IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006521

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Simon McGregor
Deceased:	Jay Joseph Harrison
Date of birth:	25 August 1976
Date of death:	Between 22 November 2023 and 23 November 2023
Cause of death:	1a : COMBINED DRUG TOXICITY (HEROIN, AMPHETAMINES, HYDROXYRISPERIDONE, OLANZAPINE)
Place of death:	1015 - 1019 Dandenong Road Malvern East Victoria 3145
Keywords:	Homelessness; Mixed Drug Toxicity

INTRODUCTION

1. On 23 November 2023, Jay Joseph Harrison was 47 years old when he died from combined drug toxicity in a hotel room. At the time of his death, Jay was homeless, sleeping mostly on the streets of Boronia, Victoria.

2. Jay had three children with his now ex-wife, from whom he had separated back in 2014. Although he was unemployed at the time of his passing, Jay had previously worked in factories and ran a small business after he had left high school half way through.[1] He had a difficult upbringing that brought him into contact with mental illness and financial stress, but is survived by his mother and six siblings.[2]

3. Jay had been homeless since around 2021 but would choose to stay in short term accommodation when he had the financial means to do so.[3]

4. He had convictions for assault, theft, criminal damage, family violence and traffic related activities,[4] coinciding with the onset of his paranoia, schizophrenia, and associated drug and alcohol abuse.

5. Jay's first mental health contact with Eastern Health was on 22 March 2016, and there were three inpatient admissions (March and December 2016, January 2019). Primary support was then provided by Eastern Area Mental Health Service (**EAMHS**) since, where he was diagnosed with Schizophrenia, and a personality disorder. [5]

6. His last recorded police involvement was a Section 232 Mental Health Assessment by the Alfred Hospital CATT team on 10 November 2023, after being found naked in an alleyway, talking to himself, having just used methylamphetamine.[6]

7. At the time of this last involvement, Jay was on a Community Treatment Order, which had been most recently varied on 25 October 2023 due to his noncompliance with intramuscular injection (**LAI**) regime. He was released by the CATT team when he agreed to resume the LAI and was not otherwise exhibiting symptoms of a Schizophrenia relapse.

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[1] Statement of Nicole Harrison, Coronial Brief.
[2] Statement of Grant Harrison, Coronial Brief.
[3] Exhibit 6 Eastern Health Medical Records, Coronial Brief.
[4] Memorandum of Senior Constable Daniel Wall, Coronial Brief.
[5] Exhibit 6 Eastern Health Medical Records, Coronial Brief.
[6] Statement of Lisa McKenzie, Coronial Brief.

8. Records of prescribed medications over time include Diazepam, Quetiapine, paliperidone, Benzotropine, but he also had a history of refusing medication, becoming combative and aggressive behaviour towards staff, and disengaging with treatment.[7]

9. In a recent call from Jay to his outreach worker on 17 November 2023, 6 days prior to his passing, he reported "he was homeless and sleeping on the streets of St Kilda- lamented current situation expressing wish to secure long-term housing. Described current mental state as 'okay'- nil concerns expressed."[8]

THE CORONIAL INVESTIGATION

10. Jay's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

11. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

12. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

13. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Jay's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

14. This finding draws on the totality of the coronial investigation into the death of Jay Joseph Harrison including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for

[7] Ibid.
[8] Ibid.

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[9]

15. In considering the issues associated with this finding, I have been mindful of Jay's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

16. On Thursday, 21 November 2023, at approximately 2:00 pm, Jay checked into the Evancourt Motel, located at 1015 Dandenong Rd, Malvern East. He paid $278 cash for two nights' accommodation, and was allocated room number 6 with a checkout time of 10:00 am on Thursday 23 November.[10]

17. On the 22 November, the venue's CCTV footage shows Jay leaving his room, and returning alone around four hours later, at about 4.30pm.[11]

18. On 23 November, when Jay did not check out on time, the hotel owner Mr. Michael Mai waited until 11:06 am to knock on his door. When he received no response, he attempted to open the door using his master key but realised it was being obstructed from the inside. Mr Mai then used the phone on his camera to discover that a naked but apparently unconscious person was leaning against the door causing the obstruction. He then called 000 immediately. Police and Ambulance members forced the door at 11.33 am, but it was obvious that Jay had passed sometime since the CCTV footage captured his return to his room, as *rigour mortis* had already set in.[12]

19. Inside, my investigators located Jay's black backpack, clothing, $72.70 in cash, bank cards, mail, another person's mobile phone, syringes, an empty zip lock bag containing a white

[9] Subject to the principles enunciated in Briginshaw v Briginshaw (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.
[10] Statement of Michael Mai, Coronial Brief.
[11] Exhibit 2 CCTV footage, Coronial Brief.
[12] Statement of Michael Mai, and Exhibit 5 Police Notes & Sketch, Coronial Brief.

residue powder and another bag containing approximately half a gram of a substance subsequently confirmed to be amphetamine.[13]

20. There were no suspicious circumstances associated with the death.

Identity of the deceased

21. On 28 November 2023, Jay Joseph Harrison, born 25 August 1976, was identified via fingerprint identification. As such, identity is not in dispute and requires no further investigation.

Medical cause of death

22. Senior Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 27 November 2023 and provided a written report of her findings dated 2 April 2024.

