STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Geoffrey Fardell
Hearing dates:	29 August 2024
Date of findings:	6 September 2024
Place of findings:	Coroners Court of New South Wales at Lidcombe
Findings of:	Deputy State Coroner, Magistrate Erin Kennedy
Catchwords:	CORONIAL LAW – homicide- in lawful custody- mandatory inquest - section 23 Coroners Act 2009 – compatibility assessment – appropriateness of shared cell placement of vulnerable inmates
File number:	2019/182081
Representation:	Coronial Advocate – Senior Constable Kai Jiang Corrective Services NSW – Mr Colin Magee, instructed by Ms Sian Pickard Justice Health and Forensic Mental Health Network – Ms Natalie Szulgit

Findings:	**Identity** The person who died was Geoffrey Fardell **Date of death** His date of death was between 10 and 11 June 2019 **Place of death** His place of death was Mid North Coast Correctional Centre, Aldavilla, New South Wales **Cause of death** Neck compression **Manner of death** Homicide by a known individual while on remand being detained in lawful custody
Non-publication orders:	Non-publication orders made on 29 August 2024. Please contact the Registry for more details.

1. This is an Inquest into the death of Mr Geoffrey Fardell who was 52 years of age at the time of his death, which was caused by unlawful homicide when on remand in lawful custody at the Mid North Coast Correctional Centre NSW, between 10 and 11 June 2019 after being locked in his cell with a cell mate overnight.

2. On 11 June 2019, Mr Fardell was found deceased in his cell. On 21 August 2019, Mr Reay was charged with Mr Fardell's murder and was subsequently convicted on 31 March 2021.

The Coroner's Role

3. The Coronial process is governed by the Coroners Act 2009, and in this case a mandatory inquest was required given Mr Fardell was held in lawful custody at the time of this death. Section 23 provides that a Senior Coroner must conduct an inquiry, through an inquest, into his death. This is appropriate given he was under the supervision and the care of the State.

4. Inquests are not adversarial, but inquisitorial. The purpose of an inquest is not to attribute blame or punish anyone, but rather to investigate how and why a person died, and to find ways, if possible, to stop preventable deaths.

5. It is the role of the Coroner to investigate and make findings about sudden, violent, suspicious or unnatural deaths.

6. Those findings are to be made in relation to

    a. the identity of the person who has died,
    b. the date and place of the person's death,
    c. the cause of death,
    d. the manner (or circumstances) of the person's death.

7. In relation to this matter, there is nothing controversial about Mr Fardell's identity, the date or place of his death. The cause of his death was ascertained and explained in the Autopsy Report. The manner of his death is also sufficiently disclosed with the available evidence gathered after thorough criminal and coronial investigations.

8. However, concerns have been raised, in relation to Mr Fardell's care in custody, particularly in relation to the appropriateness of his cell placement and the lack of compatibility assessment of the other inmate who shared the same cell.

9. Recommendations may also be made in relation to any matter connected with the person's death where appropriate.

Background to Mr Fardell and family statement

10. Mr Geoffrey Fardell was born on 21 November 1966. He had two sisters and a son. His mother, Ms Sandra Deveson was present during the inquest. Mr Fardell had a traumatic childhood due to domestic violence exposure and sexual abuse which negatively impacted on his life trajectory. Mr Fardell had resided in various locations within NSW including Bathurst, Lismore and Lennox Head.

11. Mr Fardell left school at the age of 15. He worked as a painter and a truck driver. Since around the age of 25, Mr Fardell had many adverse interactions with the criminal justice system, he had significant history of drug abuse and was often diverted under the Mental Health Act.

12. There was a gap in his offending between 2007 and 2015. On 24 March 2019, Mr Fardell was incarcerated following Police arrest and bail refusal by the court for domestic violence allegations. The related criminal proceeding was due back before the Ballina Local Court in July 2019.

