



VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST PURSUANT TO SECTION 38 OF THE CORONERS ACT, [SBC 2007] c 15, INTO THE DEATH OF

Duong
SURNAME

Christopher Tangeman
GIVEN NAMES

An Inquest was held at The Burnaby Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates: February 2-10, 2026

before: Larry Marzinzik, Presiding Coroner.

into the death of Duong Christopher Tangeman 38 Male Female
(Last Name) (First Name) (Middle Name) (Age)

The following findings were made:

Date and Time of Death: June 13, 2023 5:00 PM – 8:00 PM
(Date) (time)

Place of Death: 166 Silversides Drive Prince Rupert, BC
(Location) (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Multiple incised wounds (neck and antecubital fossae)

Due to or as a consequence of

Antecedent Cause if any: b)

Due to or as a consequence of

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death: Atherosclerotic coronary artery disease

Classification of Death: Accidental Homicide Natural Suicide Undetermined

Homicide is a neutral term that does not imply fault or blame.

The above verdict certified by the Jury on the 10th day of February AD, 2026

LARRY MARZINZIK
Presiding Coroner's Printed Name

Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Larry Marzinzik
Inquest Counsel:	Steven Liu & Rolf Warburton
Court Recorder:	Helga Sieviewright
Counsel for the Province of BC:	Maureen Abraham & June Ling
Counsel for Northern Health Authority:	Adam Howden-Duke & Mariah Friedrich
Counsel for Dr. Gerald Belgardt & Dr. Chantal Piek:	Kim Yee & David Pilley

The Sheriff took charge of the jury and recorded 18 exhibits. 21 witnesses were duly sworn and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. This is to assist in understanding, but does not replace, the jury verdict and recommendations. This summary is not evidence.

In the early hours of Saturday, June 10, 2023, two Royal Canadian Mounted Police (RCMP) officers were checking an abandoned vehicle near the intersection of Portage Road and Saskatoon Avenue in Prince Rupert, British Columbia. One of the officers testified that the vehicle's rear passenger side door was ajar, and there were several pieces of luggage loaded in the rear of the Mercedes sport utility vehicle (SUV). This witness also testified there were child seats in the vehicle's rear seat and a bag containing a significant amount of cash on the front passenger seat. During the check, Christopher Duong and his wife attended in a truck and confirmed the SUV belonged to Christopher Duong's wife. Christopher Duong advised the officers there was a 'hit' put out on him, which the officers believed to mean someone had offered compensation to have Christopher Duong killed. Christopher Duong's wife appeared stressed and fearful, indicating vehicles were following them and their family was in danger. Neither Christopher Duong nor his wife would offer further information. Christopher Duong and his wife requested that they legally park the SUV and transfer luggage and other items from the SUV to the rear of the truck. They also requested the police follow them to a nearby gas station so they could fill the truck with gas as they planned to drive around until they decided how they would leave Prince Rupert. The officers complied with the request and advised that if they wished additional police assistance, they could call 911 or attend the local detachment. The officers also testified they had previously heard unverified information from other sources that Christopher Duong was involved in the local illicit drug trade.

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After this interaction, one of the officers notified their watch commander of the incident. The watch commander testified that as soon as he was aware of the potential threat to Christopher Duong and his family, he left the RCMP detachment to search for the family as they drove around Prince Rupert. The watch commander located the truck driven by Christopher Duong, with Christopher Duong's wife in the front passenger seat and their two young sons in the rear seat on McBride Street at approximately 2:00 am and conducted a vehicle check after the truck turned left onto 11th Street. This witness testified that the truck, registered in Christopher Duong's name, had several suitcases and other items thrown into the rear of the truck. When speaking with Christopher Duong through the driver's door window, the watch commander observed the handle of a handgun and knife handles by the console of the truck. The watch commander testified he physically removed Christopher Duong from the truck and secured him in the police vehicle. The watch commander then secured the handgun, which was a bear banger gun that would only sound like a firearm but could not discharge a bullet. He also placed the knives in the rear of the truck. The watch commander then testified that he returned to his vehicle to speak with Christopher Duong. Christopher Duong appeared nervous, agitated, and shifty to the watch commander. Christopher Duong could not provide specifics with regards to the 'hit' but felt something was going to happen. Christopher Duong advised the officer there were cars always following him and circling the family residence and that his wife saw the same activity.

