.) of the safety check.[11] Title 15 also requires that facilities establish a documented process for supervisors to review safety checks to screen for and prevent inconsistent documentation and to ensure safety checks are timely.[12] Additionally, custody facilities

---

[7] Cal. Code Regs., tit 15, § 1027.5.

[8] Cal. Code Regs., tit 15, § 1027.5 (a)(d).

[9] Cal. Code Regs., tit. 15 § 1055(e).

[10] Cal. Code Regs., tit. 15 § 1056.

[11] Cal. Code Regs., tit. 15 § 1027.5(e)(1-3).

[12] Cal. Code Regs., tit. 15 § 1027.5(f).

must have policy and procedures for conducting safety checks that are consistent with Title 15 requirements.[13]

Custody Division Manual – Inmate Safety Checks

The Department's Custody Division Manual (CDM) reinforces Title 15 safety check requirements. CDM section 4-11/030.00[14] refers to the section of Title 15 governing safety checks,[15] and requires that Department staff visually observe people in custody at least hourly to ensure their safety and perform safety checks in a staggered manner to minimize the ability for people in custody to anticipate and plan safety checks.[16]

To ensure the safety of people in custody between safety checks and in instances where staff are unable to stagger safety checks, CDM section 7-06/010.00,[17] which governs video and audio recording procedures, establishes fixed surveillance closed-circuit television (CCTV) to ". . . provide real time intelligence for Department personnel."

Timeliness

The CDM designates the frequency of safety checks based upon the classification of a person in custody, which is detailed in the chart below.

Housing Area	Minimum Time Interval
• High Observation Housing (HOH)[18] / Forensic In-Patient (FIP)[19]	Every 15 minutes

[13] Cal. Code Regs., tit. 15 § 1027.5.

[14] Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.00 *Inmate Safety Checks*.

[15] Cal. Code Regs., tit. 15 § 1027.5.

[16] The Department's joint settlement with the Department of Justice provision 57 also requires that the Department conduct staggered safety checks in mental health units. *See* Joint Settlement Agreement, at 29, (Aug. 15, 2015) - *The United States of America v. County of Los Angeles et. al.*, CV. No. 15-5905 (W.D. Cal).

[17] Los Angeles County Sheriff's Department, Custody Division Manual, § 7-06/101.00 *Video and Audio Recording Procedures*.

[18] Los Angeles County Sheriff's Department, Custody Division Manual, *§ 5-01/050.10 Housing for Mentally Ill Inmates*, defines HOH as a designation for people in custody with "significant impairment," which "[g]enerally requires high observation housing (HOH) in jail with mental health supervision."

[19] Los Angeles County Sheriff's Department, Custody Division Manual, *§ 5-01/050.10 Housing for Mentally Ill Inmates*, defines FIP as a designation for people in custody with "severe debilitating symptoms," which "[show] priority for hospitalization, housing in jail with HOH or Correctional Treatment Center (CTC)."

• Sobering Cell (persons of undetermined age, possible minor)	
• Cells (including but not limited to Discipline, Administrative Segregation, Diminished Privilege Environment, Protective Custody, and Station Jails) • Dorms-Without Unobstructed Visual Observation • Medical / Infirmary • Moderate Observation Housing (MOH)[20] • High Security • Sobering Cell (adults)	Every 30 minutes
• Dorms - Unobstructed Visual Observation • Barracks (example: PDC South) • Intake / Inmate Reception	Every 60 minutes

Medical and/or mental health staff may also direct safety checks to be conducted more frequently.[21]

Quality

To ensure quality safety checks, custody staff are required to look "for signs of life (e.g. breathing, talking, movement, etc.) and obvious signs of distress (e.g. bleeding, trauma, visible injury, choking, difficulty breathing, discomfort, etc.)."[22] Custody staff conducting safety checks are required to inspect the general area, look into each room or cell, observe the entire body of each person in custody, and attempt to elicit a response from the person in custody if necessary.[23] While observing safety checks in person and on CCTV, Office of Inspector General staff have observed custody staff call out to people in

[20] Los Angeles County Sheriff's Department, Custody Division Manual, *§ 5-01/050.10 Housing for Mentally Ill Inmates*, defines MOH as a designation for people in custody with "moderate impairment," which "[g]enerally requires moderate observation housing (MOH) in jail with mental health supervision."

[21] Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.00 *Inmate Safety Checks*.

[22] Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.00 *Inmate Safety Checks*.

[23] Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.00 *Inmate Safety Checks*.

custody, knock on doors and windows, and use flashlights when attempting to elicit a response from a person in custody.

If a person in custody is found unresponsive, custody staff must "immediately notify the facility clinic and/or the facility control [booth] via handheld radio broadcast [and] describe the nature of the emergency, provide the location of the inmate, request that medical personnel respond to the location, and request an Automated External Defibrillator (AED) and the emergency response kit, as necessary."[24] Custody staff are expected to employ emergency medical services until medical staff arrive,[25] which can include cardiopulmonary resuscitation (CPR) when a person is not breathing or pulseless and administer Naloxone (Narcan Nasal Spray).[26] Where there are staff safety concerns, custody personnel must ensure that sufficient staff are present prior to entering any location and notify a sergeant if the scene is unsafe.[27]

The CDM also requires that custody personnel remove anything obstructing their view of a housing area, such as clothing or bedding hanging over bunks (tenting) or paper covering windows (boarding).[28] The Department indicates that the custody staff conducting safety checks must immediately remove any tenting or boarding,[29] or radio for back up to remove the obstruction so that custody staff can continue to conduct their safety checks.

---

[24] Los Angeles County Sheriff's Department, Custody Division Manual, § 5-03/060.00 *Response to Inmate Medical Emergencies*.

[25] Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.00 *Inmate Safety Checks*; Los Angeles County Sheriff's Department, Custody Division Manual, § 5-03/060.00 *Response to Inmate Medical Emergencies*.

[26] Los Angeles County Sheriff's Department, Custody Division Manual, § 5-03/060.00 *Response to Inmate Medical Emergencies*.

[27] Los Angeles County Sheriff's Department, Custody Division Manual, § 5-03/060.00 *Response to Inmate Medical Emergencies*.

[28] Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.00 *Inmate Safety Checks*.

[29] "Tenting" is the term the Department uses to describe when people in custody utilize linens to cover their bunk, which obstructs safety-check staffs' view of the person. Similarly, "boarding" is the term the Department uses to describe when people in custody affix objects to their cell window, which also obstructs safety-check staffs' view of the person.

Documentation

The CDM requires that safety checks are properly documented. The Department utilizes barcode scanners to create a record of safety checks within BREAVA 2.0, an internal electronic system.[30] While conducting safety checks, custody staff scan each barcode throughout the housing area. Once a barcode has been scanned, it records the time, date, and location of the check in addition to the name and employee number of the staff member who conducted the check.[31] Should a scanner be out of service or if a barcode is missing or damaged, the CDM provides a process for custody staff to report the non-functional scanner or barcode and manually record safety checks in the electronic-Uniform Daily Activity Log ("e-UDAL").[32]

Training

The Department's Custody Training and Standards Bureau (CTSB) administers training for new Department recruits and provides ongoing training to Department staff. Per CTSB, Department recruits do not receive instruction on Title 15 requirements during their basic academy training,[33] as Title 15 is not a part of the Peace Officer Standards and Training mandated academy curriculum. However, all deputies must attend a six-week jail operations course (Jail Ops) that includes Title 15 requirements and expectations. Custody Assistants (CAs) receive training on Title 15 requirements during their eight-week academy training. CTSB staff conduct both Jail Ops and the CA academy training.

CTSB utilizes one to two-minute training videos to show examples of proper and improper safety checks. In the training videos depicting quality safety checks, the deputies can be seen checking the cell bars/doors to ensure they are operational, breaking stride to look into each cell thoroughly, asking for people in custody to remove tenting or boarding that is obstructing the deputy's view, and flashing their light into cells to elicit a response. Conversely, in the training videos depicting improper safety checks,

---

[30] Department Policy (Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.00 *Inmate Safety Checks*) is not yet updated to reflect the Department's BREAVA 2.0 System.

[31] Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.00 *Inmate Safety Checks*.

[32] Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.05 *Title 15 Scanner*.

[33] The California Commission on Peace Officer Standards and Training certified basic academy establishes minimum training standards for "police officers, deputy sheriffs, school district police officers, district attorney investigators, as well as a few other classifications of peace officers."

the deputies can be seen walking briskly while failing to break stride and neglecting to look into the cells.

