DEPARTMENT OF JUSTICE
INFORMATION ON INCIDENT REVIEW

Introduction
This review focused on the circumstances surrounding the early release of an intermittent (weekend) sentenced offender from the Central Nova Scotia Correctional Facility (CNSCF) on December 8, 2014. The offender was released from custody 12 hours before his scheduled release.

Considerations
The review considered the following:

- The events leading up to the wrongful release.
- The actions of offenders.
- The actions taken in response to the incident.
- Whether all applicable policies and procedures were followed.
- If appropriate policies and procedures are in place.

Issue
On December 8, 2014 an offender was wrongfully released from custody 12 hours early.

Facts/Findings

- The offender should have been released at 6 p.m. (1800 hours) but was released at 6 a.m. (0600 hours).
- It was determined that correctional staff did not:
  - Confirm the time of day the offender was scheduled for release by referring to the schedule – both prior to leaving the housing unit and prior to leaving the facility.
  - Document the release time on the proper form at the time of release. The time was documented after the offender was released which led to the discovery of the error.
- Policies and procedures for the release of intermittent offenders are not as clear as they could be.
- The correctional officer involved was not fully trained in the processing of intermittent offenders.
- Notification and other post-incident procedures were completed in compliance with policy and procedures.

Incidental findings
The following were not factors in the early release of the offender but were noted as part of the investigation and are being addressed:

- Staff noted difficulties in processing a large number of offenders at once in the discharge area, which created confusion, and as a result, the offender was able to remove his ID bracelet without staff noticing or verifying his ID.
- The computer located in the discharge area was not working properly.

Follow-up Actions

- Corrective action has been taken with staff involved.
- Policies and procedures are being updated to clearly define roles and responsibilities. Staff will receive training and periodic audits will be conducted to confirm compliance with the new protocols.
- The computer located in the discharge area has been replaced.