IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004398

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Chenna Kesava Sai Prasangi
Date of birth:	11 August 2001
Date of death:	19 August 2021
Cause of death:	1(a) SODIUM NITRITE TOXICITY
Place of death:	Coalmine Creek Track, Eastern View, Victoria, 3231

INTRODUCTION

1. On 19 August 2021, Chenna Kesava Sai Prasangi was 20 years old when he was found deceased. At the time of his death, Chenna lived in Belmont, in a share house with friends.

2. In 2019, Chenna relocated to Australia from Visakhapatnam, India, to undertake university studies. He enrolled in a Bachelor of Information Technology at Deakin University, commencing on 24 February 2020.

3. He initially appeared to struggle with university as the classes were quite different to those in India, and they were held online due to the Covid-19 pandemic and associated restrictions. After the first semester he adjusted and was coping well. He worked at 7/11 and was assisted financially by his parents.

4. Chenna's friend Mukesh described him as a quiet and studious person who spent most of his time studying or at the gym. He was healthy and watched what he ate and did not drink alcohol or smoke. He was quite introverted and spent a lot of time alone in his room, largely keeping to himself.

THE CORONIAL INVESTIGATION

5. Chenna'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.

6. 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.

7. 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.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Chenna'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.

9. This finding draws on the totality of the coronial investigation into the death of Chenna Kesava Sai Prasangi 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 narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Circumstances in which the death occurred

10. On 10 August 2021, Chenna purchased a mobile phone, sim card, knife, rope, clothing and a backpack from Kmart in Grovedale.

11. On 12 August 2021, Chenna worked at 7/11 and requested a week off to complete university work. This was his last shift.

12. On the evening of 13 August 2021, Chenna's housemates offered him dinner, but he declined and ate leftovers at the dining table. According to his housemates, he was acting normally.

13. On 16 August 2021, Chenna was reported missing to police. They attended at his home and observed a large amount of personal property in his room, including his computer and passport.

14. At around 9am on 19 August 2021, a passerby was walking her dog near the Coalmine Creek Track when she observed a man, later identified to be Chenna, laying to the side of the track. He was sadly deceased.

15. Police located a small container with eight green pills imprinted with 'P40' and two jars with wet, green crushed tablets near his body. No "suicide note" was located.

[1] 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.

Identity of the deceased

16. On 19 August 2021, Chenna Kesava Sai Prasangi, born 11 August 2001, was visually identified by his housemate, Ravi Tholuchuri, who completed a Statement of Identification.

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

Medical cause of death

18. Forensic Pathology Registrar Dr Joanne Chi Yik Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Chenna Prasangi on 24 August 2021, supervised by Forensic Pathologist Dr Joanna Glengarry. Dr Ho considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, VIFM contact log and scene photographs and provided a written report of her findings dated 25 November 2021.

19. The autopsy showed no significant natural disease which, in itself, would cause death. No significant injuries were identified. The stomach contained green mucus material.

20. Toxicological analysis of post mortem blood samples identified the presence of metoclopramide and propranolol. In addition, excessively elevated concentrations of nitrate were detected in blood (620 mg/L) and urine (110 mg/L), and an excessively elevated concentration of nitrite was detected in urine (270 mg/L) and stomach contents (18000 mg/L).[2]

21. Dr Ho noted that in their entirety, the toxicology results are consistent with excessive consumption of nitrite/nitrate, and therefore the cause of death is most likely to be due to sodium nitrite toxicity. Given the high concentrations present in the stomach contents, it is apparent that the sodium nitrite would have been ingested. However, it is not possible to discern from the autopsy findings how the sodium nitrite was ingested, and in what form.

22. Dr Ho provided an opinion that the medical cause of death was 1 (a) SODIUM NITRITE TOXICITY.

[2] Sodium nitrite and sodium nitrate are inorganic salts that are used in preservation of meats, and often have a white crystalline appearance. Nitrates are relatively innocuous, but upon ingestion, may be converted to nitrites. Nitrites may cause death by formation of methaemoglobin, leading to reduced oxygen transport in the blood, resulting in death by asphyxia.

FURTHER INVESTIGATION

23. Shirley Rooney, General Counsel of Deakin University, provided a statement outlining Chenna's academic progress and engagement with student services. Chenna's only engagement with student services was in June 2021 when he advised the university that he was experiencing financial hardship. He was advised that he could apply for a refund in fees as his account was in credit, but he chose to keep the account in credit to cover the next semester's fees. He was also sent a Woolworths gift card to assist him with living expenses.

