



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2024 004480**

**FINDING INTO DEATH FOLLOWING INQUEST**

*Form 37 Rule 63(1)*

*Section 67 of the Coroners Act 2008*

**INQUEST INTO THE DEATH OF PHI LONG DANG**

Findings of:	Coroner David Ryan
Delivered on:	27 May 2026
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	27 May 2026
Counsel Assisting the Coroner:	Dominique Cuschieri Coroners Court of Victoria
GEO Group Australia Pty Ltd:	Edwina Arms Meridian Lawyers
Secretary to the Department of Justice: and Community Safety	Geordie Biss Office of General Counsel Department of Justice and Community Safety

## INTRODUCTION

1. On 4 August 2024, Phi Long Dang was 35 years old when he passed away at Fulham Correctional Centre (**Fulham**). He was on remand at the time on drug related charges. Fulham is a privately managed prison operated by staff from GEO Group Australia Pty Ltd (**GEO**) and medical services to prisoners at Fulham are provided by GEO Healthcare.

## BACKGROUND

2. Mr Dang was born in Vietnam on 9 October 1988. He moved to Australia in 2009 and commenced a relationship with Tram Bui. They had a period of separation but Ms Bui reported that they had been back together since 2022 and had resided in Southbank. She stated that he had been employed as a butcher and then in a warehouse. She described him as *“a happy go lucky guy who liked singing for church donations”*.
3. Mr Dang had been residing in Australia unlawfully since 28 April 2023, after previously being the recipient of a bridging visa.
4. Mr Dang’s medical history included Hepatitis B. At the time of his death, he was being prescribed entecavir<sup>1</sup> with reported poor compliance. There was no evidence that he had any mental health issues. Mr Dang also had a history of illicit drug use.
5. Mr Dang was identified by Victoria Police as being involved in a criminal syndicate which was distributing heroin in Victoria. He was arrested on 17 July 2023 and charged with various drug related offences, including trafficking a commercial quantity of heroin. He was remanded in custody at the Melbourne Assessment Prison before being transferred to Port Phillip Prison on 20 July 2023. He was then transferred to Fulham on 17 August 2023. While at Fulham, Mr Dang commenced English classes and worked diligently as a cleaner.

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<sup>1</sup> An antiviral medication used to treat Hepatitis B.

6. At the time of his death, Mr Dang was residing in the Lima Unit of Fulham in Pod 2, Room 8. His next scheduled court date was on 26 August 2024. Mr Dang was due to be deported to Vietnam upon his release.

## CORONIAL INVESTIGATION

7. Mr Dang's death constitutes a "*reportable death*" under section 4(2)(c) of the *Coroners Act 2008 (the Act)*, as immediately before his death he was a person placed in custody or care. Section 52(2)(b) of the Act requires that an inquest be held into Mr Dang's death. In the circumstances, I considered it appropriate to hold a summary inquest which occurred on 27 May 2026.
8. At the hearing, a summary of the evidence was provided to the Court by Counsel Assisting. The individual witnesses who provided statements in the brief were not required to give evidence at the inquest as, after carefully considering all of the material in the coronial brief, I was satisfied that there were no significant factual disputes or controversies which remained unresolved in order for me to make the findings required under section 67 of the Act. The Interested Parties were given an opportunity to make submissions in relation to the evidence.
9. The Coroners Court of Victoria is an inquisitorial court.<sup>2</sup> The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.
10. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.
11. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

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<sup>2</sup> Section 89(4) of the Act.

12. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.
13. Coroners are empowered to:
  - (a) report to the Attorney-General on a death;<sup>3</sup>
  - (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;<sup>4</sup> and
  - (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.<sup>5</sup>
14. These powers are the vehicles by which the prevention role may be advanced.
15. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further, they are specifically prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of an offence.<sup>6</sup> It is also not the role of the coroner to lay or apportion blame, but to establish the facts.<sup>7</sup>
16. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles enunciated in *Briginshaw v Briginshaw*.<sup>8</sup>

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<sup>3</sup> Section 72(1) of the Act.

<sup>4</sup> Section 67(2) of the Act.

<sup>5</sup> Section 72(2) of the Act.

<sup>6</sup> Section 69(1) of the Act. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.

<sup>7</sup> *Keown v Khan* (1999) 1 VR 69.

<sup>8</sup> (1938) 60 CLR 336.

17. A directions hearing was held on 28 August 2024 at which it was confirmed that Victoria Police had assigned a member to be the Coronial Investigator for the investigation into Mr Dang's death. The Coronial Investigator conducted inquiries on my behalf and submitted a coronial brief including statements from the forensic pathologist, various correctional officers, medical and custodial records and CCTV footage. Reports were also provided directly to the Court from the Justice Assurance Review Office (**JARO**). Further, the Court obtained a copy of a health review prepared by GEO Healthcare.
18. I will refer only to so much of the evidence as is relevant to comply with my statutory obligations and for narrative clarity.