23. The post-mortem examination revealed possible recent puncture wounds in both antecubital fossae, which is consistent with intravenous drug use.[14]

24. Toxicological analysis of post and ante-mortem samples identified the presence of 6-monoacetylmorphine (a metabolite of heroin use) within the urine along with morphine and codeine, amphetamines, hydroxy risperidone in the blood and the urine. Olanzapine was detected in the urine. These results are also consistent with recent use of heroin and amphetamines.

25. The postmortem CT scan showed no acute intracranial pathology. There was a remote skull fracture on the right parietal region, as well as evidence of surgical intervention with metalware in the right facial region. There was urine within the bladder, as well as increased bilateral lung markings, and focal coronary artery calcifications. None of these features were significant enough to have contributed to the cause of death, but they are indicative of a person suffering mounting health challenges.

26. Dr Francis provided an opinion that the medical cause of death was 1(a) COMBINED DRUG TOXICITY (HEROIN, AMPHETAMINES, HYDROXYRISPERIDONE, OLANZAPINE), and I accept her opinion.

[13] Memorandum of Senior Constable Daniel Wall, Coronial Brief.
[14] The area of transition between the anatomical arm and the forearm.

HOMELESSNESS IN VICTORIA TODAY

27. The services with whom Jay sporadically engaged did their best to assist him within the constraints of their current operational paradigms. His longitudinal mental health deterioration eventually cost him his family, his home, his own health and at times, his liberty.

28. His brother observed that his pattern of deterioration matched that which their mother had experienced,

> From his early 30's, Jay went from having a good job, a wife with three children, a house and a mortgage, to being homeless.
>
> I ended up cutting ties with Jay at this time and ended up obtaining a family violence intervention order for his continual harassment.
>
> …
>
> The last time I saw Jay would have been about four months prior to his death. Embarrassingly, he chose to sleep rough outside the Boronia Library in park Crescent which is 30 metres away from where my office was…[15]

29. There is a *possibility*, although in Jay's case it cannot be put as high as a *probability*, that if there was stable supportive accommodation available for him, he might have ceased harming his own family, ceased his poverty related criminal activity and more sustainably engaged with his own mental health.

30. It also now clear to me that homelessness is both a cause, and a result, of harmful and expensive social disfunction, and as such is a phenomena that in the public interest of the State of Victoria needs to be better understood, through both an actuarial and a public health lens.[16]

31. As our State Coroner recently observed: [17]

[15] Statement of Grant Harrison, Coronial Brief.
[16] See generally, The Hon. Bell. K. AM KC, *Housing: The Great Australian Right* (2024) Monash University Publishing; Prof. Hohmann J., *The Right to Housing in Australia* (2025) Human Rights Law Centre.
[17] *Inquest in the death of Bekkie-Rae Curren* COR 2019 006509 (Cain J., 14 October 2024).

a) The Australian Institute of Health and Welfare (**AIHW**) reported in 2022 that Victorian specialist housing support services were unable to assist 96 clients each day, and that 70% of cases were closed without the client having accessed stable housing.[18]

b) The Federal Government's *Economic Inclusion Advisory Committee 2024 Report* reiterated these findings and emphasised the financial stress that those receiving Centrelink payments were under. This committee recommended that the Federal Government increase in JobSeeker payments by $17 a day, with other reviews urging the Government to increase income support payments to the same rate as the pension.[19]

32. Accordingly, I shall reiterate below some of his recent recommendations about homelessness and associated poverty in Victoria.

FINDINGS AND CONCLUSION

33. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

a) the identity of the deceased was Jay Joseph Harrison, born 25 August 1976;

b) the death occurred sometime between 22 November 2023 and 23 November 2023 at 1015 - 1019 Dandenong Road, Malvern East, Victoria, 3145, from 1(a) COMBINED DRUG TOXICITY (HEROIN, AMPHETAMINES, HYDROXYRISPERIDONE, OLANZAPINE); and

c) the death occurred in the circumstances described above.

34. Having considered all of the circumstances, I am satisfied that Jay's death was the unintended consequence of the deliberate ingestion of drugs.

[18] At [63].
[19] At [65], footnotes omitted.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

A. In line with the recommendations of the *Economic Inclusion Advisory Committee 2024 Report*, the Commonwealth Government should review rates for Australian income support payments.

B. That the Victorian Government implement the recommendations outlined by the *Inquiry into the rental and housing affordability crisis in Victoria*, with special consideration given to building 60,000 new public housing dwellings by 2034, in line with projected demands.

C. That the Victorian Government, in line with recommendations outlined by *The rental and housing affordability crisis in Victoria* and the *Legal and Social Issues Committee Inquiry into Homelessness in Victoria*, include the right to housing[20] in the Victorian *Charter of Human Rights and Responsibilities Act 2006*.

I convey my condolences to Jay's family for their suffering, but hope that in a civilised society like Victoria, the sharing of such stories has some rational prospect of triggering positive change.

[20] *International Covenant on Economic, Social and Cultural Rights* (ICESCR), Article 11(1): The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions … Whilst Australia ratified ICESCR on 10 December 1975, it has since then failed to ratify the concomitant Optional Protocol complaints procedure.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Nicole Harrison, Senior Next of Kin

Carol Swift, Mother

Paul Katz, Eastern Health.

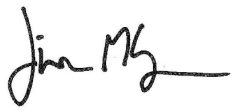
Catlin Reiger, Human Rights Legal Resource Centre

Victorian Government

Commonwealth Government

Senior Constable Daniel Wall, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 24 September 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.