In addition to providing initial training, CTSB also administers First Aid and CPR courses, which reiterate safety check requirements. These courses are offered multiple times a month and deputies are required to take these courses at least once a year. CTSB indicated that it disseminates training bulletins as necessary to remind custody staff of Title 15 requirements. However, when the Office of Inspector General requested to see examples of such Title 15 training bulletins, CTSB was unable to provide any bulletins.

The Department indicates that, in accordance with law and policy, custody staff conducting safety checks are trained to observe signs of life including movement, breathing (rise and fall of chest), and changes in body position while sleeping. If custody staff cannot observe signs of life, they are trained to elicit a response from the person in custody. If no response is made, the custody staff member is expected to initiate the emergency response protocol. In the event of tenting, boarding, or something obstructing custody staff from conducting their safety check, custody staff are trained to remove the obstruction, or if they cannot because of safety or staffing concerns, request assistance. Additionally, if the custody staff conducting the safety check observes other inappropriate activity, such as fires or smoking, they are expected to utilize their radio to request assistance to resolve the issue.

CTSB indicated that the safety checks will ultimately be the same in dorms versus cell-to-cell settings, and that custody staff are trained to check each bunk, shower, restroom, and virtually anywhere a person in custody might be during all checks. There is no documentation system for custody staff to indicate any observed issues during their safety checks. However, custody staff may informally relay issues or concerns to staff assigned to the following shift.

Although all Department staff receive initial and ongoing safety-check training from CTSB, custody staff also receive specific direction from their assigned facility leadership on safety check expectations.

Facility Leadership Expectations

The Office of Inspector General staff accompanied Men's Central Jail (MCJ) and Twin Towers Correctional Facility's (TTCF) leadership staff to observe safety-check walks and to understand Department and facility expectations of custody staff who conduct safety checks.

MCJ

On December 3, 2025, Office of Inspector General staff observed custody staff perform safety checks in dorms at MCJ on the 5000 and 9000 floors.[34] The captain and operations staff who walked with Office of Inspector General staff explained that custody staff conducting safety checks were expected to walk across every area of the dorm and make entry into the bathroom/shower areas to ensure the safety and security of every person in custody. Office of Inspector General staff noted that custody staff conducting safety checks entered the bathroom/shower area, walked across every row of bunks within a dorm, and appeared to visually observe every person in custody housed within each dorm.

Although the safety checks performed in MCJ dorm 5500 in the presence of MCJ leadership and Office of Inspector General staff were exemplary, the Office of Inspector General reviewed CCTV of the safety checks outside of this observation period, finding that the safety checks were not conducted to the same standard. In the check that occurred prior to OIG's walk through, custody staff conducting safety checks failed to make entry into the bathroom/shower area, failed to walk across the back row of bunks, and failed to walk across the dorm front. Similarly, in the check that occurred after the OIG's walk through, custody staff conducting safety checks failed to walk across the back row of bunks, the left row of bunks, and across the dorm front.

TTCF

On January 21, 2026, Office of Inspector General staff observed custody staff perform safety checks at TTCF 172 and 142 pods. The captain and operations staff who walked with OIG staff explained that custody staff performing safety checks were expected to look into each cell to observe signs of life during each check. Custody staff explained that they understood the patterns of people in custody housed in their pods and recognized their behaviors enough to determine whether or not they appeared to be in distress.

Similar to the checks conducted at MCJ, during the walk through, OIG staff noted that staff conducting safety checks broke stride, took several seconds to look into each cell, and utilized their flashlights to elicit a response from people in custody when performing safety checks. However, in the checks that occurred prior to and after the check during

[34] The Office of Inspector General staff observed safety checks that occurred in all of the dorms on the MCJ 5000 floor, and safety checks that occurred in dorms 9400 and 9500 on the 9000 floor.

the OIG walk through, TTCF staff conducting safety checks appeared to look into each cell but did not break stride when making visual observations of people in custody.

Office of Inspector General Safety-Check Review

In addition to the accompanying departmental leadership on the safety-check walk throughs, OIG staff reviewed CCTV to evaluate the quality and timeliness of safety checks in a Moderate Observation Housing (MOH) dorm at MCJ, a restrictive housing MOH module at TTCF, and a High Observation Housing (HOH) module at TTCF between October 28, 2025, at 12:00 pm and October 31, 2025, at 12:00 pm. These areas were chosen due to areas discussed at departmental death reviews. During the administrative death reviews for each of these in custody deaths, the Department developed corrective action plans (CAPs) to rectify concerns with the quality and/or timeliness of safety checks.

Men's Central Jail Dorm 5500, MOH

Dorms on the MCJ 5000 floor have historically housed people with a variety of classifications but presently houses people who have moderate mental health needs as determined by the Department of Health Services' Correctional Health Services (CHS).

Between January 1, 2020, and December 31, 2025, ten people housed in MCJ 5000 floor dorms have died. The Office of Inspector General has identified concerns with the quality and/or timeliness of safety checks in seven of these in-custody deaths.

MCJ Deaths with Safety-Check Concerns

On October 20, 2022, custody staff conducting wristband count discovered an unresponsive person in custody in MCJ dorm 5900. Custody staff, CHS staff, and paramedics rendered emergency aid, but the person died at the scene. During the administrative death review, Department executive staff opened an administrative investigation into the quality and timeliness of safety checks. The administrative investigation was founded and determined that safety checks were approximately 1 hour and 51 minutes late. Three deputy sheriffs were disciplined with a written reprimand.

On April 9, 2023, a person in custody alerted custody staff of a "man down" in MCJ dorm 5200. Custody staff, CHS staff, and paramedics rendered emergency aid, but the person died at the scene. During the administrative death review, facility leadership identified issues with the quality of the safety checks but did not identify any concerns about whether the poor quality constituted a policy violation. However, at the seven-day administrative death review, Department executives opened a CAP regarding the quality

of safety checks, which stated that "[MCJ] is developing a multi-phase [CAP] to reduce tenting and improve the quality of safety checks." Department executive staff also opened an administrative investigation into the quality and timeliness of safety checks. The administrative investigation was founded and determined that safety checks were timely, but that significant tenting obstructed the quality of the checks. Two deputy sheriffs were disciplined with a one day and a three-day suspension.

On June 13, 2023, custody staff conducting safety checks discovered an unresponsive person in custody in MCJ dorm 5500. Custody staff, CHS staff, and paramedics rendered emergency aid, but the person died at the scene. The decedent, who had suffered significant injuries nearly four hours prior to custody staff discovering him, was attacked by other people in custody in the dorm shower and then dragged from the shower to a bunk, where he remained prior to custody staff administering emergency aid.[35] During the administrative death review, facility leadership did not identify a concern with safety checks, stating that the Department lacked personnel to stop and observe signs of life for each person, inconsistent with Department policy and state law.[36] Facility leadership additionally stated that, citing inmate privacy concerns, they did not expect staff conducting safety checks to observe the shower, despite the Prison Rape Elimination Act (PREA) standard 115.15(d) stating that "[carceral facilities] shall implement policies and procedures that enable inmates to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, *except . . . when such viewing is incidental to routine cell checks*."[37] Department executive staff opened a CAP exploring the "feasibility of adding safety check Bar Codes in shower areas (facility wide), specifically in dorm settings" and that "[d]eputies [were] instructed to walk the shower areas." To date, the Department has not installed safety check bar codes in bathroom/shower area of MCJ dorms. Neither facility leadership nor Department executives opened an administrative investigation into the quality or timeliness of safety checks. However, facility leadership opened an administrative investigation into custody staff clearing wristband count while this person was suffering life threatening injuries that resulted in

---

[35] Keri Blakinger, *Beaten, dying man unnoticed by jail staff for nearly 4 hours*, Los Angeles Times (October 19, 2023).

[36] Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.00 *Inmate Safety Checks*. While Title 15 does not discuss quality of checks, it requires that safety checks "will determine the safety and well-being of individuals and shall be conducted at least hourly through direct visual observation of all people held and housed in the facility." The only way to determine the safety and well-being of individuals is for a safety check to be of sufficient quality to determine persons in custody are all safe and not in medical distress.

[37] PREA standard § 115.15(d).

his death. The administrative investigation was founded, determining that wristband count was cleared while the person was "bloody, bruised, and swelling." Two deputy sheriffs and two custody assistants were investigated, yet discipline, in the form of a written reprimand, was only imposed on one deputy.

