Ministry of Public Safety and Solicitor General
Coroners Service
Province of British Columbia

File Number: 2023-0701-0035

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	**Harlan Hoang**
SURNAME	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 (Last Name) Harlan Hoang (First Name) (Middle Name) 2 (Age) [x] Male [ ] Female

The following findings were made:

Date and Time of Death: June 13, 2023 (Date) 5:00 PM – 7:30 PM (time)

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

Medical Cause of Death:

(1) Immediate Cause of Death: a) Asphyxia

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:

Classification of Death: [ ] Accidental [x] 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

[signature]
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 Sievewright
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.

Royal Canadian Mounted Police (RCMP) officers testified that Harlan Duong (two years of age) was a passenger in a truck operated by his father checked by the police on two occasions during the early morning hours of Saturday, June 10, 2023. Harlan Duong's mother and older brother were also in the truck during these police checks. During the second check Harlan Duong's father made vague comments with relation to his and his family's lives being in jeopardy. An RCMP officer testified that he apprehended Harlan Duong's father under Section 28 of the Mental Health Act as a result of these conversations. Harlan Duong's mother drove the truck with him and his brother to his grandparents' residence in Prince Rupert and his father was escorted by police to the Prince Rupert Regional Hospital for assessment by a physician.

An emergency room physician testified that he assessed Harlan Duong's father and detained him at the hospital involuntarily under the Mental Health Act for further assessment and treatment. The police officer who apprehended Harlan Duong's father testified that the Ministry of Children and Family Development (MCFD) was advised of the situation due to safety concerns related to the children at the time of the initial apprehension. Harlan Duong's father was reassessed by another emergency department physician later that morning. The second physician believed Harlan Duong's father was not a threat to himself or others, so he was discharged with no further follow-up treatment or disclosure to the RCMP or MCFD. Harlan Duong's father went to Harlan's grandparents' residence, where their family resided until they were discovered deceased in one of the bedrooms on the evening of June 13, 2023.

Evidence was heard that while Harlan Duong's family stayed at his grandparents' residence his father exhibited unusual behaviour, including restlessness and paranoia. An RCMP officer who was involved in the subsequent police investigation into the deaths of the family members testified that Harlan Duong's parents created a video on the evening of June 10, 2023, advising of their last will and testament. This officer also testified that Harlan Duong's father was also experiencing financial challenges during this period.

On the evening of June 13, 2023, Harlan Duong's grandfather went to check for Harlan Duong and his family as they had not attended supper. The father found Harlan Duong, his father, his mother, and his brother deceased on a bed in an upstairs bedroom. The investigating RCMP officer testified that all four family members were laying supine on the bed. Harlan Duong and his brother had no noticeable signs of physical trauma. Harlan Duong's mother was found with a black cord tied around her neck and his father had numerous lacerations to his arms and legs. The officer testified that the police investigation determined Harlan Duong's father smothered or strangled Harlan and his brother, strangled their mother, and then took his own life by inflicting the cuts on his arms and legs.

A forensic toxicologist testified that Harlan Duong had been sedated with substances consistent with non-prescription medications found at the scene.

A forensic pathologist testified that Harlan Duong's cause of death was asphyxia.

The jury made recommendations in relation to this incident on the Verdict at Coroner's Inquest regarding Harlan's father's death (BC Coroners Service Case 2023-0701-0032).

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:

No recommendations.

***Presiding Coroner Note*:** Although no recommendations were made directly related to the death of Harlan Hoang Duong, the jury made recommendations relating to his father's death which may also lead to the prevention of actions like those of his father which led to his death. Those recommendations are:

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.

3. 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

4. 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.*

5. 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

6. 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.

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.*