The watch commander then spoke separately with Christopher Duong's wife who had remained in the truck. She was on her cell phone and there was a loud female voice stating, 'Chris is not crazy!' over the cell phone speaker. Christopher Duong's wife identified the female as her sister-in-law. She ended the call with her sister-in-law and advised she had not seen any suspicious activity, but stated, 'I don't know what I'm supposed to do ... he's my husband ... I have to believe him.' Christopher Duong's wife agreed with the watch commander when he suggested that Christopher Duong should attend the hospital for a physician's assessment.

The watch commander apprehended Christopher Duong under Section 28 of the Mental Health Act (MHA) and arranged for one of the officers who had the initial contact with the family to escort Christopher Duong's wife to her parents' residence on Silversides Drive in Prince Rupert.

The watch commander escorted Christopher Duong to the Prince Rupert Regional Hospital and provided background information to the medical staff, which included completion of a Mental Health Occurrence Report and a discussion with the attending physician. The watch commander knew Christopher Duong from being neighbors in the community of Port Edward, a small community outside of Prince Rupert. The watch commander remained with

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Christopher Duong until the attending physician could assess him and arrange for him to be held under the MHA in a seclusion room for further assessment and treatment.

The watch commander also advised the medical staff that Christopher Duong had received a brain injury as a result of a motor vehicle incident (MVI) a year before this incident. A physician involved in Christopher Duong's treatment for this previous brain injury testified at the beginning of the inquest that Christopher Duong received rehabilitation treatment from May 2022 until June 2022, with no prescribed medications or necessary follow-up treatment required. The physician testified that future paranoia and delusions are not typically associated with injuries like those suffered by Christopher Duong as a result of the MVI.

The watch commander testified that when he left the hospital at 5:03 am, Christopher Duong appeared content with receiving treatment at the hospital. The watch commander also testified that another police officer advised the Ministry of Child and Family Development of the incident and that Christopher Duong had been committed for treatment under the MHA due to safety concerns for Christopher Duong's young children. Later that morning, the watch commander contacted Christopher Duong's wife to update her on her husband's admission to the hospital for psychiatric assessment/treatment and to expect contact from MCFD in relation to follow-up services.

When attempting to respond to jury questions the watch commander was unable to answer some questions; he testified that when he resigned from the RCMP to join the CN Police Service he was required to leave his notebooks with the RCMP. He testified that since that time his notebooks were no longer available for him to refresh his memory prior to testifying at the inquest.

The initial attending physician testified that they received background information from the watch commander and interviewed Christopher Duong who presented as anxious, guarded, scared and confused. The physician testified that Christopher Duong appeared to be sleep deprived and relieved to be at the hospital. The physician authorized the involuntary admission of Christopher Duong for psychiatric treatment for up to forty-eight hours. Christopher Duong was secured in a seclusion room as he met the criteria for involuntary treatment of a mental disorder and posed a risk to himself or others. The physician testified they sent text messages to the physician coming on duty later that morning so they would be aware of the situation. They testified that the physician coming on duty was Christopher Duong's family physician. This witness also advised there were no psychiatrists in Prince Rupert. If psychiatric treatment was required, Christopher Duong would need to be held in seclusion until he could be transferred to the hospital psychiatric ward in Terrace. She



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stated the transfer may be delayed for an extended period as the Terrace psychiatric ward was often over capacity.

The registered nurse who admitted Christopher Duong into the seclusion room at approximately 0500 hours testified that he appeared paranoid; however, he was cooperative, respectful, and followed directions. She also stated he did not express any thoughts of suicidal or homicidal ideation during his admission to the seclusion room. This nurse monitored Christopher Duong until going off shift prior to the second physician assessing Christopher Duong.