On January 6, 2024, custody staff conducting safety checks discovered an unresponsive person in custody in MCJ dorm 5500. Custody staff, CHS staff, and paramedics rendered emergency aid, but the person died at the scene. During the administrative death review, facility leadership identified that custody staff conducting safety checks failed to walk all aisles of the dorm. Facility leadership opened a CAP in which MCJ distributed an email to "all deputies regarding the importance of walking every aisle, in every dorm, during Safety Checks," and re-briefed assigned safety-check staff on the "importance of walking the entirety of the dorm." The Department did not open an administrative investigation, but facility leadership issued a Performance Log Entry (PLE)[38] for each of the two deputies involved.

On July 22, 2024, a person in custody alerted custody staff of a "man down" in MCJ dorm 5800. Custody staff did not render emergency aid for the person who appeared to be sleeping on a mattress on the floor between two bunk beds and according to paramedics on scene presented with rigor mortis. CHS staff and paramedics rendered emergency aid, but the person pronounced deceased at the scene. The Office of Inspector General staff member who responded to the scene for this death observed that the decedent appeared stiff and had clenched hands and dark purple skin. During the administrative death review, facility leadership opened an administrative investigation into the quality and timeliness of safety checks. The administrative investigation was founded, determining that safety checks between July 21, 2024 at 2:00 pm and July 22, 2024 at 8:43 am, were of poor quality. Twenty deputy sheriffs were investigated and the department-imposed discipline, in the form of written reprimands, to all 20 deputy sheriffs.

On August 11, 2024, an anonymous person alerted custody staff of a "man down" in MCJ dorm 5200. Custody staff, CHS staff, and paramedics rendered emergency aid, but the person died at the scene. During the preliminary administrative death review, facility leadership identified that tenting within the dorm was an issue. Yet, facility leadership did not identify a concern with the quality of safety checks despite the tenting obstructing custody staff's observations of the decedent's bunk from August 9, 2024, at approximately 10:00 am until the decedent was discovered on August 11, 2024, at

---

[38] A PLE is "comprised of interim supervisory notations about employee performance during a given rating period." *See* Los Angeles County Sheriff's Department, Custody Division Manual, § 3-02/085.10 *Employee Performance Records*.

approximately 1:45 am. The Department reported that it submitted a request for an administrative investigation at the 30-day administrative death review. However, following the 30-day administrative death review, the facility opted to not conduct an administrative investigation and chose instead to conduct additional safety-check training. The Department issued 11 PLEs for failure to remove linen/tenting.

On November 25, 2025, people in custody alerted custody staff of a "man down" in MCJ dorm 5900. Custody staff, CHS staff, and paramedics rendered emergency aid. The person was transported to Los Angeles General Medical Center and was pronounced dead on December 9, 2025. During the preliminary administrative death review, facility leadership identified concerns regarding the quality of safety checks and opened a supervisor inquiry. At the third administrative death review, facility leadership presented the supervisor inquiry, which found that custody staff conducting safety checks failed to check the showers, walked at a "brisk pace," and that custody assistants who were conducting safety checks were not supervised by a deputy sheriff. Despite determining that safety checks proceeding the death were not quality checks, facility leadership did not open an administrative investigation, opting instead to brief staff and provide informal counseling to three of the custody staff who conducted the checks. The Department issued three PLEs to safety-check staff.

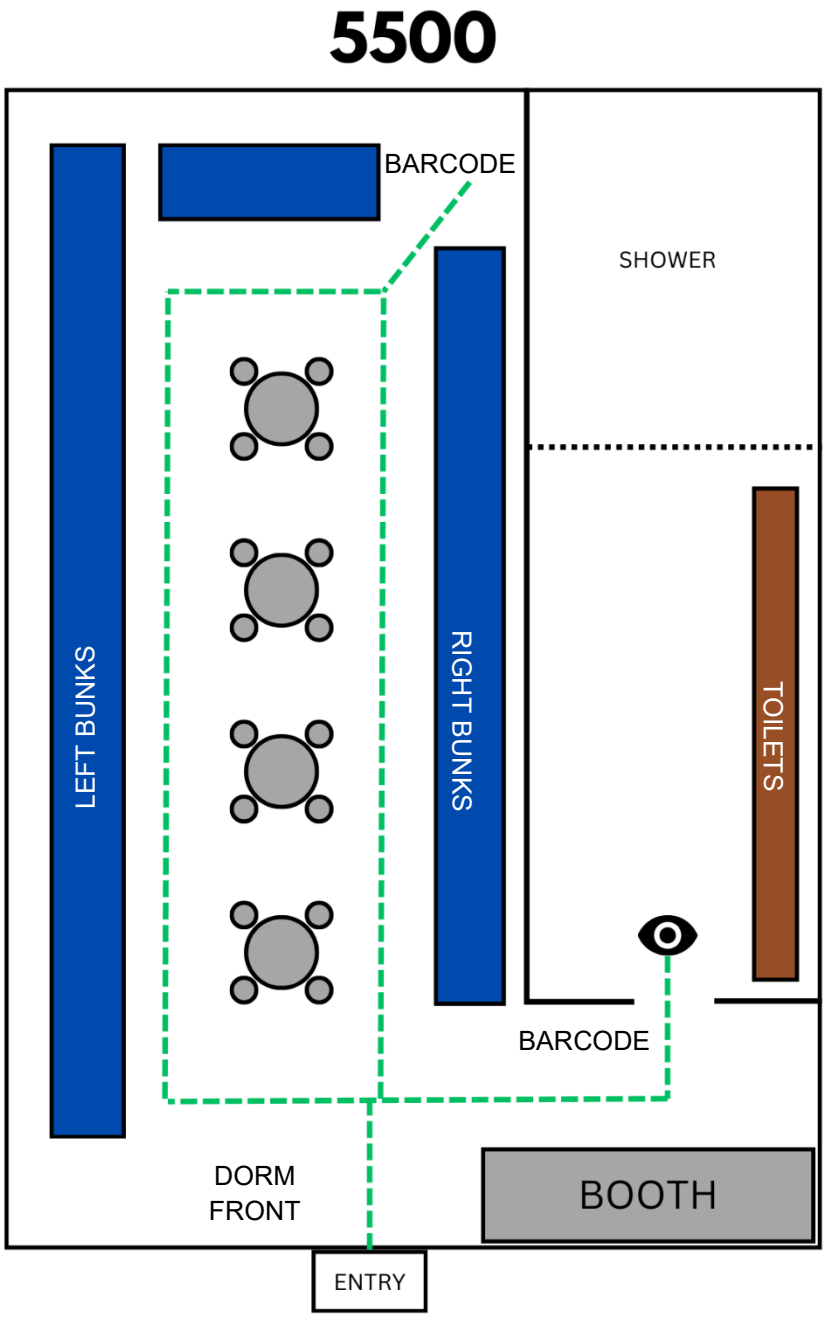
Methodology

To evaluate whether the CAPs were successful in ameliorating safety check issues, the Office of Inspector General reviewed safety checks in MCJ dorm 5500 by reviewing CCTV of MCJ dorm 5500 between October 28, 2025, at 12:00 pm and October 31, 2025, at 12:00 pm to analyze the quality and timeliness of safety checks.[39]

To evaluate quality, the Office of Inspector General referred to the schematic provided by the Department, depicted below, detailing the pathway custody staff are expected to walk when conducting safety checks. The schematic outlines that, after entering the module, custody staff are expected to walk into the bathroom/shower area and across the right row of bunks, back row of bunks, left row of bunks, and dorm front. The safety-check scanner barcodes are outside the entry way for the bathroom/shower area and in the back right corner of the dorm. Despite the schematic depicting an eye, seemingly denoting that staff are only expected to look inside the bathroom/shower area, facility leadership and Department executive staff expect that staff will enter the bathroom/shower when conducting safety checks. In evaluating the quality of a safety

[39] MCJ dorm 5500 is MOH and houses people who are part of the Substance Treatment and Re-Entry Transition (START) program. The START program provides direct in-custody substance use disorder counseling, group therapy and case management.

check, Office of Inspector General staff determined that a check qualified as a quality check when custody staff walked the expected pathway, including making entry into the bathroom/shower area.



To evaluate timeliness, the Office of Inspector General noted each time custody staff conducting safety checks entered and exited the module. Dorm 5500 is a MOH unit, where safety checks are conducted every 30 minutes. If custody staff conducting safety

checks entered the module within 30 minutes of the previous safety check, the checks were considered timely.[40]

To ensure the integrity of the analysis, Office of Inspector General conducted a double-layered quality assurance check. Each safety check was reviewed by two Office of Inspector General staff members to ensure consistent findings. Following the second review, a third Office of Inspector General staff member reviewed 20% of the safety checks to further ensure accuracy.

