CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Mark Russell
Hearing dates:	15 October 2020
Date of findings:	15 October 2020
Place of findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, unsolved homicide
File numbers:	2018/63230
Representation:	Mr T O'Donnell, Coronial Advocate Assisting the Coroner
Findings:	I find that Mark Russell died on 24 or 25 February 2018 at Surry Hills, New South Wales 2010. The cause of Mark's death was multiple stab wounds to the neck and chest. These stab wounds were inflicted by a person or persons unknown. The manner of Mark's death is therefore homicide.
Recommendation:	I recommend that the death of Mark Russell be referred to the Unsolved Homicide Unit of the NSW Police Force Homicide Squad for further investigation in accordance with the protocols and procedures of that Unit.

Non-publication orders:

1. Pursuant to section Pursuant to section 74(1)(b) of the *Coroners Act 2009* (**the Act**) the following information contained in the brief of evidence tendered in the proceedings is not be published:

   (a) Tabs 5 and 6 of Volume 1;
   (b) Pages 1211 to 1240 of Volume 5;
   (c) Tab 11 of Volume 6;
   (d) The name [redacted] and any material (including any photo) which may identify [redacted];
   (e) Any reference to [redacted] and [redacted] and any material (including any photo) which may identify [redacted].

2. Pursuant to section 65(4) of the Act, a notation is to be placed on the Court file that if an application is made under section 65(2) of the Act for access to the documents on the Court file, that material shall not be provided until the NSW Police Force has had an opportunity to make submissions in respect of that application.

Table of Contents

Introduction 1
Why was an inquest held? 1
Mark's life 1
The events of 23 to 25 February 2018 2
  23 February 2018 2
  24 February 2018 3
  25 February 2018 4
When did Mark die? 4
What was the cause and manner of Mark's death? 5
Should any recommendation pursuant to section 82 of the Coroners Act 2009 be made? 6
Findings 7
  Identity 7
  Date of death 7
  Place of death 7
  Cause of death 7
  Manner of death 7
Epilogue 7

Introduction

1. On the morning of 25 February 2018 Mark Russell was found deceased in his home with a number of fatal stab wounds that had been inflicted by a person, or persons, unknown. In the more than two years that have passed since Mark's death, despite an extensive police investigation, no person responsible for Mark's death has been identified and charged. This uncertainty, and the sudden and tragic nature in which Mark lost his life, has caused Mark's family and those closest to him immeasurable grief and distress.

Why was an inquest held?

2. A Coroner's function and the purpose of an inquest are provided for by law as set out in the *Coroners Act 2009* (**the Act**). One of the primary functions of a Coroner is to investigate the circumstances surrounding a reportable death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it.

3. Section 6(1)(a) of the Act defines a reportable death to be one which occurs in circumstances where a person died a violent or unnatural death. As Mark died from injuries sustained from a number of inflicted stab wounds his death is clearly regarded as being both violent and unnatural, making it a reportable death.

4. Further, section 27(1)(a) of the Act provides that an inquest is mandatory if it appears to a coroner that a person died or might have died as a result of homicide. In this case, the evidence establishes that the stab wounds were inflicted by another person or persons, meaning that Mark died as a result of homicide. It is therefore mandatory to hold an inquest into Mark's death.

5. In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will wish to attempt to cope with the consequences of such a traumatic event in private. The loss experienced by family members does not diminish significantly over time. Therefore, it should be acknowledged that both the coronial process and an inquest by their very nature unfortunately compel a family to re-live distressing memories and to do so in a public forum.

Mark's life

6. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Mark's life in a brief, but hopefully meaningful, way.

7. Mark was born in January 1964 to Lloyd and Gloria Russell. Mark, his older sister, Julie Ann Stewart, and their parents initially lived in the Goulburn. Mark and his sister were later placed into foster care after their father was incarcerated and their mother experienced health issues. Mark and his sister later moved to Wagga Wagga with a foster family, and spent approximately five years there before later living with another foster family in Barmedman. After about four years Mark moved with the family to Thirroul whilst Julie remained in Barmedman. After living in Thirroul for about a year, Mark later moved to a boarding house in Kings Cross, but remained in contact with his sister.