The second physician, who was Christopher Duong's family physician, testified that he received information about Christopher Duong's situation from the initial attending physician at approximately 0800 hours and then attended the hospital. He read the RCMP Mental Health Occurrence report regarding the circumstances surrounding Christopher Duong's apprehension under the MHA and subsequent medical notations of the attending medical staff. He testified that when he attended the seclusion room, Christopher Duong presented as friendly and cooperative and gave no indication of suicidal ideation. He testified when he inquired about Christopher Duong's comments to the police officers that someone was planning to harm him, Christopher Duong advised he did not hold that belief any longer and the whole matter was a misunderstanding. The doctor testified that he discharged Christopher Duong, noting the police were not present to provide any additional information and Christopher Duong was not under arrest. The physician testified Christopher Duong did not present with any mental disorders requiring treatment or indications of being a risk to himself or anyone else. The doctor advised he did not think follow-up support planning was necessary, noting that the Outpatient Mental Health Support Team was not available on weekends. The physician did not notify anyone of Christopher Duong's discharge from the hospital.

The physician also testified that holding a person in the seclusion room(s) was inhumane to the point of torture, which made him reluctant to hold anyone for an extended period, unless necessary. He also mentioned two other factors in his decision-making process to hold a patient under the Mental Health Act in Prince Rupert: the lack of psychiatric nurses at the Prince Rupert Regional Hospital, and a wait time of up to three weeks to have a patient transferred to the psychiatric unit at the Terrace hospital due to capacity issues..

An MCFD intake social worker testified that a police officer notified her at approximately 0600 hours on June 10, 2023, of the circumstances leading to Christopher Duong's apprehension. The information was provided for MCFD assessment of any ongoing risk to the children involved. She noted that there was no recent MCFD reporting with regards to the family. She testified that she consulted with her team leader and a decision was made

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to conduct a follow-up assessment within five days. Key factors in that decision included Christopher Duong being held under the MHA and the rest of the family staying with Christopher Duong's spouse's parents. She stated there was an ability to instead conduct an immediate follow-up by an on-call social worker, if the circumstances warranted it. The intake social worker also testified that this immediate response may have been considered during a subsequent team lead consultation, if MCFD had been made aware of Christopher Duong's discharge from the hospital.

The involved MCFD team lead social worker testified that they consulted with the intake social worker and confirmed the decision made to assign a response within a five-day period, due to the circumstances disclosed by the police. He clarified that the other option would have been to direct action to be taken by a social worker within 24 hours of the report. He also stated that if they had known that Christopher Duong was discharged from the hospital, the team lead would have had the response changed to within 24 hours. He stated there is always an on-call social worker to conduct inquiries when necessary. The team leader also testified that the police did not disclose to the intake social worker that there were bladed weapons present in the vehicle when they apprehended Christopher Duong. He testified this information would also have altered their decision to ensure contact would be made with the family within the 24-hour period.

A social worker who is employed on a casual basis with MCFD testified she was on duty on Tuesday, June 13, 2023, and followed up on the initial report from the police, received on June 10, 2023. She stated she called Christopher Duong's spouse's cell phone number at approximately 1400 hours and a male answered. The social worker asked to speak to Christopher Duong's spouse by using her first name and the male responded that she was asleep. The social worker did not identify herself or leave a message due to privacy issues and to not alarm anyone that MCFD was making inquiries. The social worker testified she called again at approximately 1500 hours and there was no answer.

An audio statement provided to police after the deaths by an acquaintance of Christopher Duong, who was staying at the spouse's parent's residence at the time of the incident, was played for the jury. The acquaintance indicated Christopher Duong had been acting strange during the days prior to the deaths. He stated on the morning of the deaths Christopher Duong 'freaked out' and took the children into their vehicle parked in the driveway. Christopher Duong was 'very paranoid' and had to be convinced to return to the residence. He also stated later that night Christopher Duong's mother-in-law advised him that Christopher Duong, the spouse, and the two children were deceased in their bedroom. He went to the bedroom and observed all four individuals on a bed and described the scene with Christopher Duong having cuts to his arm and legs.

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An audio statement provided by Christopher Duong's mother-in-law to the police was played for the jury. The mother-in-law stated her daughter came to their residence with her grandchildren after Christopher Duong's apprehension due to exhibiting paranoid behavior. She stated that later that day Christopher Duong returned from the hospital and her daughter's family stayed at her residence for the days leading up to their deaths. During those four days she stated Christopher Duong was 'acting really weird', noting he was constantly pacing back and forth. She also stated that on the day of their deaths, she last saw her two grandchildren in the house between 1100 – 1200 hours and her daughter in the garage sometime in the afternoon. Her husband returned from working on their fishing boat later on the evening of June 13, 2023 and they both noticed their daughter, son-in-law, and grandchildren had not come down from their bedroom for dinner. The husband attended upstairs and discovered the daughter and her family members deceased in their bedroom. She stated her husband called the police at this time.