Analysis

The Office of Inspector General reviewed all of the 171 safety checks that occurred in MCJ 5500 dorm between October 18, 2025, at 12:00 pm and October 31, 2025, at 12:00 pm. All the reviewed checks were timely, but OIG staff did not observe staggered safety checks. Only approximately 2% of checks were determined to be quality safety checks.

The analysis showed that custody staff conducting safety checks walked:

- Into the bathroom/shower area in approximately 7% of the checks;
- Across the right row in 100% of the checks;
- Across the back row in approximately 79% of the checks;
- Across the left row in approximately 82% of the checks; and
- Across the dorm front in approximately 29% of the checks.

The data indicates that custody staff were least likely to enter the bathroom/shower area or walk across dorm front when conducting safety checks. However, the data shows that custody staff walked across the right row of dorm bunks in 100% of the safety checks, as the barcode that staff are required to scan when conducting safety checks is in the back right corner of the dorm.

Although custody staff conducting safety checks were observed removing tenting to ensure an unobstructed view of each person in custody, Office of Inspector General staff noted that staff often walked quickly and rarely broke stride to ensure that each

[40] The Department's BREAVA 2.0 system automatically monitors safety check timeliness based on barcode scans. However, because the Office of Inspector General's review determined timeliness based on CCTV observations of safety-check staff entering and exiting the housing location, there may be some slight variance in the Department's and the Office of Inspector General's timeliness determinations. To account for this variance, the Office of Inspector General considered checks timely where they occurred within thirty-five minutes of the previously conducted check.

person in custody exhibited signs of life, pursuant to policy and Title 15 requirements.[41] The average duration of each safety check was approximately 39 seconds.[42] During the review timeframe, there were an average of 82 people housed in MCJ dorm 5500. Thus, custody staff conducting safety checks spent an average of less than half a second, approximately .48 seconds, observing signs of life for each person housed within MCJ dorm 5500.

Twin Towers Correctional Facility Module 142 A Pod, MOH Restrictive Housing

Between January 1, 2020, and December 31, 2025, 98 people in custody have died in TTCF. The Office of Inspector General identified concerns with the quality and/or timeliness of safety checks in 33 of the in-custody deaths in this facility.

The Office of Inspector General reviewed safety-check concerns for the two deaths that occurred in TTCF Module 142 and the two deaths that occurred in TTCF Module 242. The concerns with these safety checks are consistent with concerns with the safety checks that occurred in the other 29 deaths.

TTCF Module 142 Deaths with Safety-Check Concerns

TTCF module 142 is an MOH module for people with high security restrictive housing, or administrative segregation, custody classifications. Two people in custody have died in TTCF module 142 between 2020 and 2025 (both deaths occurred in 2025). Office of Inspector General identified concerns with the quality of safety checks in one of these in-custody deaths.

On July 12, 2025, custody staff conducting safety checks discovered a person bleeding from both arms on the floor of a cell in TTCF module 142 A pod. Custody staff, CHS staff, and paramedics rendered emergency aid, but the person died at the scene. During the administrative death review, facility leadership identified that the decedent's cell windows had been boarded and obstructed custody staff's view inside the cell for approximately three hours prior to the custody staff discovering the person. Facility leadership opened an administrative investigation into the quality and timeliness of safety checks. Three deputy sheriffs are being investigated in the administrative investigation, which has not been completed.

---

[41] Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.00 *Inmate Safety Checks*.

[42] Facility leadership reported to Office of Inspector General staff that they believed that it was "unreasonable" to conduct a quality safety check in a dorm setting in 30 seconds.

While OIG staff did not have concerns about the quality or timeliness of safety checks that occurred prior to an in-custody death on July 21, 2025, the Department opened an investigation into the timeliness and quality of the safety checks. While no violations of law or policy were found, the Department created a CAP to open an internal investigation into safety check issues that is far-reaching and applies to future reviews of in-custody deaths.

To evaluate whether the CAPs were successful in ameliorating safety-check issues, the Office of Inspector General reviewed safety checks in TTCF 142 A pod.

Methodology

The Office of Inspector General conducted a review of CCTV footage for TTCF 142 A pod between October 28, 2025, at 12:00 pm and October 31, 2025, at 12:00 pm to analyze the quality and timeliness of safety checks.

Unlike the safety checks in MCJ dorms, custody staff conducting safety checks at TTCF are not expected to walk a particular pathway, as TTCF pods have two rows (both on an upper tier and a lower tier) with safety-check scanner barcodes at the beginning, middle, and end of each row. Because safety-check staff are required to walk along each row to scan each barcode to effectuate each safety check, to evaluate quality, the Office of Inspector General staff analyzed whether custody staff conducting safety checks were observed looking into individual cells.

Ascertaining whether a custody staff member conducting safety checks is looking into each cell is difficult; custody staff explained that they are often able to observe movement in each cell with their peripheral vision, meaning that facing toward the cell may not be necessary to ascertain signs of life. To mitigate subjectivity, Office of Inspector General staff were conservative in analyzing the checks, only determining that custody staff were sufficiently checking when they were observed not moving their head or looking away from a cell.

As with the evaluation of MCJ, OIG staff evaluated timeliness by noting each time custody staff conducting safety checks entered and exited the 142 A pod, where safety checks are conducted every 30 minutes. If safety-check staff entered the module within 30 minutes of the previous safety check, the checks were considered timely.[43]

[43] The Department's BREAVA 2.0 system automatically monitors safety check timeliness based on barcode scans. However, because the Office of Inspector General's review determined timeliness based on CCTV observations of

To ensure the integrity of the analysis, the Office of Inspector General conducted a quality assurance check. Each safety check that was determined to not be quality was reviewed by another Office of Inspector General staff member to ensure consistent findings. A third Office of Inspector General staff member reviewed 20% of the safety checks to further ensure accuracy.

Analysis

The Office of Inspector General reviewed all 147 safety checks that occurred in TTCF 142 A pod between October 28, 2025, at 12:00 pm and October 31, 2025, at 12:00 pm.

The Office of Inspector General determined that approximately 91% of safety checks appeared to be quality safety checks. The Office of Inspector General staff did not observe boarding in any of the checks.

Similar to the safety checks in MCJ dorm 5500, Office of Inspector staff noted that staff often walked quickly and rarely broke stride when conducting safety checks. However, on several occasions, Office of Inspector General staff noted that custody staff conducting safety checks stopped to either attempt to illicit a response or seemingly engage with a person in custody. The average duration of the entire pod safety checks for both the lower and upper tiers was approximately 38 seconds. Because the Office of Inspector General counted the time custody staff conducting safety checks entered the pod and exited the pod, as opposed to the time staff conducting safety checks entered the tier and exited the tier, it is not possible to calculate an average time that safety-check staff spent observing signs of life for each person housed within TTCF 142 A pod. Although a majority of the safety checks reviewed were timely, the Office of Inspector General noted that one check was not completed and one check was delayed. OIG staff did not observe staggered safety checks.

Twin Towers Correctional Facility Module 242 B Pod, HOH

TTCF module 242 is an HOH module that houses people who have high mental health needs, as determined by CHS. Five people in custody have died in TTCF module 242 between 2020 and 2025. The Office of Inspector General has identified concerns with the quality or timeliness of safety checks in two of these in-custody deaths.

---

safety-check staff entering and exiting the housing location, there may be some slight variance in the Department's and the Office of Inspector General's timeliness determinations. To account for this variance, the Office of Inspector General considered checks timely where they occurred within thirty-five minutes of the previously conducted check.

TTCF Module 242 Deaths with Safety-Check Concerns

On April 11, 2021, custody staff conducting safety checks discovered an unresponsive person on the floor of a cell in TTCF 242 C pod. Custody staff, CHS staff, and paramedics rendered emergency aid, but the person died at the scene. During the administrative death review, facility leadership identified that the decedent, who presented with rigor mortis upon discovery, was laying on the floor of his cell for approximately 18 hours prior to discovery. Facility leadership opened a supervisor inquiry into the quality and timeliness of safety checks, finding that the "safety checks were completed in a timely manner and [were] of good quality."

On April 9, 2024, custody staff conducting safety checks discovered an unresponsive person on the floor of a cell in TTCF 242 B pod. Custody staff, CHS staff, and paramedics rendered emergency aid, but the person died at the scene. Office of Inspector General staff reviewed the person's incarceration records prior to the administrative death review, which revealed that the person was transported to TTCF 242 B pod from MCJ dorm 5100 approximately 33 hours before he died. CCTV footage from MCJ dorm 5100 showed that, immediately before the person was transported to TTCF, he was on the floor of the dorm in different positions and seemingly unable to rise for approximately 22 hours. The video additionally showed that during a safety check, people in custody appeared to wave their arms to get assistance from the custody staff members conducting the check, who walked to the individual and appeared to speak to him briefly before leaving. Custody staff did not transport the person to TTCF for a higher level of mental health care until after he had defecated on himself. At the administrative death review, both TTCF and MCJ opened supervisor inquiries into the quality and timeliness of safety checks. However, both facilities determined that safety checks were compliant with Department policy.