8. Mark later formed a relationship with Narelle Dodds and they had a son, Shayne, together. This relationship later ended when Shayne was still a young boy. Mark subsequently commenced a new relationship with Melinda Moffit and they later had a daughter, Abbey, together. After living in Teralga for a period of time, this relationship also subsequently ended after approximately five years.

9. Following this, it appears that Mark maintained only intermittent contact with his family. For a period of time he lived in Goulburn and then had periods of homelessness, before becoming a long-term resident at a hostel in Woolloomooloo. In 2016 Mark moved to Department of Housing accommodation in a unit at 10 Clisdell Street, Surry Hills (**the Clisdell Street units**).

10. By all accounts, Mark was well-liked and had many friends. He was known to be a social person and often had many friends come to visit him and socialise.

11. There is no doubt that the sudden and violent manner in which Mark's life ended has been extremely distressing to his family members and those closest to him. There is equally no doubt that Mark's loss is deeply felt and that he is greatly missed as much-loved son, father, brother and friend.

The events of 23 to 25 February 2018

12. It has been difficult to establish a reliable timeline of the days preceding Mark's death and the lead up to his discovery inside his unit on the morning of 25 February 2018. This is because reconstruction of these events has been largely dependent upon the recollection of Mark's friends, neighbours and other persons who interacted with him during this period. Unfortunately, the recollections of these persons have been affected by the use of alcohol and illicit drugs, the inability to recall dates and details with reliable precision, and the passage of time. It became apparent from an early stage in the investigation that witnesses who were spoken to and interviewed, and who may have been able to provide the investigation with important information, were either poor or unreliable historians.

13. Mark was known to many of the other residents at the Clisdell Street units as a good neighbour, who often had visitors to his unit. These visitors would often stay at Mark's unit overnight, or for longer periods of time. Mark was also known to frequently leave his front door open, but with the front fly screen shut, so that passers-by could see and hear visitors within Mark's unit.

23 February 2018

14. David Albert, one of Mark's close friends, went to visit Mark at around 8:00am on 23 February 2018. Mr Albert resided in a separate block of units in Redfern, approximately 10 minutes' walk away. Mr Albert found that Mark was not at home and later saw him at the Matthew Talbot hostel in Woolloomooloo at around 9:00am. Mark and Mr Albert went to purchase a quantity of wine before later returning to Mark's unit at around 9:45am. Once there, Mark and Mr Albert remained in the unit, drinking wine and port, until approximately 1:00am on 24 February 2018. Mr Albert later left Mark's unit to return home.

15. At around 7:00pm on 23 February 2018 Athol Young, a nearby resident, heard the sound of two male voices arguing in the direction of Mark's unit for approximately five minutes.

16. Sometime between 8:00pm and 9:00pm on 23 February 2018, Nicholas Katavic was home inside his unit when he heard a loud argument coming from Mark's unit. Mr Katavic had previously heard many arguments coming from Mark's unit prior to this day, but described this as one of the loudest and most aggressive that he had ever heard.

24 February 2018

17. At around 7:00am on 24 February 2018 one of Mark's neighbours, Stephen Ward, left home and saw that the door to Mark's unit was open. Mr Ward heard Mark's voice from within the unit, together with the voices of other people.

18. At around 9:00am on 24 February 2018 Stephen McRoberts, another one of Mark's friends, saw Mark in his unit. Mr McRoberts spoke to Mark for about 15 minutes and noticed that he was moderately affected by alcohol.

19. Sometime between about 9:00am and 10:00am on 24 February 2018 Mr Albert returned to Mark's unit but found no one there. Mr Albert subsequently went to look for Mark at the Matthew Talbot hostel without success, before later returning to Mark's unit where again he could not be found.

20. When Mr Ward returned to the Clisdell Street units at around 6:00pm he again saw that the door to Mark's unit was still open, and that the voices of Mark and other persons could be heard from within. Sometime later Mr Ward heard the sound of raised voices from within Mark's unit.

21. At around 7:00pm or 7:30pm on 24 February 2018, another resident of the Clisdell Street units and one of Mark's friends, Rajesh Kumar, saw Mark sitting on his couch and drinking wine from a glass. Mark greeted Mr Kumar, and Mr Kumar saw Mark again about five minutes later when he returned to his unit.

