CORONERS' REPORT

死因裁判官報告

2024

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第一部

2024年死因裁判官報告

死亡數字上升趨勢

1. 今年共有 52,366 宗死亡登記，至於曾向死因裁判官報告的死亡個案，則有 12,281 宗。過去 24 年的數字列出如下：

	死亡登記數字	曾向死因裁判官報告的個案
2001	33,305	7,733
2002	34,316	7,890
2003	36,421	9,315
2004	37,322	9,108
2005	38,683	9,506
2006	37,415	9,025
2007	39,963	9,422
2008	41,530	10,314
2009	41,034	10,070
2010	42,705	9,999
2011	42,188	10,017
2012	43,672	10,472
2013	43,399	10,249
2014	45,710	10,598
2015	46,757	10,767
2016	46,662	10,773
2017	45,883	10,768
2018	47,479	10,976
2019	48,706	11,168
2020	50,653	12,680
2021	51,536	12,694
2022	61,557	17,193

2023	56,776	12,996
2024	52,366	12,281

2. 從上表可以看到，死亡登記數字由 2001 至 2005 年按年遞升，到了 2006 年才稍微下跌；而在過去 16 年，即 2007 至 2022 年期間，數字反覆向上。2024 年的死亡登記數字及向死因裁判官報告的個案相對 2023 年下跌，而向死因裁判官報告的個案，更有超過百分之五的跌幅。

死亡個案調查

3. 警方會調查每宗有向死因裁判官報告的死亡個案，並把調查報告連同臨床病理學家或法醫科醫生的驗屍報告提交死因裁判官。死因裁判官會考慮警方的報告和驗屍報告，如果認為警方所進行的調查已提供足夠資料，令死因裁判官能夠履行《死因裁判官條例》第 9 條中所述的職責，而死亡原因和有關的情況又清晰並無可疑之處，便會根據世界衞生組織所制訂的《疾病和有關健康問題的國際統計分類》，把有關的死亡個案分類並給予編碼，以便生死登記官登記。

4. 縱使警方初步認為該死亡個案沒有可疑，如果我們認為有關的死亡個案須予進一步調查，便會通知警方展開相關的調查和提交更詳盡的死亡調查報告。我們會根據警方第一份調查報告考慮每一死亡個案的所有情況後，行使司法酌情權作出上述指示。警方展開進一步調查和提交更詳盡的報告通常需時六至十二個

月，有時甚至更久。我們會在閱讀該份報告和考慮有關個案的所有情況後，決定是否進行死因研訊。

5. 至於受官方看管期間死亡的個案，法例規定必須進行研訊。死因裁判官會要求警方就這些個案展開進一步調查和提交詳盡的死亡調查報告，以便進行死因研訊。

6. 下表列出關於過去二十四年曾向死因裁判官報告的死亡個案的處理方式的數字：

	向死因裁判官報告的個案	須予進一步調查的個案	進行研訊的個案	有陪審團參與的研訊	沒有陪審團參與的研訊	有陪審團的研訊的百分率
2001	7,733	2,374	158	71	87	45%
2002	7,890	2,451	132	83	49	63%
2003	9,315	2,678	108	67	41	62%
2004	9,108	2,059	141	99	42	70%
2005	9,506	1,351	189	150	39	79%
2006	9,025	1,061	210	181	29	86%
2007	9,422	767	185	155	30	84%
2008	10,314	1,364	145	135	10	93%
2009	10,070	1,260	193	167	26	87%
2010	9,999	1,106	172	131	41	76%
2011	10,017	1,224	182	149	33	82%
2012	10,472	1,420	164	138	26	84%
2013	10,249	1,099	176	140	36	80%
2014	10,598	967	148	139	9	94%
2015	10,767	751	100	93	7	93%

2016	10,773	730	77	63	14	82%
2017	10,768	1,128	117	112	5	96%
2018	10,976	1,083	161	152	9	94%
2019	11,168	1,047	130	114	16	88%
2020	12,680	1,099	74	64	10	86%
2021	12,694	1,120	163	150	13	92%
2022	17,193	1,199	139	122	17	88%
2023	12,996	999	184	172	12	93%
2024	12,281	995	147	128	19	87%

7. 近年越來越多死者的家人、死者家人的律師代表及有利害關係人士要求進行公開研訊，所牽涉的議題亦較過往複雜，而且有關的死亡個案大多涉及醫療或手術事故。提出要求研訊的人士通常誤解研訊的目的是調查和決定死者是否死於醫療或手術不當。在處理這些要求時，死因裁判官通常會行使酌情權滿足死者家人的要求，命令警方提交進一步調查報告，以及獨立的醫學專家報告，以便死者的家人可藉此更詳細了解死因和有關的情況。此外，在有需要的情況下，尤其是在看來可以作出有用的建議的情況下，死因裁判官也會進行死因研訊。