During the administrative death reviews for each of these in custody deaths, facility leadership developed CAPs to evaluate the quality of safety checks. The CAPs ultimately determined that the safety checks conducted were of sufficient quality, despite obvious issues indicating the contrary. Thus, the Office of Inspector General reviewed safety checks in TTCF 242 B pod.

Methodology

The Office of Inspector General reviewed CCTV footage of TTCF 242 B pod between October 28, 2025, at 12:00 pm and October 31, 2025, at 12:00 pm to analyze the quality and timeliness of safety checks. Safety checks are conducted every 15 minutes in HOH settings. Apart from evaluating timeliness in 15-minute increments, the

methodology and quality assurance check used to evaluate TTCF 242 B pod mirrors that which was used to evaluate TTCF 142 A pod.[44]

Analysis

The Office of Inspector General reviewed all 299 safety checks that occurred in TTCF 242 B pod between October 28, 2025, at 12:00 pm and October 31, 2025, at 12:00 pm.

The Office of Inspector General found that all reviewed checks were timely, but OIG staff did not observe staggered safety checks. Approximately 90% of safety checks appeared to be quality checks. Office of Inspector General staff did not observe boarding in any of the checks.

Similar to the safety checks in TTCF 142 A pod, Office of Inspector staff noted that staff often walked quickly and rarely broke stride when conducting safety checks. However, on a few occasions, Office of Inspector General staff noted that custody staff conducting safety checks used their flashlights to look into each cell, broke stride to stop to look into cells during checks and stopped to seemingly engage with people in the cell. The average duration of the safety checks for the lower tier was approximately 25 seconds and the average duration of the safety checks for the entire upper tier was approximately 14 seconds. Because the Office of Inspector General counted the time safety-check staff entered the pod and exited the pod, as opposed to the time staff entered the tier and exited the tier, it is not possible to calculate an average time that staff spent observing signs of life for each person housed within TTCF 242 B pod.

Safety-Check Audits

Pursuant to statutory requirements,[45] the Captains at both MCJ and TTCF have reported to the Office of Inspector General that the Department conducts robust safety-check audits at both facilities to ameliorate concerns with safety check quality and timeliness.

---

[44] The Department's BREAVA 2.0 system automatically monitors safety check timeliness based on barcode scans. However, because the Office of Inspector General's review determined timeliness based on CCTV observations of safety-check staff entering and exiting the housing location, there may be some slight variance in the Department's and the Office of Inspector General's timeliness determinations. To account for this variance, the Office of Inspector General considered checks timely where they occurred within twenty minutes of the previously conducted check.

[45] Cal. Code Regs., tit. 15 § 1027.5(f).

The Department utilizes a system called BREAVA 2.0 to audit safety checks. The BREAVA 2.0 system generates a dashboard detailing the timeliness of safety checks in progress. Green means safety checks are timely, yellow means there may be timeliness concerns and that a sergeant should review the cameras in that area to ensure the safety checks are in progress, and red means the safety checks are behind or that custody staff may have missed a barcode scan and a sergeant needs to take action to ensure compliance. As detailed above, each facility has an assigned safety check sergeant for each shift who monitors the BREAVA 2.0 system in real-time. Floor sergeants are also able to observe the dashboards in real-time.

When safety check timeliness is an issue, both facilities generate a "deficiency list," which utilizes barcode scanner data generated from the BREAVA 2.0 system to identify late or missed checks. When the floor and safety-check sergeants are notified of a late or missed check, they are responsible for investigating why the check was late or missed, and potentially counseling or referring custody staff who had the late or missed safety check for discipline.

Both facilities evaluate quality by reviewing CCTV of the safety check and utilizing a "thumbs up" or "thumbs down" emoji in the BREAVA 2.0 system to indicate compliance and non-compliance, respectively. Where a check is considered non-compliant, floor and safety-check sergeants are to select from a drop down containing four options denoting why the safety check quality was non-compliant: "Did not appear to look into rooms, cells, or bunks," "missed area," "missed barcode(s)," and "walking too fast." After choosing a rationale from the dropdown, evaluating sergeants have the option to input a note further describing the finding. Should custody staff be unable to conduct the required safety check, a supervisor must be advised, and the supervisor is then responsible for ensuring safety checks are completed.[46]

Safety-check sergeants also conduct random reviews of safety checks by reviewing CCTV footage. If custody staff conduct a questionable check, the sergeant may provide informal counseling. If the issue persists, the Department may issue a PLE or open an administrative investigation. The Department also issues positive PLEs for quality safety checks.

The safety-check sergeants at MCJ and TTCF are expected to complete five random safety-check audits of the facility per shift per day. In addition to conducting audits, watching timers, and notifying floor staff of possible late checks in real time, safety-check sergeants have collateral duties including checking that all CCTV cameras are

[46] Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.00 *Inmate Safety Checks*.

working and recording and submitting work orders for non-operational cameras. The safety-check sergeants must also ensure that all scheduled facility searches and town halls are completed, and conduct audits of pill call.

Office of Inspector General Review of Safety-Check Audits

The Office of Inspector General reviewed the safety-check audits that both MCJ and TTCF performed between October 28, 2025, at 12:00 pm and October 31, 2025, at 12:00 pm, which is the same time period reviewed by the Office of Inspector General.

MCJ 5500

During the time period denoted above, an MCJ floor sergeant conducted one random audit evaluating safety checks in MCJ dorm 5500.[47]

The evaluating sergeant audited a safety check that occurred on October 30, 2025, at 4:20 pm. The evaluating sergeant found that the safety check was both timely and of sufficient quality. Office of Inspector General staff evaluated the same safety check during its review and found the check to be timely. However, OIG staff disagree that the check was of sufficient quality, as the custody staff conducting the check failed to walk into the bathroom/shower area and across the dorm front.

Acknowledging reported improvements by the Department that MCJ made to improve the quality of safety checks since October 2025, OIG staff additionally reviewed random audits evaluating safety checks in MCJ dorm 5500 between January 18 and 23, 2026. The evaluating sergeants found that three out of the four safety checks completed during this timeframe to be timely and of sufficient quality. While OIG staff found that all of the checks were timely, only one of the four checks was determined to constitute a quality safety check.

Specifically, the evaluating sergeant found the safety check on January 18, 2026, at 8:54 pm to be a quality check. OIG's disagreement with this determination is due to safety-check staff failing to walk the entirety of the back row, left row, and dorm front. The evaluating sergeant found the check on January 19, 2026, at 10:24 pm to be of sufficient quality. However, the Office of Inspector General found that the safety check

[47] Sergeants who audit safety checks are expected to review checks that occur throughout the floor. However, Office of Inspector General staff only reviewed checks that occurred in dorm 5500.

was not a quality check, as the staff conducting the check failed to walk into the bathroom/shower area and across the entirety of the back row, left row, and dorm front.

For the two remaining checks, occurring on January 19, 2026, and January 21, 2026, the evaluating sergeant and OIG staff had consistent findings. For the safety check occurring on January 19, 2026, at 6:26 pm, both the evaluating sergeant and OIG staff found the check to be of poor quality. The evaluating sergeant determined that the check was non-compliant, as the safety-check staff "missed [an] area;" OIG's finding was based on the failure of staff to walk into the bathroom/shower area. For the safety check occurring on January 21, 2026, at 4:21 pm, the evaluating sergeant and the Office of Inspector General found the check to be of sufficient quality. Specifically, the Office of Inspector General identified that the custody staff conducting the check walked into the bathroom/shower area, and across the right row, back row, left row, and dorm front.

TTCF 142 A

During the time period denoted above, TTCF sergeants conducted four random audits evaluating safety checks in TTCF 142 A pod.[48]

The evaluating sergeant audited safety checks that occurred on October 28, 2025, at 4:00 pm, October 29, 2025, at 4:43 pm, October 29, 2025, at 5:41 pm, and October 30, 2025, at 5:05 pm. The evaluating sergeant and the Office of Inspector General had consistent findings for these checks, determining that three out of the four checks were timely and were quality safety checks. For the check that was not timely or of sufficient quality, TTCF's deficiency log indicated that staff began conducting the safety check but did not complete the check due to a use of force that occurred in the module 142 staging area.