22. Mr Ward subsequently left his home between about 7:00pm and 7:30pm to go for a walk and again heard the voices of Mark and other persons from within the unit. When Mr Ward returned home at around midnight, he noted that Mark's unit was quiet with no lights on.

23. At around 9:30pm on 24 February 2018 Nelu Romnaiuc, another resident of the Clisdell Street units, left home and saw that the front door to Mark's unit was partially open. Mr Romnaiuc heard the

sounds of voices coming from within Mark's unit. When Mr Romnaiuc returned home a short time later at around 10:00pm, he heard similar sounds of voices coming from within Mark's unit.

25 February 2018

24. At around 1:30am on 25 February 2018 Mr Young heard a number of what he described as loud bangs from somewhere below his unit.

25. At around 3:00am on 25 February 2018, another resident of the Clisdell Street units, Michael Muller, who lived on the floor above Mark's unit heard some noise coming from the unit. Mr Muller later left home before returning at around 6:30am. On his way back Mr Muller looked through one of the windows into Mark's unit. He observed a person sitting on the lounge in what he described as an "*uncomfortable*" position. Mr Muller believed that the person was Mark but was not entirely sure.

26. Mr Albert returned to Mark's unit at around 11:00am. He knocked on the window but received no response. After looking through the window Mr Albert saw Mark lying on a couch with a red pillow on his chest. Mr Albert called out to Mark a number of times and after receiving no response, Mr Albert entered the unit.

27. Mr Albert found Mark lying on a couch, unresponsive and with no signs of life. Mr Albert ran next door to alert Mr Kumar of his discovery. Mr Kumar subsequently rang Triple Zero at about 11:10am. Paramedics arrived at the scene at around 11:18am. On examination, the paramedics observed that Mark had a penetrating chest wound to his left upper chest, congealed blood on his neck (which was a result of wounds to Mark's neck) and that Mark was showing signs of rigor mortis. Police were requested to attend the scene and Mark was later pronounced life extinct.

When did Mark die?

28. From the events described above, it appears that a number of persons had interactions with Mark and visited him in his home on 23 and 24 February 2018. There is also evidence consistent with some disagreement or altercation occurring within Mark's unit, most likely on more than one occasion, over these two days. However, the precise nature of these events, and the circumstances which may have contributed to them, is unclear.

29. Notwithstanding, the best available evidence indicates that Mark was last known to be alive at around 7:00pm to 7:30pm on 24 February 2018 (when he was seen by both Mr Kumar and Mr Ward), and that he died sometime prior to 6:30am on 25 February 2018 (when he was seen lying on the couch by Mr Muller). This timeline is most consistent with the sounds of voices from within Mark's unit up to around 10:00pm on 24 February 2018; some noticeable sounds heard by both Mr Young and Mr Muller coming from Mark's unit in the early hours of the morning on 25 February 2018; and Mr Albert's discovery of Mark in the same position some five hours after Mark was seen by Mr Muller.

30. Having regard to the above evidence it is therefore most likely that Mark died sometime on the evening of 24 February 2018 after about 7:30pm or during the early morning of 25 February 2018 before about 6:30am.

What was the cause and manner of Mark's death?

31. Mark was later taken to the Department of Forensic Medicine where an autopsy was performed on 28 January 2014 by Dr Lorraine Du Toit-Prinsloo, forensic pathologist. The autopsy identified the following injuries:

    (a) Two stab/incised wounds on the posterior aspect of the neck on the right, resulting in haemorrhage and stab wounds to the right sternocleidomastoid muscle, right lobe of the thyroid, and sharp force defect to the lateral aspect of the 5th cervical vertebra;

    (b) Five stab/incised wounds on the anterior aspect of the neck in the central aspect and towards the left side of the neck, resulting in stab wounds of the left carotid artery and left jugular vein;

    (c) Five stab/incised wounds to the central and left side of the chest, associated with sharp force injury of the left pectoral as muscle and a penetrating injury through the intercostal muscles;

    (d) Small superficial incised wounds to the right side of the back and anterior aspect of the left forearm ;

    (e) A number of incised wounds to the palmar and dorsal aspects of both hands

32. In the autopsy report dated 30 May 2018 Dr Du Toit-Prinsloo opined that the cause of Mark's death was multiple stab wounds to the neck and chest. Having regard to the circumstances in which Mark was found on 25 February 2018, together with the findings from the postmortem examination, it is evident that Mark died as a result of the actions taken by a person or persons unknown as part of alleged criminal activity. The manner of Mark's death is, therefore, homicide.

