**HAMILTON POLICE SERVICE
CONFIDENTIAL
INFORMATION REPORT**

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| **TO:** | Chair and MembersHamilton Police Service Board |
| **BOARD MEETING DATE:** | June 26, 2025 |
| **SUBJECT:** | Special Investigation Unit’s Probe into the death of P.K.SIU File 24-OCD-296 |
| **REPORT NUMBER:** | 25-043 |
| **PRESENTATION:** | No |
| **OUTSTANDING BUSINESS ITEM:** | No |
| **SUBMITTED BY:** **SIGNATURE:** | Frank Bergen, Chief of PoliceActing Chief Bergen's Signature |

**BACKGROUND**

Provincial legislation requires that the Chief or designate shall conduct an investigation promptly into any incident in which the Special Investigations Unit (SIU) has investigated a member of a police service. The purpose of the Chief’s investigation is to investigate the member’s conduct in relation to the incident, the policing provided by the member in relation to the incident, and the procedures established by the Chief of Police as they related to the incident (Section 81(4)). The Chief is mandated to make the report to the Board within 90 days after the SIU Director publishes a report in respect of the incident (if no charges are laid), or within 90 days after the disposition of the charges (if charges are laid) (Section 8(3) of Ontario Regulation 90/24). The Board shall publish the report on the internet within 30 days of receiving the report (section 8(5) O. Regulation 90/24).

**EXECUTIVE SUMMARY**

On July 8, 2024, Hamilton Police Service (HPS) officers responded to a call for service to assist paramedics with an emergency medical call. Officers assisted in restraining the Complainant while paramedics administered doses of sedation. The Complainant went vital signs absent. The Complainant was taken to hospital, but died on July 10, 2024. Due to officers assisting with the initial medical call, a notification of the Special Investigations Unit (SIU) was required. The SIU undertook an investigation; their determination was that the involved Officers were legally justified in their actions (The SIU was notified of this incident three times by the HPS and invoked their mandate only after a Regional Coroner classified the death as an “in custody death”).

* On July 8, 2024, Subject Official #1 (SO #1), Subject Official #2 (SO #2), Subject Official #3 (SO #3), Witness Official #2 (WO #2) and Witness #1 (W #1) were dispatched to the Complainant’s residence to assist paramedics with an emergency medical call. The Complainant appeared to be suffering from excited delirium. Paramedics required police to restrain the Complainant so he could be administered a sedative and transported to hospital.
* The Complainant was administered a sedative but soon stopped breathing. CPR was commenced by paramedics. The Complainant was admitted to hospital in critical condition. The SIU was notified but did not invoke their mandate, deeming the matter non-jurisdictional.
* On July 10, 2024, the Complainant died in hospital. The Hamilton Police Professional Standards Branch were made aware on July 11, 2024. The SIU were again contacted but did not invoke, still deeming the matter non-jurisdictional. A Regional Coroner classified the death as an “in custody death”. The SIU were contacted a third time and made aware of this classification, they invoked their mandate and commenced an investigation.
* In the report prepared by the SIU Director Joseph Martino, he stated “The subject officials were lawfully placed and in the execution of their duties through the series of events culminating in the Complainant’s loss of vital signs on July 8, 2024. Following CW #1’s 911 call for help in relation to the Complainant, and the subsequent call by paramedics seeking police assistance, the officers were within their rights in doing what they reasonably could to protect and preserve the Complainant’s life – an officer’s foremost obligation. In the discharge of that duty, I am satisfied that the subject officials comported themselves with due care and regard for the Complainant’s health and wellbeing.”
* The SIU report also addresses the cause of death “The pathologist at autopsy attributed the Complainant’s death to “complications of cocaine toxicity in a man with hypertensive heart disease, atherosclerotic coronary artery disease and physical activity”.”
* As provincially mandated, a comprehensive investigation was undertaken of the events and information gathered in relation to the complaint. It was determined that there were no breaches of Hamilton Police Service Policies and Procedures and no misconduct on the part of the Officers.

FB/W. Mason

c: Paul Hamilton, Deputy Chief – Support

 Will Mason, Superintendent – Professional Development Division

Marco Visentini, Legal Counsel