IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 001615

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Steven David Callanan
Date of birth:	1 March 2002
Date of death:	26 March 2023
Cause of death:	1(a) Neck compression 1(b) Hanging
Place of death:	6 Costain Court, Gladstone Park, Victoria, 3043

INTRODUCTION

1. On 26 March 2023, Steven David Callanan was 21 years old when he was found deceased at home in circumstances suggestive of suicide. At the time, Steven lived in Gladstone Park with his sister, Charlene Brown.

2. Steven was born in 2002 to parents Paul Callanan and Evelyn Brown. He had four siblings, an older stepbrother, Nicholas, two older sisters, Charlene and Samantha, and a younger sister, Danielle.

3. Steven was a very active and happy child who was naturally talented at Australian rules football which was evident from a young age. He also played cricket growing up and around the time of his death was involved in coaching the local West Meadows junior cricket team. Growing up, Steven had a strong social network from both his cricket and football clubs and was well liked amongst his peers.

4. In year ten of his studies, Steven's footballing talent was recognised and he was one of 26 students in Australia accepted into the SEDA advanced football school program run in North Melbourne. As a junior, Steven played football with the Westmeadows Football Club until 2021. He left the club and played one season with the West Preston football club before being recruited by the Wallan Football Club (**Wallan FC**) in 2023.

5. When he was 17 years old, Steven commenced a plumbing apprenticeship with a local plumbing business, Dynamic Plumbing. He remained with Dynamic Plumbing for several years until he gained employment with the Kennedys Group in 2022 where he continued his plumbing apprenticeship. Family and friends did not know Steven to have any issues or workplace related stress at either workplace and he was known to be a hardworking and respected employee at both.

6. Around the onset of the COVID-19 pandemic, Steven's parents and youngest sister, Danielle, moved to live at the family farm in Beaufort. Steven remained living at the family home in Gladstone Park. Throughout this time Steven remained in contact with his family over the phone and his parents would regularly visit when able, with his mother often staying between Sunday nights and Tuesdays.

7. Steven was in a relationship with Torie Killender for around two to three years. While they did not live together, Torie would regularly stay with Steven at his home in Gladstone Park. They enjoyed a happy relationship without issues and often talked about moving into their

own place. In the weeks leading up to his death, Steven told his friends that he wanted to marry Torie in the future. In her statement included in the coronial brief, Torie said Steven "*never mentioned much about mental health*" although he occasionally had difficulty sleeping.[1]

8. Steven was not a regular drug user but was known to use illicit substances occasionally in the company of his friends. Although he had a past history of drug use, there is no evidence to suggest that Steven had any underlying substance dependency problem. Moreover, it appears his infrequent drug use was limited to the occasional social setting.

9. Steven attended multiple General Practitioners (**GPs**) at the Greenvale Medical Centre since childhood. The medical records from the Greenvale Medical Centre indicate Steven was never diagnosed or treated for any mental ill health and that each of his presentations were for minor medical ailments or injuries. He did not have any underlying medical conditions and was not prescribed any regular medications.

10. Similarly, family and friends reported that Steven did not appear to struggle with any mental ill health at any point in his life. In the weeks leading up to his death, Steven appeared happy and normal to friends and family alike.

THE CORONIAL INVESTIGATION

11. Steven'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.

12. 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.

13. 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.

[1] Statement of Torie Killender dated 4 May 2023.

14. Victoria Police assigned First Constable Zoe Tudor (**FC Tudor**) to be the Coroner's Investigator for the investigation of Steven's death. The Coroner's 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.

15. This finding draws on the totality of the coronial investigation into the death of Steven David Callanan including evidence contained in the coronial brief and correspondence received from Steven's famiy. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Circumstances in which the death occurred

16. On Saturday, 25 March 2023, Steven's football team was scheduled to play an away match in Torquay. He was picked up in the morning by his friend and Wallan FC teammate, Hayden Gill who drove to the match which started at 2.00 pm. During the drive to Torquay, Hayden noted that Steven was happy, spoke about his future and about saving money to buy a house with Torie.