An RCMP officer with the Integrated Homicide Investigative Team (IHIT) testified that he attended the scene on June 14, 2026. He testified to his observations of the scene and identified several scene photographs as exhibits. He testified that Christopher Duong, his spouse, and their two young sons were deceased and laying supine on the bed. He noted that there was an electrical cord around the neck of Christopher Duong's spouse and cuts to the arms and legs of Christopher Duong. He stated there were no obvious traumatic injuries to the two children. He also testified that there was a black handled steak knife near Christopher Duong and a box cutter on the floor under Christopher Duong's arm, which was hanging off the edge of the bed.

The officer continued his testimony by providing the jury with a global overview of the investigative steps taken, including the results of the postmortem diagnostic examinations, which indicated sedation of the children and smothering or strangulation of the children by Christopher Duong, possibly with the cooperation of his spouse. The investigation also determined sedation and strangulation of the spouse by Christopher Duong, after which he took his own life by cutting himself on his arms and legs. The officer also testified that along with Christopher Duong having previously mentioned mental health issues, there was information that he also had financial challenges leading up to this incident.

A forensic pathologist testified that the toxicology results indicated sedation of the children and the spouse at the time of their deaths. He testified this was consistent with non-prescription medications found at the scene. He stated the toxicology results regarding Christopher Duong did not indicate the presence of any substances of significance.

A forensic pathologist testified that Christopher Duong's cause of death was multiple incised wounds (neck and antecubital fossae), with atherosclerotic coronary artery disease as a

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contributing factor. The pathologist testified the incised wounds causing death were consistent with being self-inflicted.

A psychiatrist who works for the University Hospital of Northern BC and the Northern Health Authority, advising in areas of Quality of Standards and Staff Recruitment, testified on the provision of psychiatric treatment in northern areas of BC. She testified that referrals are usually from emergency department physicians and waiting lists can be long for in-person or virtual sessions. The witness stated psychiatric wards are available in hospitals in Prince George, Dawson Creek, Terrace, and Quesnel. Other locations such as Prince Rupert, Vanderhoof, and Smithers have five-day observation / seclusion units from which patients can be transferred to the psychiatric units when requiring extended inpatient treatment. She testified that criteria for involuntary admissions and treatment are prescriptive; however, the final determination relies on the clinical judgment of the involved physician. She stated that all physicians, including herself, have released patients from involuntary treatment sooner than they should have due to psychiatric ward capacity issues.

This witness testified that wraparound care for outpatients involving outreach counsellors, medication, appropriate housing, and proactive support services, are provided but are not always consistently available. Availability depends on the location, resources, and clinical judgment of the involved physician. She stated it would be beneficial to hire psychiatric/mental health nurses in all emergency departments to assist physicians in processing mental health patients. The psychiatrist testified recruiting mental health care professionals was more of a challenge than retaining them in northern BC communities. She testified there was a lack of secure, involuntary care facilities and substance use treatment capacity in both the Northern Health Authority area and around the province.

A Regional Director for the Northern Health Authority testified to policies and procedures relating to patient information disclosure and related limitations due to privacy laws.

The Deputy Director of Child Welfare for MCFD testified to the policy and process for case reviews. He also testified that a review related to this incident concluded that the actions taken by the intake social worker in consultation with the team lead social worker were appropriate, considering the information provided. He noted that since the initial report from police did not disclose that bladed weapons were present within the vehicle driven by Christopher Duong and occupied by his children, that significant factor was not available to MCFD staff making the response decision.

At the conclusion of witness testimony, inquest counsel, in agreement with all participating counsel, informed the jury that hospital staff did not finalize or consider Christopher Duong's lab tests prior to his release from hospital the day of his apprehension.