24. I make no criticisms of Deakin University regarding the support provided to Chenna or to international students generally; it appears to me that they have a well-considered and fulsome suite of initiatives aimed at supporting this cohort. Rather, the investigation into Chenna's death highlights an ongoing issue repeatedly identified by Victorian coroners. That is, how to encourage international student engagement with services, and, as succinctly put by Coroner Simon McGregor in his investigation into five international student deaths, *how to encourage international students to seek help at all.*

25. I have previously investigated the suicides of Zhikai Liu[3] and Nguyen Pham Dinh Le[4], who were both international students studying in Melbourne at the time of their deaths. I was assisted in these investigations by the Coroners Prevention Unit (CPU)[5]. The CPU identified 27 international student suicides in Victoria for the period of 2009 – 2015.

26. To identify any distinctive features of international student suicides, the CPU compared this cohort with suicides of students aged over 18 who were born in Australia, for the same period. The CPU noted there was a far lower prevalence of diagnosed mental illness, history of self-harm and history of suicide attempts in the international student cohort compared to the Australian-born student cohort. Further, international students were far less likely to attend health services for reasons of mental health, with 22.2% of the international student cohort attending a health service for mental health related issues within six weeks of their death, compared with 57.1% of the Australian-born cohort.

[3] COR 2016 001035.
[4] COR 2018 006222.
[5] The CPU was established in 2008 to strengthen the coroner's 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.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. In the matter of Zhikai Liu, I commented:

   While I am unable to conclude that Zhikai Liu would still be alive if he had engaged with a health service to treat his deteriorating mental state, at the very least this would have created prevention opportunities that did not otherwise exist. Further to this point, the extant literature on international student mental health suggests that there is an underlying systemic issue with engaging international students in mental health treatment in Australia. Published studies have repeatedly found that international students in Australia experience a range of stressors impacting on their mental health, and they are less likely than domestic students to seek assistance for mental health issues because of cultural and financial and linguistic and other hurdles.

   I acknowledge that greater international student engagement with mental health services is a goal far easier articulated than achieved. Researchers have long identified cultural, linguistic, financial and other barriers to such engagement, and I do not have the evidence before me to make specific recommendations about how to overcome these barriers.[6]

2. Some four years later, Coroner Simon McGregor, in investigating the deaths of five international students, commented:

   In reflecting on the circumstances of the five deaths, I have not developed any clear insights into how help-seeking among international students might be promoted, and I consider that a coronial investigation may not be the most suitable mechanism to explore this.[7]

3. As part of his investigation, Coroner McGregor commissioned Orygen[8] to prepare an evidence-based Quality Evaluation Framework which identified ten areas where universities are recommended to review their policies, guidelines and practices, including in the areas of mental health, suicide prevention and postvention, staff training in mental health and suicide awareness, initial orientation for international students, ongoing support for international students, and access to mental health services.

[6] COR 2016 001035, *Finding into death of Zhikai Liu,* delivered 10 January 2019.
[7] COR 2020 001132, *Finding into death of FSB*, delivered 2 October 2023.
[8] Orygen is a not-for-profit mental health service and research institute dedicated to youth mental health.

4. Coroner McGregor provided a copy of the Quality Evaluation Framework to the Suicide Prevention and Response Office of the Victorian Department of Health and recommended that they review the framework and consider whether a resource such as it would *assist universities to assess and review how they support international student health and wellbeing*. He further recommended the Victorian Department of Health consider *developing and maintaining a resource of this type to assist Victorian universities in implementing and reviewing their programs targeted at international student wellbeing.*

5. I reiterate my earlier comments that I do not have the evidence available to me to make recommendations as to how to overcome the barriers for international students to engage with supports. However, I support the recommendations made by my colleague Coroner McGregor and I encourage the Department of Health and universities to continually review the policies and programs they have available to international students to ensure that they are accessible, available and reaching the intended audience.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Chenna Kesava Sai Prasangi, born 11 August 2001;

    b) the death occurred on 19 August 2021 at Coalmine Creek Track, Eastern View, Victoria, 3231;

    c) I accept and adopt the medical cause of death ascribed by Dr Joanne Chi Yik Ho and find that Chenna Kesava Sai Prasangi died from sodium nitrite toxicity in circumstances where I find he intended to take his own life;

2. AND, having considered the evidence before me, I am unable to determine any precipitating factors that led Chenna Kesava Sai Prasangi to adopt the course of action he ultimately chose.

I convey my sincere condolences to Chenna's family for their loss.

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:

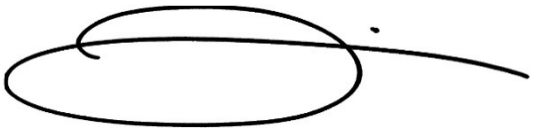
Kavitha & Srinivasu Prasangi, Senior Next of Kin

Deakin University

Department of Health

Detective Senior Constable Mitchell Hardisty, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 22 July 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.