17. Steven played well and was noted to be one of the best players on ground that day. After the game, Steven and his teammates went to the local pub where they socialised until about 2.00am. According to Hayden, Steven was happy while they were at the pub, everyone appeared to be having a good time and there were no issues amongst the group.

18. After leaving the pub, Steven and a number of his teammates returned to an Airbnb they had booked in Torquay. The young men continued to party, and the evidence suggests Steven likely ingested cocaine at some point during the night. It is unclear what time Steven retired to bed.

19. At some point during the weekend, Torie stated that Steven messaged her and apologised for being a bad boyfriend. Torie was unaware what prompted the message but noted in her

[2] 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.

statement that Steven had made similar remarks when he had taken drugs on previous occasions.

20. The following morning, being 26 March 2023, Steven and his friends left the Airbnb in Torquay to return to their respective homes. Steven was driven home by Hayden. During the car ride home Hayden thought that Steven "*looked a bit sick*" and kept his head in his hands as though he was struggling with the light. Hayden attributed Steven's state to being hungover from the previous night out and tired from the game. Over the course of the trip home, Hayden thought Steven appeared "*a bit down*" and they talked about trivial things.[3]

21. At some point during the morning Mr Callanan phoned his son and asked for his help the following Sunday. According to Mr Callanan, his son did not sound good on the phone which he attributed to a hangover.

22. Hayden dropped Steven off at his home in Gladstone Park at around 11.30 am and did not stay. Later, he sent a message to Steven asking if he was ok and Steven replied that he was. This exchange appears to be the last known time that Steven was known to be alive.

23. Later that night, as previously arranged, Mr and Mrs Callanan arrived at the Gladstone property where Steven was living. They found the front gate closed but the front door open. Inside, on the kitchen bench, Mrs Callanan discovered a handwritten note with the instructions and the passcode to open Steven's phone, as well as the phone itself. Mrs Callanan unlocked Steven's phone which opened to a typed note saying he was in the backyard and indicating an intention to end his own life.

24. Both of Steven's parents rushed to the backyard where they discovered Steven hanging from a strap tied to the second story balcony in front of a water tank. His parents acted immediately and freed Steven from the ligature, contacted emergency services, and commenced cardiopulmonary resuscitation (**CPR**).

25. Ambulance Victoria paramedics received the call at 8.24 pm and arrived five minutes later at 8.29 pm. Attending paramedics did not detect any signs of life and withheld resuscitation efforts. Tragically, Steven was verified deceased at the scene at 8.35 pm on 26 March 2023.

[3] Statement of Hayden Gill dated 10 May 2023.

26. Victoria Police attended a short time later and conducted a search of the scene. Attending police did not find any evidence of third-party involvement in Steven's death or anything to suggest that he died in suspicious circumstances.

Identity of the deceased

27. On 26 March 2023, Steven David Callanan, born 1 March 2002, was visually identified by his mother, Evelyn Brown, who signed a formal Statement of Identification to this effect.

28. Identity is not in dispute and requires no further investigation.

Medical cause of death

29. Forensic Pathologist Dr Sarah Parsons, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 28 March 2023 and provided a written report of her findings dated 30 March 2023.

30. The post-mortem examination showed a ligature injury to the neck consistent with the stated circumstances but no other significant traumatic injuries and no significant natural disease.

31. Routine toxicological analysis of post-mortem samples detected cocaine[4] and its metabolites at relatively low levels and no alcohol or other commonly encountered drugs or poisons.

32. According to the toxicologist's report, Cocaine is a highly unstable substance which is rapidly metabolised/hydrolysed to the inactive metabolites Benzoylecgonine and Ecgonine Methyl Ester that are further hydrolysed to Ecgonine. The levels detected are consistent with the remote use of cocaine.

33. Dr Parsons provided an opinion that the medical cause of death was *1(a) neck compression* secondary to *1(b) hanging*.