To evaluate whether TTCF continued to demonstrate quality safety checks, the Office of Inspector General additionally reviewed random audits evaluating safety checks in TTCF 142 A pod between January 18 and 23, 2026. The evaluating sergeant audited safety checks that occurred on January 18, 2026, at 5:50 pm, January 19, 2026, at 2:37 am, January 20, 2026, at 1:27 pm, January 22, 2026, at 1:45 am, and January 22, 2026, at 11:02 am. The evaluating sergeant and the Office of Inspector General had

[48] Sergeants who audit safety checks are expected to review checks that occur throughout the entire module. However, Office of Inspector General staff only reviewed checks that occurred in pod A of module 142.

consistent findings for these checks, determining that all of the checks were quality safety checks and timely.

TTCF 242 B

During the time period denoted above, TTCF sergeants conducted five random audits evaluating safety checks in TTCF 242 B pod.[49]

The evaluating sergeant audited safety checks that occurred on October 28, 2025, at 12:23 pm, October 28, 2025, at 1:36 pm, October 28, 2025, at 7:26 pm, October 29, 2025, at 9:51 am, and October 30, 2025, at 5:54 am. The evaluating sergeant and the Office of Inspector General had consistent findings for these checks, determining that all of the checks were quality safety checks and timely.

To evaluate whether TTCF continued to demonstrate quality safety checks, the Office of Inspector General additionally reviewed random audits evaluating safety checks in TTCF 242 B pod between January 18 and 23, 2026. The evaluating sergeants found that all of the five safety checks completed during this timeframe to be timely and were quality safety checks. The Office of Inspector General found that all of the checks were timely, but only three of the five checks were of sufficient quality.

Specifically, for the safety checks that occurred on January 18, 2026, at 2:35 am, January 18, 2026, at 10:12 pm, and January 19, 2026, at 9:36 am, the evaluating sergeant and the Office of Inspector General had consistent findings, determining that all of the checks were of sufficient quality and timely.

The Office of Inspector General found that the checks that occurred on January 21, 2026, at 3:37 pm and January 22, 2026, at 8:18 pm to be of poor quality, as the custody staff conducting each check failed to look into every cell. The evaluating sergeant, however, determined that these checks were quality safety checks.

CONCLUSION AND RECOMMENDATIONS

The Department reported that it would ideally utilize technology, such as heart rate monitors for people in custody[50] and cameras that detect body heat, to ensure the safety

[49] Sergeants who audit safety checks are expected to review checks that occur throughout the entire module. However, Office of Inspector General staff only reviewed checks that occurred in pod B of module 242.

[50] The Department has reported that it is piloting a smart watch program in Century Regional Detention Facility module 1400 in 2026.

of people in custody. The Department has also reported that staff shortages, specifically staff fatigue resulting from mandatory overtime and staff working overtime in unassigned custody positions, have impacted the quality of safety checks. The Office of Inspector General agrees that enhanced technology and regularly assigned safety-check staff would improve and supplement safety checks in ensuring the safety of people in custody. However, to comply with statute and Department policy requiring that custody staff conduct timely and quality safety checks, the Office of Inspector recommends that the Department: standardize safety-check audits, hold staff who fail to conduct compliant safety checks accountable, install additional safety-check scanner barcodes in MCJ dorms, stagger safety checks, require that staff break stride when conducting safety checks, real time monitor CCTV, and reduce the jail population.

Standardize Safety-Check Audits

As discussed above, although the Department's audit of safety check timeliness is automatically generated by the BREAVA 2.0 system, the Department does not have a uniform metric for sergeants to audit safety check quality. Because evaluating the quality of safety checks is subjective and the Department does not have standardized criteria that auditing sergeants are expected to use to evaluate safety check quality, the Department's safety-check audits have resulted in inconsistent findings.

Moreover, the Office of Inspector General's review determined that several of the checks that were considered to be of sufficient quality by evaluating sergeants at both MCJ and TTCF were not quality checks when evaluated against training and facility leadership expectations. Specifically, sergeants who audited safety checks at MCJ dorm 5500 determined that checks were quality checks when staff did not walk the required pathway and sergeants who audited safety checks at TTCF module 242 determined that checks were quality checks when staff did not look into every cell. Although evaluating sergeants are required within the BREAVA 2.0 system to select a rationale for determining why a check was non-complaint,[51] the auditing sergeants did not provide a description of why they determined that a check was compliant or non-compliant in the notes section of any of the audits that the Office of Inspector General reviewed.

> **Recommendation 1:** The Office of Inspector General recommends the Department develop a standardized metric for sergeants who audit safety checks to evaluate safety check quality.

[51] As noted in the *Safety-Check Audits* section, the dropdown options in the BREAVA 2.0 system are: "Did not appear to look into rooms, cells, or bunks," "missed area," "missed barcode(s)," and "walking too fast."

Recommendation 2: The Office of Inspector General recommends the Department require auditing sergeants to enter a "note" in the BREAVA 2.0 auditing tool to explain the justification for why they determined that a safety check was compliant or non-compliant.

Hold Staff Who Fail to Conduct Compliant Safety Checks Accountable

As noted above, in several administrative death reviews, facility leadership have been reticent to impose discipline on custody staff who have conducted untimely and/or poor-quality safety checks. Instead, the Department often opened supervisor inquiries (which ultimately concluded that the safety checks were timely and of sufficient quality)[52] and/or opted to conduct additional briefings or re-train staff on how to properly conduct safety checks.[53]

The Office of Inspector General recognizes that staff must be properly trained and regularly briefed to adequately fulfill the functions of their assignments.

The exemplary safety checks conducted when OIG staff and Departmental leadership were present at each MCJ and TTCF, suggest that custody staff are aware of the legal, policy, and facility expectations for conducting safety checks and will perform accordingly when in the presence of facility leadership. Thus, the Office of Inspector General reasons that the custody staff who conduct safety checks are aware of the proper protocol and facility expectations, and do not require additional training or briefings to better

---

[52] See the deaths that occurred on April 11, 2021, and April 9, 2024, where the Department opened supervisor inquiries during the administrative death review that determined that the safety checks were compliant with Title 15 and Department policy.

[53] See the death that occurred on April 9, 2023, where the Department implemented a CAP stating that "[Men's Central Jail] is developing a multi-phase [CAP] to reduce tenting and improve the quality of Title 15 safety checks;" the death that occurred on June 13, 2023, where the department issued a directive that MCJ staff conducting safety checks walk into the bathroom/shower; the death that occurred on January 6, 2024, where the department opened a CAP in which Men's Central Jail distributed an email to "all deputies regarding the importance of walking every aisle, in every dorm, during Safety Checks," and re-briefed assigned safety-check staff on the "importance of walking the entirety of the dorm;" the death that occurred on August 11, 2024, where the department decided to not conduct an administrative investigation into the quality of safety checks and rather opted to conduct additional safety-check training; and the death on November 25, 2025, where facility staff noted that custody staff conducting safety checks walked at a "brisk pace" but opted to brief staff and provide informal counseling to three of the custody staff members who conducted the checks.

understand how to properly conduct safety checks.

> **Recommendation 3:** The Office of Inspector General recommends the Department impose discipline on staff who fail to conduct quality and timely safety checks and floor and safety check sergeants who fail to conduct thorough audits.

Install Additional Safety-Check Scanner Barcodes in MCJ Dorms

When conducting safety checks in MCJ dorms, staff are expected to walk a specific pathway to ensure that custody staff visually observe people in custody. Yet, the Office of Inspector General's review of safety checks conducted in MCJ 5500 determined that custody staff rarely adhered to walking the dorm pathway, and that staff were least likely to enter the shower area or walk across dorm front when conducting safety checks. However, the Office of Inspector General's review determined that custody staff conducting safety checks walked across the right row of dorm bunks during every check.

During the administrative death review for the death that occurred on July 13, 2023, in MCJ dorm 5500, the Department opened a CAP to "[explore the] feasibility of adding safety-check bar codes in shower areas (facility wide), specifically in dorm settings" and instructed custody staff to walk "shower areas" when conducting safety checks. Although facility staff may have instructed custody staff conducting safety checks to walk into shower areas, the Department has not installed barcodes in any of the dorm showers. Despite instruction that custody staff walk into the bathroom/shower area when conducting safety checks, the Office of Inspector General's review found that custody staff conducting safety checks failed to make entry into the bathroom/shower area in approximately 93% of the checks.