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Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:

JURY RECOMMENDATIONS:

To: Minister of Health

1. Consider implementing a change to the involuntary admission form (Form 4.1, Section 28 of the *Mental Health Act*) that would allow the apprehending police officer or constable to indicate their contact information and that they need to be informed on discharge of a patient that is involuntarily admitted under Section 28 of the *Mental Health Act*. If this is requested, the hospital will need to inform the party upon discharging the patient.

Presiding Coroner Comment: *The jury heard testimony from witnesses that the RCMP and MCFD were not updated on the patient's situation. Such an update would have triggered a different response. In addition, witnesses stated they did not contact other agencies or the hospital to get information, as they felt they would not be given it.*

Evidence and testimony from the discharging physician showed that the RCMP was not on site during his examination. Since they were not there, he stated he had no way to "confirm or refute allegations", gain additional information, or provide an update to the RCMP.

This recommendation is intended to improve information sharing between involved parties, such as allowing police officers to update their reports to other agencies, for example the Ministry of Children and Family Development. It will also increase physicians' ability to collect collateral information.

2. Direct resources towards expanding the number of hospitals that offer psychiatric and mental health resources and services.

Presiding Coroner Comment: *The jury heard that there were little to no mental health or psychiatric resources available in Prince Rupert, or that such resources were not available on the weekends. In addition, testimony was heard that due to high volumes of long-term and intensive care patients, most existing treatment centres have limited beds, resources, and time for patients with milder mental health issues.*

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- Investigate ways to improve follow-up and wraparound services to patients following discharge from involuntary admission under the *Mental Health Act*.

Presiding Coroner Comment: *The jury heard conflicting testimony from different agencies and professionals on available psychiatric and mental health resources. A witness stated that the lack of consistency in care and resources often left patients feeling unsupported upon leaving care.*

To: RCMP "E" Division

- Review training to ensure the quality and specificity of information provided by law enforcement to the Ministry of Children and Family Development regarding child protection matters.

Presiding Coroner Comment: *The jury heard from the Ministry of Children and Family Development that they were not informed of the presence of bladed weapons. Witnesses stated that this information would have changed their assessment of the situation and their response time. Additionally, witnesses stated that if they had been aware of Mr. Duong's discharge from the hospital, they would have responded faster.*

- Consider an enhanced system to ensure preservation of discharged police officers' notebooks.

Presiding Coroner Comment: *The jury heard evidence that the individual notebooks of Cst. Jones, which he handed over to the detachment when leaving Prince Rupert, were later lost. They contained information that could have been crucial in later investigations, including this inquest.*

To: Northern Health Authority

- Consider ways to support the recruitment and retention of psychiatric nurses and/or Mental Health Liaisons, potentially by expanding training opportunities in rural and remote communities.

Presiding Coroner Comment: *The jury heard evidence about a lack of psychiatric nurses or other mental health support staff in the Northern Health Authority.*

The jury also heard testimony by witnesses that local training programs in northern health communities have improved recruitment and retention of health-care professionals — and of mental health professionals, in particular.

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To: Prince Rupert Regional Hospital

7. Review the physical setup of the seclusion rooms and assessment spaces, and the policies concerning how patients are lodged when involuntarily admitted under the *Mental Health Act*.

Presiding Coroner Comment: *The jury heard testimony that physical setup of the seclusion rooms was such that it approached "torture". Physicians testified they were uncomfortable keeping patients in these rooms for extended periods of time. In addition, the jury heard virtual consultations between patients and psychiatrists are not an ideal assessment method but a necessity in locations such as Prince Rupert, where no psychiatrists are available for in-person assessments.*

8. Consider completing all tests ordered by physicians managing the care of a patient involuntarily admitted under the *Mental Health Act*. If tests are no longer relevant, consider if there should be a necessary sign-off from a physician before such tests are discontinued.

Presiding Coroner Comment: *The jury heard evidence that the hospital never completed tests ordered by the admitting physician.*

To: Minister of Children and Family Development

9. Provide training to social workers locally and in screening centres on admission, duration, and release criteria for patients admitted to hospital involuntarily under the *Mental Health Act*.

Presiding Coroner Comment: *The jury heard that social workers made assumptions concerning hospital procedures regarding a patient apprehended under Section 28 of the *Mental Health Act*, and those assumptions affected the decisions they made in assessing and responding to the case.*