34. I accept Dr Parson's opinion.

[4] Cocaine is an alkaloid found in the leaves of Erythroxylon coca and is abused for its stimulant properties. In Steven's case the levels detected in post-mortem blood were Cocaine at ~0.02 mg/L, Benzoylecgonine at ~0.4 mg/L and Ecgonine Methyl Ester at ~ 0.1 mg/L.

FAMILY CONCERNS & FURTHER INVESTIGATION

35. Over the course of the coronial investigation, Steven's family raised a number of concerns about Steven's death, both in statements included in the coronial brief and in correspondence directly with the court. These concerns included:

    i. That there was a 'drug culture' within the Wallan Football Club and more broadly within the Australian Football League (AFL).

    ii. The precipitant events occurred during a football trip organised by Wallan Football Club and therefore on their watch.

    iii. That there was a falling-out between Steven and his teammates from the West Meadows Football Club that may explain his decision to end his life.

36. Having received these concerns, I passed them on to FC Tudor with a direction that she obtain a statement from Steven's football coach at Wallan FC. Subsequently, A statement was obtained from Mr Daniel Nolan who was the coach of the men's senior team at the Wallan FC at the time of Steven's death.

37. Mr Nolan stated that since being recruited to the Wallan FC at the start of the 2023 season, Steven had settled in well to his new club, attended all training sessions on a regular basis, and was performing well on the field and ticking all the boxes a club could want from a new player. Mr Nolan had observed no signs of conflict between Steven and any other players nor any signs that he might be mentally unwell. He was unaware that Steven or any other players were using any substances. As Steven had just paid his yearly registration in full, he did not know of Steven having any financial difficulties.

38. On the day of Steven's final match, Mr Nolan believed he appeared happy and normal. They had a conversation post-game and Steven appeared well and pleased with his performance. Following the game, the club arranged a water recovery session during which Steven showed no signs of anything out of the ordinary.

39. Mr Nolan was aware some of the players were staying at an Airbnb in Torquay for post-match celebrations but this was not a club function. He and the other coaches had separate accommodation to the players and the players were, essentially, on their own time.

40. I am satisfied that Mr Nolan and the Wallan FC provided a reasonable standard of care to Steven as a senior footballer in their capacity as a community football club.

41. The role of a coroner in the coronial jurisdiction is limited to making findings under section 67 of the Act, namely the identity of the deceased, the cause of death, and the circumstances in which the death occurred, and more broadly to identify any opportunities for prevention. I note the family's concerns regarding a drug culture within the AFL. Without making any comment or finding, I consider these concerns fall outside the reasonable scope of the coronial investigation into Steven's death.

42. As regards to a falling out between Steven and his former teammates at the Westmeadows Football Club, the evidence before me on the coronial brief suggests Steven hosted an event in September for the 2021 AFL grand final after which he distanced himself from some of his then teammates.[5] Although the dissolution of friendships would have no doubt been stressful for Steven, these events occurred sometime prior to his death and are a common experience for young men moving from their adolescent to adult years. Further, I note the overwhelming evidence that proximate to his death, Steven had a vast social network, a healthy relationship with partner Torie, and a strong relationship with his parents and family.

Employment

43. To understand what, if any, stressors were being experienced by Steven around the time of his death, I also asked for a statement from Steven's employer, Kennedys Group, where he was employed as an apprentice plumber. Subsequently, a statement was provided by Mr Shannon Kennedy, the director of the group.

44. Mr Kennedy described Steven as a good worker who was always happy and would approach challenges in a level-headed way. Mr Kennedy did not observe any changes in Steven's behaviour at work or any indications that he was struggling with his mental health.

45. Moreover, after Steven's death, Mr Kennedy approached Steven's workmates enquiring about their observations of Steven in the period preceding his death and none of them were aware of anything that may have been troubling him.[6]

FINDINGS AND CONCLUSION

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

[5] Statement of Jack Hatton dated 4 May 2023; Statement of Jordan Kosteas dated 4 May 2023.
[6] Statement of Shannon Kennedy dated 6 March 2024.

i. the identity of the deceased was Steven David Callanan, born 01 March 2002;

ii. the death occurred on 26 March 2023 at 6 Costain Court, Gladstone Park, Victoria, 3043;

iii. the cause of Steven's death was neck compression secondary to hanging; and

iv. the death occurred in the circumstances described above.