13. Mr Fardell's mother attended the inquest and provided a very moving family statement. She recalled him as a small child fondly, and recalled her desire to protect him and ensured he had every opportunity to grow up with a life that left him well balanced and happy. He was presented with some significant challenges as a young person, and circumstances extrinsic to Ms Deveson and her children's control meant that they were exposed to events that were criminal, negative, devastating and life changing.

14. She reflected how, through the hardships that he faced, he taught her a lot about life. She recalled in happier times spending time with him, at cafes, picnicking, and socialising. He loved his family and they him. She described him as "cheeky" and would greet her with "hello darling" or "hello mummy darling". She loved him his entire life and continues to love him.

15. Mrs Deveson's words painted a beautiful picture of closeness and connection between a mother and her son. Recognising that there were hard times she was able to recall the good and better times, and the connection that remained strong always between them.

16. I am very grateful for her contribution together with her support and attendance in what can only be recognised as a shocking and devastating tragedy. She faced this tragedy at the time of his death, and came to Court again for the purpose of these proceedings to show her continued support for him, and the life that he lost. She was supported by Ms Seng from the Victims Support Group who attended and assisted, whom I also thank and acknowledge.

Mr Fardell's Medical history and Custodial events

17. Mr Fardell had a lengthy history of schizophrenia and poly substance abuse. He had contracted the Human Immunodeficiency Virus (HIV) around the age of 36 and was treated in the community under Dr David Smith at Lismore. His mental health issues were managed by the Lismore Community Mental Health Unit.

18. Prior to entering custody in March 2019, Mr Fardell was scheduled to Lismore Hospital due to acute behavioural disturbance and psychotic features secondary to amphetamine use. He was discharged on the same day and transferred into Police custody.

19. Justice Health records noted that Mr Fardell was on medications for HIV treatment, substance abuse and mental health conditions. He was regularly reviewed by Justice Health public sexual health nurse and immunologist for HIV management. He also received fortnightly intramuscular injection of long-acting antipsychotic medication which was continued in custody following psychiatrist review. The records indicate that Mr Fardell had his last medical consultation with Justice Health on 6 June 2019 where no acute issues were identified.

20. Mr Fardell was first housed in the Grafton Correctional Centre. On 13 April 2019, he was placed under Special Management Area Placement (SMAP) following his own application seeking protective custody due to his medical conditions and fears for his own safety. He reported that there had been direct threats made against him from other inmates, however there had been no reports of actual assaults or violence inflicted upon him. Mr Fardell's placement was such that he was protected against the mainstream inmate cohort but could be placed with other SMAP inmates, if assessed appropriate. Mr Fardell was classified as a C1 unsentenced inmate.

21. On 31 May 2019, Mr Fardell was transported to the Mid North Coast Correctional Centre in Aldavilla NSW. On 3 June 2019, Mr Fardell was allocated cell 234 of Pod F which was designated for working inmates. He commenced employment at the Buyups Business Unit the following day. Mr Fardell shared his cell with a Mr Richard Reay, who was also on a SMAP.

22. Mr Reay had a history of violence. He was subjected to segregation for violence only a week prior and was moved from a previous facility as a result. He had sought a SMAP as a result and sought protection for himself. He had assaulted a corrective officer and he was classified as an A2 maximum security inmate who was serving an imprisonment sentence at the time. He was placed in cell 234 on 2 June 2019, one day before Mr Fardell's placement. There were no prior associations between Mr Fardell and Mr Reay.

Events leading to his death

23. On 10 June 2019, Mr Fardell and Mr Reay were locked into their cell at 3:19pm. No one entered or exited from this cell until about 6:05am on 11 June 2019 when another inmate conducting sweeper duties approached the cell to deliver coffee and milk. Mr Fardell was seen lying face down motionless on the floor. Mr Reay stated that Mr Fardell was dead and had been there since around 11pm the night before. The sweeper alerted corrective officers who attended at 6:18am. Upon examination, Mr Fardell had no signs of life and was declared deceased at 6:48am by attending NSW Ambulance officers.

