**HAMILTON POLICE SERVICE  
CONFIDENTIAL  
INFORMATION REPORT**

|  |  |
| --- | --- |
| **TO:** | Chair and Members  Hamilton Police Service Board |
| **BOARD MEETING DATE:** | September 25, 2025 |
| **SUBJECT:** | Special Investigation Unit’s Probe into the death of E.K.  SIU File 24-OFD-479 |
| **REPORT NUMBER:** | 25-054 |
| **PRESENTATION:** | No |
| **OUTSTANDING BUSINESS ITEM:** | No |
| **SUBMITTED BY:**  **SIGNATURE:** | Frank Bergen, Chief of Police  Acting 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 November 9, 2024, Hamilton Police Service Officers responded to a Suspicious Person call for service at 1964 Main Street West, Hamilton. The Caller stated a male she did not know attended her apartment door and knocked. The Caller thought he had a gun in his hand. Attending Officers spoke with the Caller and upon exiting that apartment, the Complainant exited his apartment and approached the Officers while pointing a black handgun at them. The Officers moved away down the hallway, gave verbal commands and ultimately discharged both their service pistols and a Conducted Energy Weapon (CEW). The Complainant was struck by multiple shots and went down. Emergency Medical Services (EMS) transported the Complainant to Hamilton General Hospital (HGH); he was pronounced deceased on November 10, 2024. The Special Investigations Unit (SIU) was notified and invoked their mandate. The SIU investigation determined that the involved Officers were legally justified in their actions.

* On November 9, 2024, Hamilton Police Officers, Subject Official #1 (SO #1) and Subject Official #2 (SO #2), were dispatched to 1964 Main Street West, Hamilton, regarding a suspicious person call. From dispatch they were told there was a 15 minute time delay with this call. The Caller (CW #1) had a man she did not know attend her door, when she opened it he said something similar to “I didn’t know you moved”. The Caller believed he had a gun in his right hand. The male was described as black complexion, about 40 years old, 5’ 11”, average build and wearing a black baseball hat. This call was classified as a Suspicious Person call and listed as a Priority 2. A Supervisor was not made aware of this call.
* Upon arriving at the Caller’s floor, both SOs observed the Complainant in the hallway. Both SOs called out to him. The Complainant entered apartment #503 and locked the door. This was communicated with dispatch. At that time, the Complainant was not seen to be brandishing a firearm. From the dispatch system, the dispatcher was unable to provide any background information about this apartment or its occupants. SO #2 watched apartment #503 as they spoke with the Caller. It was confirmed with the Caller that the male she reported was the same individual Officers saw in the hallway (the Complainant) and that he had attended her door multiple times.
* The Complainant exited his apartment. Both SOs stepped into the hallway. The Complainant was holding a handgun at his side (later determined to be a replica handgun). He raised the handgun in the direction of the SOs. SO #2 gave orders to the Complainant to drop the gun. SO #1 observed the Complainant pulling the trigger. SO #2 fired rounds at the Complainant first; she fell as she moved backward. The Complainant continued to move forward with the handgun raised. SO #1 fired rounds at the Complainant; he too fell as he moved backward. The Complainant continued to move forwards with the handgun raised. SO #2 had lost possession of her firearm due to her fall, and attempted to deploy her CEW on the Complainant; it had no effect. SO #1 fired a second volley of rounds at the Complainant, the Complainant collapsed and fell to his back.
* At 1700 hours, SO #1 relayed to dispatch that shots had been fired. Two Patrol Sergeants were notified and dispatched to the call. SO #1 also relayed that he had been hit; he had incurred an injury to the back off his head. Although initially thought to be a gunshot injury to SO #1, the injury to his head was incurred as a result of his fall. SO #2 checked on SO #1, then began to render first aid to the Complainant.
* The Complainant was transported to HGH on November 9, 2024, by EMS. He was pronounced deceased on November 10, 2024.
* The Hamilton Police Professional Standards Branch was advised on November 9, 2024. The SIU was contacted, they invoked their mandate and commenced an investigation.
* In the report, attached as Appendix ‘A’, prepared by the SIU Director Joseph Martino, he stated “On my assessment of the evidence, there are no reasonable grounds to believe that either subject official committed a criminal offence in connection with the Complainant’s death.”

Director Martin also stated “SO #1 and SO #2 were lawfully placed and in the execution of their duties through the series of events culminating in the shooting. They were at the home of CW #1 to investigate CW #1’s recent encounter with the Complainant in which he persisted in trying to enter CW #1’s apartment while holding what CW #1 believed was a possible firearm.

The evidence further establishes that SO #1 and SO #2 fired their weapons at the Complainant believing it necessary to protect themselves from a reasonably apprehended assault. That is the account that each officer provided the SIU, the former by way of an interview and, the latter, in her notes. And their accounts are buttressed by the circumstantial evidence, namely, the appearance of the Complainant pointing what appeared a gun in their direction at close range.

I am also satisfied that the force used by the officers constituted reasonable force. The officers honestly believed they were looking at an actual gun in the Complainant’s possession. Though mistaken, their misapprehension was a reasonable one. The object looked like a gun, the Complainant brandished it as a gun, and CW #1 had just reported what CW #1 believed was a gun in his possession.”