47. The available evidence, including the lethality of the means chosen and the presence of a suicide note, supports a finding that Steven intentionally took his own life.

48. Cocaine was detected in post-mortem samples and, in all likelihood, was consumed by Steven at some point during his football trip the night prior to his death. Toxicological analysis alone does not allow me to determine what impacts, if any, cocaine had on Steven's mood and judgement at the time of his death.

49. Despite a thorough coronial investigation, I have been unable to determine to the applicable standard why Steven made the decision to take his own life or identify any suicide stressors Steven was experiencing proximate to his death.

50. Importantly, despite close family and personal relationships and a good network of friends, it appears that Steven did not confide in anyone and did not present to those around him at risk of self-harm, thus depriving those around him of the opportunity to intervene and provide further support or encourage him to seek professional help. While Steven's death was a shock to many people who knew him, it is not uncommon in the coronial jurisdiction, to find that some people manage to take their own life without making previous threats to do so or without changes in mood or behaviour raising concerns in their loved ones and friends.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comment:

1. Steven's death reflects the inherent difficulty of identifying those at risk of suicide, particularly among young men. This is highlighted by the fact that Steven was not diagnosed with or treated for any form of mental illness, and by all accounts was a happy, well liked and promising young man with a bright future ahead.

2. The Victorian Suicide Register (**VSR**) is a database containing detailed information on suicides that have been reported to and investigated by Victorian Coroners between 1 January 2000 and the present.

3. Upon my request, the Coroners Prevention Unit[7] (**CPU**) collated data on the prevalence of mental ill health and related medical treatment among people who suicided, with a particular focus on young males like Steven.

4. Suicide data including diagnosed and suspected mental ill health was only available for Victoria between 2009 and 2016. Although more recent data was not available, I am satisfied that it remains useful to help understand Steven's death and place it in context.

5. Analysis of the data showed that overall, 52% of males and 70% of females who suicided in Victoria between 2009 and 2016 had been diagnosed with mental illness at some time prior to death. These proportions varied with age and were lower among both males and females who were in the youngest and oldest age groups.

6. For example, in males aged 24 years and under, the proportion was only 45% whereas in males aged 45-54 years it was 57%.

7. When the analysis was expanded to include not only people who experienced diagnosed mental illness but also those who were suspected to have mental ill health in the absence of formal clinical diagnosis, the proportions were notably higher: 74% of males and 85% of females. Again, these proportions varied by age and were lowest in the youngest and oldest groups.

8. Of particular interest in this case, 70% of males aged 24 years and under who suicided between 2009 and 2016 in Victoria experienced either diagnosed or suspected mental ill health.

9. Conversely, this means that in 30% of cases for young men aged 24 and under there was no evidence of any mental ill health, either diagnosed or suspected.

10. Steven's tragic death highlights the importance of young men engaging in open and honest dialogues about their mental health. Without any suggestion that Steven was neglected by

[7] The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

those around him, it is unclear how long he suffered alone and if a different outcome would have occurred had Steven had been able to voice his thoughts to any of his large support network.

11. Steven was a talented footballer, widely liked by his peers, had a loving family and partner, and a promising career as a plumber. His death illustrates the need for people to check-in on those around them, even those who do not appear to be struggling.

12. Without making any adverse comment or finding against the Wallan Football Club, as the evidence does not support doing so, I would invite Wallan Football Club management to carefully consider how they might best promote a culture within the club that encourages young players, like Steven, to feel supported enough to openly discuss their mental health.

I convey my sincere condolences to Steven's loved ones for their loss. Steven's family provided a moving account of his life and it is clear that Steven was widely loved and is dearly missed by not only his family, but by his partner, friends, and his community more broadly.

PUBLICATION OF FINDING

Pursuant to section 73 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:

Paul Callanan and Evelyn Brown, Senior Next of Kin

Wallan Football Club

First Constable Zoe Tudor, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date : 10 October 2024

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.