24. The exact sequence of events between 3:19pm on 10 June and 6:05am on 11 June 2019 is unknown and unable to be accurately determined despite thorough investigation and evidence adduced and examined at the criminal trial. Mr Reay, being the only other person involved, provided evidence at trial which was deemed to be implausible by the presiding Judge and was contradicted by other evidence. However, on the balance of probabilities, at some time during the night, Mr Reay strangled Mr Fardell using an unknown ligature. Mr Fardell was then left on the floor until the morning of 11 June 2019.

Police investigation following his death

25. After the discovery of Mr Fardell's death, Mr Reay was removed and secured. Cell 234 was guarded. NSW Police were informed and attended shortly after to investigate. The criminal investigation undertaken by Police was outlined in the judgment of the murder trial against Mr Reay. After the completion of the criminal proceedings, additional coronial enquiries were made with CSNSW given the concern as to why and how Mr Fardell came to be in the cell with Mr Reay, given his violent history. In summary, the following were done in the investigation:

26. Police made enquiries with various correctional officers involved and obtained statements.

a. Information about Mr Fardell was gathered from Ms Deveson.
b. Relevant documents from CSNSW for both Mr Fardell and Mr Reay, as well as the CCTV footages were obtained and reviewed.
c. The inmate who first attended Cell 234 and discovered Mr Fardell's death on 11 June 2019 was spoken to and later provided his evidence in an interview.
d. Mr Reay was questioned in relation to Mr Fardell's death and participated in two electronically recorded interviews.
e. Cell 234 was forensically examined with photographs and measurements taken of injuries on Mr Fardell and items of interest located within the cell. A statement was produced by the Scene of Crime Officer. Mr Fardell's death was formally considered suspicious after the observation of the ligature mark around his neck, the position of which was inconsistent with the possibility of suicide or self-harm.
f. Forensic procedures were carried out on Mr Reay, including photographs and swabs of his hands. He had no notable injuries.
g. Mr Fardell's medical records were obtained from Justice Health and reviewed. No issues were noted or raised about Mr Fardell's mental health and medical conditions, which appeared to be appropriately treated and managed in custody.
h. An internal investigation was conducted by CSNSW and the corresponding report and supporting documents were produced and considered.
i. All relevant CSNSW policies and procedures were also produced.
j. A statement was provided by an appropriate representative at CSNSW addressing the coronial issue identified.

27. A postmortem examination was conducted which concluded that Mr Fardell died due to neck compression. The ligature mark was described as almost circumferential, with a possible cross over point at the left lateral aspect of the neck. The mark measured around 6mm in width. Other external injuries observed included bruising on the right temporal scalp, an abrasion on the right eyebrow, multiple abrasions on the right cheek, abrasions on the fingertips of the hands, and arms. These injuries are supportive of the fact that Mr Fardell was assaulted by Mr Reay prior to his death.

28. In August 2019, Mr Reay was charged with the murder of Mr Fardell and was later convicted after a Judge alone trial at the Port Macquarie Supreme Court on 31 March 2021. The presiding Judge, His Honour Justice Hulme found that Mr Fardell died from ligature strangulation which was not an act of suicide and that he was killed by Mr Reay who was sentenced to 30 years of imprisonment.

29. No specific findings were made regarding the exact item used, however, the description of the injuries and the length required, are mostly consistent with the TV

power or the antenna cable. It was also found likely, that Mr Fardell was attacked by Mr Reay without provocation.

Evidence at the Inquest

30. Mr Malcolm Brown, general manager of the statewide operations of CSNSW produced two statements during the course of the coronial investigation. He also attended and gave further evidence at the inquest. He stated that there were procedures in place that were not properly followed at the time of Mr Fardell's death. It was unable to be identified as to who placed Mr Fardell in the cell with Mr Reay given no documentation was kept to indicate how that was arrived at. There is also no evidence that any compatibility assessment occurred at all. This is a lacuna in the evidence, however not one that in the circumstances works in support of any such assessment having been undertaken.