### **CIRCUMSTANCES IN WHICH DEATH OCCURRED**

19. In the afternoon on 3 August 2024, Mr Dang received a visit from a female friend. The friend and Mr Dang spoke regularly on the phone and she had previously visited him at Fulham on multiple occasions.
20. In accordance with policy, all persons entering Fulham are required to comply with screening processes including walking through metal detectors, passing items through an x-ray machine and submitting to screening from handheld scanners. The x-ray machine detects contraband concealed in the items that pass through it but cannot detect contraband within the person's clothes or otherwise concealed on their person. Should custodial staff have reasonable grounds to suspect that a visitor has concealed contraband, a strip search can be requested.
21. Prior to her visit on 3 August 2024, the friend had complied with the screening process at Fulham and no contraband was detected. A Drug Detection Dog and their handler were operational at the time but they had no involvement in detecting any contraband that may have been carried by the friend as they were occupied in searching another visitor. Further, although available, an Ion scanner<sup>9</sup> was not used to screen the friend.

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<sup>9</sup> Portable Ion scanners provide an additional avenue for screening to detect contraband. They can detect a wide variety of explosives and drugs by collecting samples from items and clothing. The scanners are limited in their

22. CCTV cameras recorded that Mr Dang and his friend spent time at a table in the visitors' centre and also walking in the yard. At times they engaged in intimate behaviour.
23. After the friend's visit and in accordance with policy, Mr Dang was strip searched before he returned to his unit. After he returned to his unit and over the following 18 hours, CCTV cameras recorded that Mr Dang went to the bathroom in his unit on 19 occasions. He also cooked dinner for the other prisoners in his unit.
24. Mr Dang was last known to be alive in the morning on 4 August 2024 when he was seen laying on his bed in his room and gave a verbal response to custodial staff from his cell during a security walk at 10.11am.
25. At 11.47am, after Mr Dang did not present for the midday count, staff found him unresponsive on his bed. A Code Black<sup>10</sup> was called at 11.50am and CERT<sup>11</sup> and medical staff attended shortly afterwards. Medical staff noted that rigor mortis was present with no signs of life. Emergency services were contacted and cardiopulmonary resuscitation (CPR) was commenced. Ambulance Victoria arrived at 12.12pm and Mr Dang was pronounced deceased by paramedics at 12.22pm.
26. Victoria Police did not identify any evidence of suspicious circumstances in Mr Dang's cell.
27. Mr Dang's friend has refused to provide a statement to police and provided "no comment" when she was formally interviewed on 12 November 2024. She was then charged with criminal offences relating to smuggling methylamphetamine into Fulham. The charges were subsequently discontinued on 17 February 2026.

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capacity in that they do not provide explicit evidence that a person has a prohibited substance in their possession, rather the results can provide insight as to whether a person may have had some contact with a prohibited substance.

<sup>10</sup> A Code Black is a medical term which signifies a serious medical incident requiring urgent assistance.

<sup>11</sup> Correctional Emergency Response Team.

## OTHER INVESTIGATIONS

28. Section 7 of the Act requires the coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations.

### *JARO*

29. Mr Dang's death was reviewed by JARO which is part of the Department of Justice & Community Safety (**DJCS**) and reported to the Secretary to the Department (**the Secretary**), who is responsible for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners.<sup>12</sup>
30. JARO prepared a report containing its findings and recommendations which it submitted to the Court in July 2025. The review was conducted in collaboration with Justice Health.<sup>13</sup>
31. In summary, JARO made the following relevant findings:
- (a) Intelligence from the Prison Intelligence Unit (**PIU**) at Fulham suggested that Mr Dang and his female visitor had been trafficking contraband on multiple visits;
  - (b) Custodial staff failed to adequately monitor the friend's visit with Mr Dang on 3 August 2024 in accordance with policy and their intimate contact provided multiple opportunities for contraband to be exchanged.<sup>14</sup> Further, custodial staff failed to report the intimate behaviour to PIU;
  - (c) Barrier control<sup>15</sup> measures at Fulham have limitations that impact drug detection. Further, lack of information sharing between PIU and custodial teams hampers drug detection efforts;

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<sup>12</sup> Section 7 of the *Corrections Act 1986*.

<sup>13</sup> Justice Health is a part of the Department of Justice and Community Safety and has responsibility for the delivery of health services to Victoria's prisoners.

<sup>14</sup> Mr Dang had 97 visits while at Fulham.