* The replica handgun brandished by the Complainant:



* The Report of Postmortem Examination attributed the cause of death of the Complainant as multiple gunshot wounds. Eight gunshot wounds are medically described, one of which was fatal injuring the heart, liver and kidney. Many of the other wounds were deemed medically significant. The toxicological analysis of postmortem blood was also included. Results indicated a blood ethanol level of 252mg/100ml as well as the presence of ketamine, amphetamine, tetrahydrocannabinol (a cannabinoid found in cannabis known as THC), hydroxytetrahydrocannabinol (a metabolite of THC), carboxytetrahydrocannabinol (a metabolite of THC), fluoxetine (an antidepressant, sold under the brand name Prozac) and norfluoxetine (a metabolite of fluoxetine).
* The Hamilton Police Service Use of Force Section was requested to review the interaction and provide an assessment of the SO’s actions. To assist in this task, data from the Force Science Institute was utilized. The Force Science Institute focuses on the research and application of unbiased scientific principles and processes to determine the true nature of human behaviour in high stress and deadly force encounters. Their organization undertakes research, training and consulting. Force Science fulfills an essential need for psychological and physiological analysis of the demanding and often-controversial situations in which force is used, up to and including officer-involved shootings. They are relied upon by the Ontario Police College and other police organizations throughout North America. The assessment of the Hamilton Police Service Use of Force Section determined:
  + The SOs initially interacted with the Complainant with a short engagement distance, limiting the decision to use force. They were in a long, narrow hallway, with no immediate way to exit the hallway to disengage. There was also no area to provide cover from the perceived firearm. The Complainant was out in the hallway, with many other tenant doorways so containment was not an option. There was no viable de-escalation or conflict prevention strategy that would have been suitable.
  + The SOs, believing that they were in a situation where grievous bodily harm would result to themselves or the public, responded by discharging their firearms at the Complainant. The force used was necessary to prevent this harm and that less force could not stop the threat in time (a CEW was also discharged with no effect). The force was proportional to the force encountered; i.e., lethal force with a firearm was used to stop a lethal force (by firearm) encounter. The force was reasonable as it was not disproportionate to the force encountered.
  + Regarding the number of projectiles discharged at the Complainant, as per the Force Science Institute, the most common reaction to being shot is no reaction. Physical incapacitation requires damage and time. A mortally wounded subject can continue to function for up to 15 seconds. This helps to explain the number of rounds discharged by responding SO’s because the complainant kept moving toward them.
  + Regarding the number of projectiles that actually struck the complainant, again Force Science Institute indicates that the average is a 30% hit rate (7 out of 10 rounds will miss in a dynamic environment). The SOs fired 21 projectiles and the Complainant was struck 8 times.
  + Regarding the perceived gunshot injury by SO #1, being involved in a lethal force encounter is accompanied by high levels of stress. When SO #1 discovered he had a head injury, his initial belief that he had been shot is both reasonable and normal.
* 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.

The Special Investigations Unit Act, section 35.1 (1), dictates that if, during the SIU’s investigation, potential police officer misconduct is discovered (as defined in the Community Safety and Policing Act), The SIU Director shall notify the Complaints Director. As well, section 35.2 of the SIU Act dictates that if, during the SIU’s investigation, potential issues are discovered relating to the adequacy and effectiveness of policing including policies and procedures, the SIU Director shall notify the Inspector General of Policing. At the conclusion of the SIU Investigation, the SIU Director did not make any notifications to the Complaints Director or the Inspector General of Policing.

* The initial call for service was entered as a Suspicious Person. From the Standard Operating Procedures, this event type is used for a person(s) who appears to be acting in an unusual or suspicious manner. Two officers will be dispatched to this type of call, no supervisor is made aware and it is deemed a Priority 2. In this case there was a 15 minute time delay, the Caller didn’t know who the Complainant was, or where he went. The officers were made aware the Caller believed she saw the Complainant armed with a handgun.

This call could have been dispatched as a Weapon/Armed Person call. The Standard Operating Procedures would have directed that two officers are dispatched, a supervisor is made aware, and it would be deemed a Priority 1. If an officer on scene advises the incident is high risk, the supervisor would be dispatched and further steps, such as seeking the Emergency Response Team (ERU), would be considered.

The initial dispatch response of two officers is the same for either dispatch type call. The call Priority 1 translates to “in progress” while a Priority 2 call translates to “just occurred”. In this incident, a time delay in reporting of 15 minutes accompanied with no known location for the Complainant (at the time of report) would downgrade the dispatch priority to a Priority 2. With the limited information provided to SO #1 and SO #2, it is reasonable they would not have, initially, sought out a supervisor or additional assistance from the ERU. Further, given that the call came from an apartment building, which would have a large number of residents, not entering the building would not be a viable option when weighed against the safety of the residents. As well, without knowledge of the Complainant’s location, having the Caller leave her secure apartment would also not be an acceptable option. A similar situation may be assessed differently if the premise had been a single detached dwelling.

* The Hamilton Police Service Homicide Unit were tasked with undertaking a parallel investigation. Although their investigation has not been concluded, it includes the actions of the Complainant prior to contact with the police; when he attended the door of the Caller with a handgun and later returned to the door, at one point attempting to open it. Should the Complainant have survived, criminal charges of criminal harassment (with the Caller as the victim) and assault with a weapon (with the SOs as the victims) could have been potentially laid against him.
* A comprehensive review of this incident has been conducted both internally and externally. While the circumstances are tragic, the involved members responded in accordance with provincial training and the law. The circumstances here will be used to assist in training for all HPS members.

**APPENDICES AND SCHEDULES ATTACHED**

Appendix A – SIU Director’s Report

FB/W. Mason

c: Paul Hamilton, Deputy Chief – Support

Will Mason, Superintendent – Professional Development Division

Marco Visentini, Legal Counsel