31. Mr Brown's evidence was, however, most informative as to the changes and improvements that have been made over the years, and certainly part of those improvements and changes came about as a result of the loss of Mr Fardell.

32. Mr Brown agreed in evidence that a major priority of the corrective environment is to ensure the protection of inmates, both for themselves and for others. He also indicated that unfortunately there will be cases of violence in prison. As a result, this must be considered as a factor.

33. Mr Reay was on an extended supervision order. Mr Brown discussed in his evidence the recognised importance and significance of such orders, and also agreed that the significance of the Supreme Court making these determinations may be lost on the general community corrections staff. He indicated that he would raise this issue for consideration in education and training. He also was able to extrapolate to give other examples of where matters might be relevant to important placement decision making in custody, and I was reliably informed by Mr Magee that immediately after the evidence Mr Brown had already commenced discussions about these issues with the relevant individuals.

Consideration of the issues

34. The major issue related to Mr Fardell's death was the appropriateness of his placement into Cell 234 with Mr Reay. The problem with the placement was that apart from both inmates being on SMAP, Mr Fardell and Mr Reay's security status and risk levels can be seen in stark contrast.

35. Mr Fardell was a fearful inmate, had experienced threats, suffered with a significant health issue being HIV and who was granted SMAP for protection from others.

36. Mr Reay also sought, and was, placed on SMAP. However, Mr Reay was a violent offender and steps were taken to protect others from being harmed by him. His SMAP application in some ways can be seen as an attempt for him to seek protection as a result of his own previous violent behaviour. Additionally, Mr Reay was a maximum-security inmate, whereas Mr Fardell was of the lowest security classification.

37. The CSNSW death in custody serious incident investigation found the same issue, that there was a deficiency with the screening and housing of inmates prior to their placement whereby alerts were checked on Mr Fardell prior to his movement (being the incoming inmate), but the same checks were not conducted on Mr Reay who was already occupying the cell.

38. In accordance with the Custodial Operations Policy and Procedure applicable at the time of Mr Fardell's cell placement, an assessment on his compatibility with any existing cell mate should have occurred prior to his placement into a two-out cell. Sub-section 2.7 of the policy made it the Wing Officer's responsibility to check the alerts and non-associations in the system for each inmate to ensure there are no known factors which would preclude the inmates sharing the same cell and complete the relevant checklists. Sub-section 2.3 required the allocating officer, when placing inmates, such as Mr Fardell, in a shared cell, to check the cellmate for any risks that may be posed to or from the other inmate.

39. However, there is no evidence of whether any such compatibility assessment was conducted before the placement of Mr Fardell and Mr Reay together in the same cell. Similarly, CSNSW was unable to identify, through their records, as to how Mr Fardell and Mr Reay came to be assigned the same cell due to lack of reference in the records and documents kept at the time. The only explanation as to why Mr Fardell and Mr Reay were assessed suitable to be sharing the same cell was the fact that they were both subject to SMAP and were working inmates.

40. Noting the issue and deficiency identified, the following relevant changes were made by CSNSW, both locally at MNCCC and also the COPP, to ensure proper assessments are conducted prior to placement of inmates in shared cells and to reduce the risk of the same issue from occurring in the future:

    i. In August 2019, the Governor of MNCCC issued an order for the Senior Correctional Officer Accommodation to be responsible for sector 1 (where pod F was located) inmate movements and all pod officers to be responsible for checking alerts prior to moving or receiving inmates.

    ii. On 23 August 2019, COPP 5.2 was updated, which included additional information and clarification regarding the responsibilities for determining inmate cell placement. It is now mandatory for inmates

who are to be placed in a shared cell to be assessed as compatible and not posing risks to each other.

iii. COPP 5.2 was further updated in May 2020, version 1.4, to include "cell placement decision guide" to assist officers in determining and recording appropriate cell placement decisions for inmates based on consideration of relevant factors including the risk of harm from others and their compatibility with inmates in shared accommodations.