Because MCJ leadership relayed staff concerns about violating PREA when entering bathroom/shower areas, staff training on the exception in PREA section 115.15(d) that specifically allowing custody staff to view people in custody in the bathroom/shower "when such viewing is incidental to routine [safety] checks" is necessary.[54] MCJ leadership reported that they requested that the Department PREA Coordinator refresh custody staff on the PREA standards and brief staff that making entry into the bathroom/shower when conducting safety checks does not violate PREA. However, at issuance of this report, the PREA Coordinator reported that neither he nor his staff had been contacted by MCJ leadership to conduct a briefing with safety-check staff.

---

[54] PREA standard § 115.15(d).

Although staff conducting safety checks at MCJ did not walk the expected pathway in a majority of cases reviewed, they walked across the right row of bunks in all safety checks in order to scan the barcode placed in the back right corner of the dorm. Similarly, as staff at TTCF conducting safety checks are expected to walk across the entire row of cells, the facility placed barcode scanners at the beginning, middle, and end of each row. In the Office of Inspector General's review of TTCF safety checks, there were no instances in which custody staff conducting safety checks failed to walk the entirety of the row. Thus, by placing safety check scanner barcodes in the back of the shower and at the end of each pathway that staff are expected to walk when conducting safety checks in MCJ dorms, the facility can guarantee that custody staff comply with walking the expected pathway.

> **Recommendation 4:** The Office of Inspector General recommends the Department install additional safety-check scanner barcodes at the end of each area in the pathway that staff are expected to walk when conducting safety checks.

> **Recommendation 5:** The Office of Inspector General recommends that the Department conduct PREA training on entering showering and bathroom areas to conduct safety checks.

Stagger Safety Checks

Title 15 requires that custody staff perform safety checks at "random or varied intervals."[55] Department policy also requires that "[a]ll inmate safety checks shall be staggered to minimize the ability of inmates to plan around anticipated checks."[56] Although almost all of the checks that the Office of Inspector reviewed were timely, the data generated from the review indicates that there was not notable variance in the timeframe in between each check.

Because people in custody are able to anticipate safety checks, they are able to plan to engage in behavior that results in harm to themselves and others without immediate department detection. For instance, in its review, the Office of Inspector General staff observed a fight that occurred between safety checks and multiple instances in which people in custody appeared to be smoking between safety checks. If custody staff conducting safety checks staggered the checks, it would increase custody staff's

[55] Cal. Code Regs., tit. 15 § 1027.5(d).

[56] Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.00 *Inmate Safety Checks*.

opportunity to detect and potentially prevent misbehavior in addition to potentially deterring people in custody from engaging in injurious behaviors.[57]

> **Recommendation 6:** The Office of Inspector General recommends the Department comply with law and policy that require safety-check staff to conduct checks in staggered intervals.[58]

Require That Staff Break Stride When Conducting Safety Checks

CDM section 4-11/030.00 requires that custody staff look for "signs of life and obvious signs of distress." The policy mandates that the safety checks include "looking into rooms/cells and by entering the dormitories of housing areas, visually inspecting each inmate's entire body, and inspecting the general area." To attempt to achieve adherence to policy, CTSB trains custody staff to regularly break stride to ensure that custody staff conducting safety checks are visually observing people in custody. Both policy and CTSB require that custody staff attempt to elicit a response where staff do not observe signs of life.

Although leadership from both facilities articulated that they expect custody staff to visually observe people in custody when conducting safety checks, facility staff were clear that they did not expect staff to break stride during every check to observe signs of life. Specifically, facility leadership articulated that custody staff may not need to break stride to observe signs of life where they observe the person in custody moving, either through direct or periphery line of sight, during the safety check.

The Office of Inspector General noted few instances in which custody staff broke stride and/or elicited responses from people in custody when conducting safety checks. However, there were instances during the 72-hour review timeframe where people in custody were asleep, in which custody staff conducting safety checks were not observed breaking stride and/or eliciting responses to ensure signs of life.

---

[57] The Department's joint settlement with the Department of Justice provision 57 also requires that the Department conduct staggered safety checks in mental health units. *See* Joint Settlement Agreement, at 29, (Aug. 15, 2015) - *The United States of America v. County of Los Angeles et. al.*, CV. No. 15-5905 (W.D. Cal).

[58] The Department reported that it agreed that safety checks should be staggered but stated that it would be difficult to stagger safety checks in HOH modules where each safety check is required in 15-minute intervals. The Department reported that recent safety check reports show that safety checks in HOH modules may vary in three-to-four-minute increments and that safety check staff have been instructed to not conduct safety checks on the hour.

Recommendation 7: The Office of Inspector General recommends the Department require safety-check staff to break stride when conducting safety checks.

Real Time Monitor CCTV

Title 15 does not require custody staff to monitor CCTV in real time, CDM section 7-06/010.00, *Video and Audio Recording Procedures*, states that one of the objectives of the Department's fixed-surveillance CCTV system is to ". . . provide real time intelligence for Department personnel." In lieu of positioning Department staff in every living area of MCJ and TTCF,[59] which the department states it is not able to achieve due to its staffing shortage, the Office of Inspector General has previously recommended that custody staff monitor CCTV in real time to ensure the safety and security of the jails.[60]

As noted above, during its review, the Office of Inspector General noted several instances of people in custody engaging in misbehavior between safety checks. While staggering safety checks may rectify some concerns about people in custody being able to engage in misbehavior undetected, custody staff live monitoring CCTV would assist staff in more quickly identifying suspicious behavior, intervening in instances of misbehavior, and rendering aid if a person in custody is ill, injured, or unresponsive.

Recommendation 8: The Office of Inspector General recommends the Department require custody staff to monitor CCTV in real time to ensure safety and security between safety checks.[61]

Reduce The Jail Population

The Office of Inspector General has long held that "overcrowding in the Los Angeles County jails continues to jeopardize the ability of the Sheriff's Department to provide habitable, humane, and safe conditions of confinement as required by the Eighth and

[59] Live monitoring CCTV would not assist in providing the Department with real time intelligence in some parts of MCJ and TTCF where CCTV does not show the interior of cells.

[60] *Report Back on Transparency and Accountability: Proper Maintenance and Accounting for All Cameras in the Los Angeles County Jails, Court Holding Tanks, and Patrol Station Lockups* (October 21, 2024) at page 2.

[61] The Department reported that real time CCTV is displayed in the MCJ 5000 control booth. However, the Department does not expect that staff conduct continuous monitoring of CCTV, citing staffing constraints.

Fourteenth Amendments to the U.S. Constitution."[62] The Office of Inspector General has previously recommended that the Department, "work with the County justice partners to conduct an analysis of the current jail population based on charges, criminal procedural status, and other categories as appropriate to determine which people in the custody the Sheriff possesses the legal authority to release unilaterally."[63]

As of July 31, 2026, the total Los Angeles County jail population in Board of State and Community Corrections (BSCC) rated areas of the jails is 11,780, which is below the BSCC total rated capacity of 12,404.[64] However, the facility count in several jails, including MCJ, continue to operate above the BSCC rated capacity. [65]

Even in instances where the count of people in custody is below the BSCC rated capacity, the Department has reported that insufficient staffing has limited the Department's capability to comply with its own policy requiring that staff observe each person in custody for signs of life.[66] Where the Department is unable to comply its obligations pursuant to policy and statute, the Sheriff has multiple legal authorities[67] that he may employ to reduce the jail population.

---

[62] *See* *Reform and Oversight Efforts: Los Angeles County Sheriff's Department - October to December 2025* (February 26, 2026) at page 28, *citing Fischer v. Winter (1983) 564 F. Supp. 281, 299* (noting that while overcrowding may not be unconstitutional in itself, overcrowding is a root cause of deficiencies in basic living conditions, such as providing sufficient shelter, clothing, food, medical care, sanitation, and personal safety).

[63] *Report Card On Sheriff's Department's Reforms 2019 to 2023* (February 20, 2024) at page 70 *See also* *Reform and Oversight Efforts - Los Angeles County Sheriff's Department - July to September 2021* (N.D.) at page 33.

[64] The total rated capacity is arrived at by adding the rated capacity for each of the County jail facilities: MCJ 3512, TTCF 2432, Century Regional Detention Facility 1708, Pitchess Detention Center (PDC)-East 926, PDC-North 830, PDC-South 782, and North County Correctional Facility (NCCF) 2214. Some portions of the jail facilities are not included in the BSCC capacity ratings. The rated capacity has not been recently updated and does not take into account the understaffing or the deteriorating physical plant of MCJ, meaning that the current safe capacity of the Los Angeles County jails is certainly substantially lower than the rated maximum.