<sup>15</sup> Barrier control assists in the detection of controlled and restricted items, limiting their ability to be brought into the facility. They include x-ray machines, handheld metal detectors, Drug Detection Dogs and portable Ion scanners.

- (d) Mr Dang's telephone calls, most of which were in Vietnamese, were not being monitored and there was no information to indicate that he was trafficking contraband into the prison;<sup>16</sup>
  - (e) Improved information sharing could be utilised to better guide intelligence-led operations to detect and intercept contraband being introduced to Fulham; and
  - (f) Management of the emergency response to Mr Dang being found unresponsive met the standards prescribed by Corrections Victoria.
32. JARO identified that the following relevant remedial action had been taken since Mr Dang's death:
- (a) Fulham established a Barrier Control Review Committee to address the increase in contraband across the facility. The committee consists of a multi-disciplinary team of correctional managers, subject matter experts and Barrier Control Champions trained by Corrections Victoria. A focus of the committee is reviewing barrier control technology with a view to upgrading the technology and improving barrier control detection systems. Various new technologies have been identified together with a review of the associated environment where they will be installed.<sup>17</sup>
33. JARO recommended that PIU at Fulham complete and disseminate a monthly intelligence product on emerging trends and risks to relevant custodial staffing groups to influence a more proactive prevention approach.

### ***GEO Healthcare***

34. A Root Cause Analysis was conducted by GEO Healthcare in relation to the medical care provided to Mr Dang at Fulham and the management of the emergency response to him

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<sup>16</sup> In the two weeks prior to his death, Mr Dang made approximately 142 telephone calls to the community.

<sup>17</sup> Independent of Mr Dang's death, the Security Standards Unit of Corrections Victoria is also undertaking a barrier control review project to identify barrier control deficiencies across public and private prisons.

being found unresponsive on 4 August 2024. In its report dated 26 September 2024, the panel identified a number of “learnings” and also made a number of recommendations which are not sufficiently connected to the cause and circumstances of his death to require specific attention in the coronial investigation.

## **IDENTITY OF THE DECEASED**

35. On 4 August 2024, Phi Long Dang was visually identified by Correctional Officer, Anthony Watson.
36. Identity is not in dispute and requires no further investigation.

## **MEDICAL CAUSE OF DEATH**

37. On 6 August 2024, Dr Brian Beer, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) performed an autopsy and prepared a report of his findings dated 13 November 2024.
38. Dr Beer did not find any injuries which would have caused or contributed to death. Evidence of chronic hepatitis was found consistent with a diagnosis of a Hepatitis B infection.
39. An intact 20mm diameter balloon was found in the stomach contents which contained methylamphetamine. Associate Professor Dimitri Gerostamoulos from VIFM advised that methylamphetamine from the balloon had likely leaked into the stomach.
40. Toxicological analysis of post-mortem samples detected the presence of methylamphetamine in the blood and stomach contents. Dr Beer was unable to determine when the balloon was ingested. The level of methylamphetamine detected was 6.2mg/L which is very high. Dr Beer attributed the mechanism of death to stimulant related cardiac arrhythmia and acute heart failure.
41. Dr Beer formulated the cause of death as “*1(a) Methylamphetamine toxicity; 2 Chronic hepatitis*”.

42. I accept Dr Beer's opinion.

## **FINDINGS AND CONCLUSION**

43. I am satisfied that Mr Dang passed away from drug toxicity after ingesting a balloon containing methylamphetamine. It is likely that the ingestion occurred during his visit with his friend on 3 August 2024. The evidence suggests that Mr Dang was unable to pass the balloon over the following hours and some of the contents have leaked into his stomach, leading to cardiac arrhythmia and acute heart failure.

44. There were limitations in the operation of barrier control technology at Fulham at the time of Mr Dang's death which may not have detected contraband being brought into the prison on 3 August 2024. These limitations have been reviewed by GEO and Corrections Victoria and changes have been made to improve the effectiveness of barrier control measures.

45. Having held an inquest into Mr Dang's death, I make the following findings, pursuant to section 67(1) of the Act:

- (a) the identity of the deceased was Phi Long Dang, born on 9 October 1988;
- (b) the death occurred on 4 August 2024, at Fulham Correctional Centre, 110 Hopkins Road, Fulham, Victoria;
- (c) from methylamphetamine toxicity with chronic hepatitis as a contributing factor;  
and
- (d) that the death occurred in the circumstances set out above.

I convey my sincerest sympathy to Mr Dang's family.

Pursuant to section 73(1) 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:

Tram Ngoc Bui, Senior Next of Kin

GEO Group Australia Pty Ltd

Department of Justice & Community Safety

Detective Senior Constable Emily Truin, Coronial Investigator

Signature:



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Coroner David Ryan

Date: 27 May 2026



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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 inquest. 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.

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