iv. Sub-section 2.4 of version 1.4 makes it mandatory to ensure that inmates placed in a shared cell are assessed as compatible and not posing a risk to each other. This is the same requirement as version 1.1 of the policy, but now with additional guidance.

v. In accordance with subsection 1.1 of COPP 5.2, MNCCC has developed and implemented in September 2023 the "Approved Cell Placement" Local Operating Procedure (LOP) number 23 008, which is to be complied with by all staff within the correctional centre when assessing an inmate's compatibility with cellmate(s) prior to their placement in an approved cell to ensure that there are no known factors precluding the relevant inmates, meaning both the incoming and the existing inmate of the intended cell, from sharing the same accommodation.

vi. Subsection 5 of the LOP provides the procedure to be followed for the compatibility assessment and specifies the officers who is responsible for such assessment. The responsible officer is to check all alerts, non-associations, the relevant health and care recommendations for all relevant inmates and is to record the assessment on the Offenders Information Management System as an Electronic Case Note. This note will contain the name of the officer who approved the cell placement and the records checked by the officer to complete the compatibility assessment.

vii. In August 2024, the COPP 5.2 has been amended again with the introduction of its version 1.6, which now, relevantly, provides guidelines and procedures for specific circumstances, such as when there is a negative change in an inmate's circumstances or behaviours, where the decision of their cell placement must be reviewed to ensure that the decision concerning their accommodation remains appropriate. Each correctional centre is to adopt and implement this policy in the LOP.

Concluding remarks

41. These changes are relatively new. Mr Fardell's death has prompted significant improvement and change. He was placed in a cell with a known violent offender. Simple enquiries may, and arguably should have, resulted in a different decision in relation to housing him. It appears now that consideration would be given to Mr Reay's history in custody and his history of violence and classification status. Consideration would also be given to Mr Fardell's personal situation. Records would be kept of the decision-making process, and the decision maker would be identified along with the reasoning behind the decision.

42. Considering the changes and updates already made and implemented within the CSNSW, especially in relation to inmate compatibility assessment prior to their cell placement and the LOPs that specify the officers responsible for conducting such assessment and how and where it is to be recorded to ensure accountability, the Commissioner has avoided the need for this inquest to move to further recommendations.

43. The approach taken by the Commissioner to act to make these changes was positive approach, and the fact of the acknowledgement of the death of Mr Fardell, and the working to rectify both failure to comply with existing policy and the creation of better and more detailed policy for the protection of inmates was a necessary and appropriate response to this tragedy. This had the effect of resulting in a reduction in the scope of the inquest, but importantly resulted in changes already in process.

44. This doesn't detract from the errors made in this case and the devastating consequences. Mr Fardell's life mattered, his loss is felt deeply by those who love him and highlights that care must be taken to carefully follow policy and procedure in the custodial setting. The responsibility of maintaining the safety of inmates rests with the State, and therefore time, care, attention and common sense should always be applied when making important housing decisions.

45. I note this is of little comfort to Ms Deveson and Mr Fardell's family, not just for the fact of his death, but the devastating nature and manner of his death. As Ms Deveson said she would have done anything to protect him that tragic night. She was in no position to do so. The changes however will ensure for the safer housing of future inmates.

Acknowledgements

To Mr Jiang for his careful preparation of requisitions, engagement and written work.

To the family of Mr Fardell, in particular to his mother, I extend my sincere condolences.

FORMAL FINDINGS

Findings section 81

Identity

The person who died was Geoffrey Fardell

Date of death

His date of death was between 10 and 11 June 2019

Place of death

His place of death was Mid North Coast Correctional Centre, Aldavilla, New South Wales

Cause of death

Neck compression

Manner of death

Homicide while on remand while being detained in lawful custody

I now close this inquest.

Deputy State Coroner

Magistrate E Kennedy