What investigation was conducted into Mark's death?

33. The New South Wales Police Force (**NSWPF**) Homicide Squad subsequently established a strike force in order to investigate Mark's death. As the investigation involves consideration of information which is of a sensitive nature, and because any person involved in Mark's death has not yet been apprehended, it is not proposed in these findings to recount in detail every aspect of the police investigation. Rather, the summary below is provided. In doing so it should be emphasised that the relative brevity of the inquest and these findings in no way reflects the extent of the investigation that has taken place in an attempt to identify and apprehend any person responsible for Mark's death, or the loss which has been, and continues to be, felt by Mark's family and friends.

34. Since February 2018 Mark's death, and the circumstances surrounding it, have been investigated by a number of experienced and senior NSWPF investigators. The brief of evidence tendered in the coronial proceedings contains a large number of witness statements, forensic reports and other documentary and electronic material gathered over the course of the investigation. This investigation involved:

    (a) Extensive canvases of residents of the Clisdell Street units and neighbouring residences;

(b) Extensive physical canvases of the Clisdell Street units and surrounding locations;

(c) Numerous statements taken from, and interviews conducted with, Mark's friends and associates;

(d) Review of available CCTV footage of the area in and around the Clisdell Street units, some of which was able to identify the last occasion that Mark was seen walking towards the Clisdell Street units at 3:58pm on 23 February 2018;

(e) Forensic examination of Mark's unit, and other areas within the Clisdell Street units; and

(f) The use of both overt and covert investigative strategies to identify persons of interest to the investigation.

35. Despite this extensive investigation no person involved in Mark's death has been identified and criminal proceedings have not yet been commenced against any person.

36. As already noted above the investigation into Mark's death has been made more challenging by difficulties in reconstructing a timeline of the last days and hours of Mark's death. This reconstruction has been dependent on accounts provided by persons whose recollections have been inherently unreliable. Additionally, forensic evidence gathered during the investigation has been difficult to interpret. This is because, as described already, many friends and neighbours often visited Mark's unit and had a legitimate reason to be there. Therefore, using the forensic evidence that has been gathered, investigators have experienced challenges in excluding those persons who may be of interest to the investigation.

37. All of the above is to both acknowledge the many challenges faced by the police investigation, and to also recognise the enormous time and work that has been put into the investigation.

Should any recommendation pursuant to section 82 of the Coroners Act 2009 be made?

38. Section 82 of the Act allows a Coroner to make recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable. Such recommendations are often made with view to hopefully improving public health and safety.

39. Any alleged unlawful act resulting in the death of a person is unquestionably a matter of utmost seriousness which impacts upon the safety of members of the community. There is obviously considerable public interest in having the person, or persons, responsible for such any alleged criminal act being brought to justice.

40. Accordingly, the following recommendation is both necessary and desirable: ***I recommend that the death of Mark Russell be referred to the Unsolved Homicide Unit of the NSW Police Force Homicide Squad for further investigation in accordance with the protocols and procedures of that Unit.***

Findings

41. Before turning to the findings that I am required to make, I would like to thank Mr Tim O'Donnell for his assistance during both the preparation for the inquest, and the inquest itself. I also thank Detective Sergeant Peter Smith, the officer-in-charge of the police investigation, for conducting a comprehensive investigation and compiling the extensive brief of evidence.

42. The findings I make under section 81(1) of the Act are:

Identity
The person who died was Mark Russell.

Date of death
Mark died on 24 or 25 February 2018.

Place of death
Mark died at Surry Hills, New South Wales 2010.

Cause of death
The cause of Mark's death was multiple stab wounds to the neck and chest.

Manner of death
These stab wounds were inflicted by a person or persons unknown. The manner of Mark's death is therefore homicide.

Epilogue

43. On behalf of the Coroners Court of NSW I extend my sincere and respectful condolences to Mark's family and friends for their painful and tragic loss. It is hoped that those criminally involved in Mark's death will eventually be brought to justice.

44. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
15 October 2020
Coroners Court of New South Wales