8. 死因研訊的主要作用，是通過公開聽證，希望能得知有關死亡的真相，務求在適當的個案中提出切實可行的建議，以期防止類似死亡事故。研訊另有一個重要的功能，是希望家人能夠在研訊過程中，親眼見到證人作供，親耳聽到證人的證詞，從而希望對於親人的死亡，能夠釋懷。

內庭申請

9. 死者的家人可以到死因裁判官席前申請豁免進行屍體剖驗，有關的申請程序在以前的報告中已有所說明。處理這些申請是死因裁判官一項非常重要而困難的工作。由於公眾須了解死因裁判官這方面的工作，因此有關的程序會在此再予以說明。

10. 公立醫院的臨床病理科醫生或衞生署的法醫科醫生通常都會查看死者的醫療記錄和致死經過，以及對屍體進行外部檢驗。如果他們未能決定死因，便會向死因裁判官建議須進行屍體剖驗以查明死因。死者的家人對這項建議很多時候都深感不悅，並會到死因裁判官席前提出他們所堅信的文化上、宗教上和其他方面的理由，以證明不應進行屍體剖驗。於 2024 年，死因裁判官一共處理了 486 宗屬於此類別的申請。

11. 在處理這類申請時，死因裁判官絕對明白死者家人的關注，他們本身已因痛失親人而情緒深受困擾，再加上如果死者生前一向表示害怕和厭惡施手術或甚至住院治療的話，許多死者的家人便會對須進行屍體剖驗的建議感到極難接受。

12. 每一個案都必須根據它本身的情況處理，而進行屍體剖驗的目的通常都是找出死亡原因。根據世界衞生組織和《生死登記條例》的規定，死因裁判官有法定責任找出每一死亡個案的死亡原因，以及按照訂明的分類準則把死亡個案分類。生死登記官在

死亡登記冊上登記一宗死亡個案之前，亦有責任先找出死亡原因。死因裁判官在找出死亡原因時，很多時會致電法醫科醫生或病理科醫生或甚至病房醫生跟他們討論研究，以決定可否根據相對可能性的衡量標準來推斷某項死因。不過，在某些個案中，法醫科醫生或病理科醫生可能由於死者的病歷資料不足而沒有足夠的醫學證據來推斷死亡原因，在此情況下，便須向死者家人詳盡解釋須進行屍體剖驗的理由。

13. 近年來，由於公立醫院和衞生署法醫部門在死因裁判官的建議下加強病歷資料的交流，法醫科醫生現在已可以獲得更多在臨終前曾於公立醫院接受治療的病人的病歷資料，因此有較大機會無須進行屍體剖驗也能確定死亡原因。

14. 死因裁判官一方面有責任確定每一宗死亡個案的死亡原因，但另一方面亦須考慮死者家人的情緒和感情。因此，在處理每一項要求豁免進行屍體剖驗的申請時，死因裁判官都必須在考慮所有有關因素和情況後謹慎地行使他的職權。

<u>自殺個案</u>

15. 今年有 1,138 宗自殺個案，較 2023 年增加了百分之四。其中 160 宗須由警方進一步調查並提交更詳盡的死亡調查報告。男性自殺人數和往年一樣，遠高於女性，比率為 762:376。青少年自殺組別的個案與去年相若。

意外死亡個案

16. 今年有 767 宗意外死亡個案，其中 272 宗須由警方進一步調查並提交更詳盡的死亡調查報告。上述意外死亡人數較去年相若。男性因意外引致死亡的數字遠高於女性，比率為 523:244。

職業死亡個案

17. 過往直至 2009 年的死因裁判官報告，均只提到有進行死因研訊的職業死亡個案的數目，我們經過考慮之後，認為這樣並不能較全面反映整體情況，因此自 2010 年開始提到的數字，便包括了所有與職業有關的意外(包括陸上和海上) 而引致的死亡個案。整體職業死亡個案共有 47 宗，全部在陸上發生的。42 名死者是男性，5 名是女性，比率為 42:5。

殺人個案

18. 今年有 14 人死於被殺，其中男性佔 9 人，女性佔 5 人。

車輛導致死亡的個案

19. 今年有 110 宗由車輛導致的死亡，其中 62 名死者是行人，佔去死亡數字約一半。62 名死者中，有 29 名是 70 歲以上的老人家，佔此組別的死亡數字約一半。很明顯，老人家在交通意外中，比任何其他年齡組別的人，更容易成為受害者。男女性死者的比率是 80:30。

與毒品及藥物有關的個案

20. 今年有 140 宗死亡與毒品或藥物有關，和去年比較減少了百分之十六，大部份為危險藥物，當中包括自殺、意外及意圖不明的個案，男女死者的比率是 101:39。

自然死亡個案

21. 今年因各種疾病而死亡的人數是 10,478 人，其中因循環系統疾病而死亡的有 4,862 人，佔這個類別的死亡人數約一半。根據《疾病和有關健康問題的國際統計分類》，循環系統疾病包括各種高血壓病、各種心臟病、腦血管病等等。男女性死者的比率是 6,136: 4,342。