[65] The BSCC rating for MCJ is 3512; the BSCC rated population for MCJ as of July 31, 2026, is 3628. The BSCC rating for NCCF is 2214; the BSCC rated population for NCCF as of July 31, 2026, is 2811. The BSCC rating for PDC-North is 830; the BSCC rated population for PDC-North as of July 31, 2026, is 1267.

[66] Los Angeles County Sheriff's Department, Custody Division Manual, § 4-11/030.00 *Inmate Safety Checks*.

[67] The Office of Inspector General has previously reported that the Sheriff could elect to "cite and release prisoners on bail amounts below a level of his choosing and the ability to release prisoners after they have served a percentage of his choosing of their jail sentence," to reduce the jail population. *Reform and Oversight Efforts: Los Angeles County Sheriff's Department – April to June 2022* (N.D.) at page 18.

Recommendation 9: The Office of Inspector General recommends the Department employ its authority to reduce the jail population to a level commensurate with staffing to ensure the safety and security of the people in its custody.

SHERIFF'S DEPARTMENT'S RESPONSE

The Sheriff's Department was provided with a draft of this report and sent a letter in response, which is incorporated on the following pages.

OFFICE OF THE SHERIFF

COUNTY OF LOS ANGELES

HALL OF JUSTICE

ROBERT G. LUNA, SHERIFF

July 29, 2026

Eric D. Bates, Interim Inspector General
Office of Inspector General
County of Los Angeles
312 South Hill Street, Third Floor
Los Angeles, California 90013

Dear Mr. Bates:

RESPONSE TO THE OFFICE OF INSPECTOR GENERAL'S REPORT AN ANALYSIS OF A SAMPLE OF TITLE 15 SAFETY CHECKS AT MEN'S CENTRAL JAIL AND TWIN TOWERS CORRECTIONAL FACILITY JULY 2026

On July 15, 2026, the Office of Inspector Geneal (OIG) provided the Los Angeles County Sheriff's Department (Department) with its report titled *An Analysis of a Sample of Title 15 Safety Checks at Men's Central Jail and Twin Towers Correctional Facility* and requested a response by July 29, 2026.

The report was distributed to the Department's units responsible for the subject area addressed in the report – Men's Central Jail (MCJ) and Twin Towers Correctional Facility (TTCF). The Department responded to the topics of training and standardized safety-check audit recommendations set forth by the OIG in the report.

The following sections address training as well as the recommendations:

Training

The OIG report commented on a training video that was developed by Custody Training Standards Bureau (CTSB). The video was created to depict inmate safety checks and utilized as a training mechanism to demonstrate "proper" and "improper" methods of conducting inmate safety checks. This training video is no longer in use. CTSB is currently developing a training video

comprised of actual Closed-Circuit Television (CCTV) footage of proper and improper inmate safety checks.

TTCF and MCJ training units conduct comprehensive training sessions on regular intervals to reinforce the critical importance of inmate safety checks, the monitoring of inmate well-being, and the continued development of staff skills in responding effectively to inmate medical emergencies.

Standardized Safety-Check Audits

Recommendation 1: The OIG recommends the Department develop a standardized metric for sergeants who audit safety checks to evaluate safety check quality.

The Department agrees that several essential components are necessary for a safety check to be deemed compliant. These include maintaining an appropriate pace that allows a deputy to perceive signs of distress, including slowing down or "breaking stride" when necessary to determine whether an inmate requires assistance; demonstrating through CCTV footage that personnel positioned their head in a manner that would have allowed them to see inside the cell, rather than focusing solely on scan tags; and following a path that brings the deputy close enough to the cells being checked to maintain adequate visibility, rather than walking a central path between rows of cells that provide a more limited view into the cells on either side. Additionally, personnel should take extra time and, when necessary, adjust their positioning if an inmate has engaged in any tenting or boarding that obstructs normal visibility to any degree.

Recommendation 2: The OIG recommends the Department require auditing sergeants to enter a "note" in the BREAVA 2.0 auditing tool to explain the justification for why they determined that a safety check was compliant or non-compliant.

Currently, if the check is deemed noncompliant, auditing sergeants must explain what corrective actions were taken to inform the deputy and/or corrective measures. Moving forward, they will also be required to state why it was determined to be non-complaint.

Recommendation 3: The OIG recommends the Department impose discipline on staff who fail to conduct quality and timely safety checks and floor and safety check sergeants who fail to conduct thorough audits.

From 2022 to present, the Department recognized incidents at MCJ and TTCF related to inmate safety checks that did not meet Department standards. As a

result, the Department opened 31 administrative investigations and imposed discipline on 81 staff members. Three employees are still awaiting a disposition on their case.

However, there are circumstances where training or coaching is the more appropriate corrective action, particularly if it stems from limited experience, or a training deficiency rather than intentional or willful misconduct.

This data reflects that the Department is proactive in its efforts to address Title 15 deficiencies, demonstrating a consistent commitment to identifying, reviewing, and addressing potential concerns in a timely manner. The Department's approach supports ongoing compliance, accountability, and continuous improvement.

Recommendation 4: The OIG recommends the Department install additional safety-check scanner barcodes at the end of each area in the pathway that staff are expected to walk when conducting safety checks.

The Department agrees. As of July 14, 2026, barcode scanners have been installed at the shower walls in dormitories in MCJ to extend the distance deputies are expected to walk into the dorms. An exact path has not been established; however, a suggested route was created. The requirement is that each area of a dorm is visually checked.

Recommendation 5: The OIG recommends that the Department conduct Prison Rape Elimination Act (PREA) training on entering showering and bathroom areas to conduct safety checks.

The Department agrees. Per PREA standard 115.31, "Employee Training," all staff are mandated to complete annual PREA training. Additionally, staff who identify as a gender other than those they are going to view, announce their gender upon entering the location.

Recommendation 6: The OIG recommends the Department comply with law and policy that requires safety-check staff to conduct checks in staggered intervals.

The Department agrees with the OIG's recommendation and confirms that staggered safety checks are currently being conducted in compliance with existing policy; however, it is not feasible to achieve significant staggering when safety checks are required at 15-minute intervals.

Per **Custody Division Manual (CDM) Section 4-11/030.00 (Inmate Safety Checks)**, safety checks must be staggered to prevent inmates from anticipating

or planning around staff rounds. To achieve meaningful variance while strictly adhering to the mandatory **15-minute operational window**, personnel introduce slight, randomized variations within the limited time blocks assigned to each specific housing location.

Recommendation 7: The OIG recommends the Department require safety-check staff to break stride when conducting safety checks.

Pausing briefly or breaking stride during an inmate safety check may occasionally be necessary; however, it is not always required. In most instances, an inmate's safety and well-being can be reasonably assessed through a momentary visual observation, particularly when the individual is seated, standing, or otherwise awake.

Recommendation 8: The OIG recommends the Department requires custody staff to monitor CCTV in real time to ensure safety and security between safety checks.

Maintaining continuous, direct CCTV surveillance, monitoring of all inmates around the clock between scheduled safety checks would be extremely labor intensive and impose substantial financial costs. Moreover, the practical benefit of such monitoring would be limited, as camera systems generally do not provide visibility into the interior of most inmate cells. While dorm housing CCTV monitoring would enhance the current level of observation provided by our booth officers, it will function as a responsive measure rather than preventative control.

Recommendation 9: The OIG recommends the Department employs its authority to reduce the jail population to a level commensurate with staffing to ensure the safety and security of the people in custody.

The Department already utilizes multiple factors within its control to reduce the jail population. Several years ago, the minimum bail amount accepted at the Inmate Reception Center was raised from $25,000 to $50,000. Additionally, inmates serving traditional County sentences are only required to serve 10 percent of their time for non-violent charges. The amount of time for short releases also increased from 180 days to 240 days. As a result, anyone sentenced to 240 days or less will not actually serve time in jail. The Department also regularly seeks approval from the presiding judge to release inmates up to 30 days early due to overcrowding. Nearly all pre-sentence inmates are being held by remand orders from the courts or because they have been sentenced previously on other matters.

Conclusion

The Department appreciates the opportunity to work with the OIG on issues that are fundamental to our mission. We recognize the significance of these reports, as they reflect the Department's ongoing commitment and efforts across several key areas. The Department welcomes the opportunity to provide its comments to offer additional context, enhance clarity, and promote transparency for your office and the public.

Should you have any questions or concerns, please contact Commander Ernest Bille, Office of Constitutional Policing, at (323) 307-8358.

Sincerely,

ROBERT G. LUNA, SHERIFF

C. Coles

CHRISTINE COLES, CHIEF
CUSTODY SERVICES DIVISION, GENERAL POPULATION