22. 我們可以看到，以上各項所提到的死亡數字，都是男性高於女性，有些死亡類別，例如職業死亡個案甚至是 42 與 5 之比。

建議

23. 一如往年，死因裁判法庭在今年內亦作出各種各樣的建議，部分已被接納和付諸實行。以下為死因裁判官或陪審團所作的部分建議：

(i) 乙型肝炎帶菌者獲處方高劑量免疫抑制療法，但未獲處方預防性抗病毒藥物後出現暴發性肝衰竭

醫院管理局

1. 高劑量類固醇使用時間

建議服用時間少於 7 日都要歸納為高風險類別，需要處方抗病毒藥。

2. 乙型肝炎帶菌者即使沒有病徵，可考慮資助到私家診所定期檢查。

3. 教育乙型肝炎帶菌者注意事項及徵狀。

4. 醫生排版記錄要清晰及其他醫生能夠理解。

5. 化驗室取消測試時要交代原因。

(ii) 病人在離世前四天被發現心臟跳動異常，但醫院隨後未有替病人再作檢測，病人最終因肺炎離世

醫院管理局

若心電圖顯示病人的 QT 間期延長(prolonged QTc)，醫院應在隨後的 24 小時內，替病人再作心電圖檢查，並提供心臟監測。

(iii) 病人在接受血液導管置入手術期間，導管意外地進入了病人的右股動脈，病人最終因併發症離世

醫院管理局

1. 局方應考慮發出內部指引，列明病人在何等情況下適宜進行洗血程序。
2. 局方應為所有會進行超聲波穿刺術的醫生(特別是深切治療科醫生及麻醉科醫生)提供培訓及作定時考核。
3. 局方應考慮規定醫生為病人進行穿刺手術時，使用壓力系統(Pressure system)，以監測病人的血壓。
4. 局方應考慮要求醫生為病人進行穿刺手術時，使用注射咀(Angio Catheter)進行導管置入，以防止穿刺後針孔移位。
5. 局方應考慮發出指引，列明錯誤置入導管後應如何處理。

(iv) 疫情期間，醫護未能在擠擁的急症室內找到等候入院的死者，結果死者被發現時已不省人事

醫院管理局／廣華醫院

1. 急症室應善用科技，加快設立系統追蹤並確定正等候入院病人的位置。
2. 在上述系統設立前，急症室必須確保醫護及工友有系統地尋找在急症室內等候入院的病人。

(v) 病人被診斷患上心肌梗塞後，短時間內離世

醫院管理局／屯門醫院

1. 局方應提醒前線醫護需使用清晰詞彙向病人及其家屬解釋病情。
2. 院方應考慮制定休克指引(shock protocol)，指引應列明在何種情況下，醫護應考慮替病人安裝體外膜氧合(Extracorporeal Membrane Oxygenation (ECMO))。

(vi) 病人在等候胸部 X 光檢查報告期間，病情惡化，並最終因呼吸衰竭而離世

醫院管理局／衞生署

署方及局方應積極研究透過電子平台(包括現有的醫健通平台)，在病人同意下，分享病人的醫療影像資訊，並在

有關影像被上載時，由系統自動向要求拍攝影像的醫生發出提示訊息，讓醫生能即時檢視有關影像。

(vii) 病人在初期沒有明顯病徵下，因主動脈剝離(Dissection of aorta)離世

醫院管理局

1. 若病人投訴胸口出現撕裂性痛楚，並伸延至背部，醫護應提高警覺及考慮病人是否出現主動脈剝離(Aortic dissection)的情況。此外，醫護應以新近拍攝的胸腔 X 光片對比舊有的 X 光片，以確定病人的縱膈腔(Mediastinum)有否擴大。
2. 若醫生懷疑病人患上急性心臟疾病，醫護應安排病人接駁心臟監察儀器，並每隔四小時檢查病人的心電圖及安排抽血檢驗心臟酵素。
3. 醫生以口頭方式處方藥物後，應在切實可行的情況下，盡快會見病人。

(viii) 病人接受內窺鏡逆行性膽胰管道造影術(ERCP)後，出現併發症，並最終因併發症而離世

醫院管理局／瑪麗醫院

醫生替病人進行內窺鏡逆行性膽胰管造影術(ERCP)時及術後，除留意病人有否出現氣腹(pneumoperitoneum)

外，亦應留意病人的腹膜後腔有否氣體(retroperitoneal gas)出現。若有任何懷疑，醫生應在可行的情況下，盡早安排病人接受電腦掃描，以確定腸道有否穿破。

(ix) 學童在校被含有蒟蒻的啫喱哽斃

香港潮商學校

學校應考慮舉辦演習或模擬訓練，並特別着重危機溝通及分工，以應付日後的緊急醫療事故。

食物安全中心 (風險傳達組)

中心應考慮永久禁止銷售所有高度或寬度為 45 毫米或以下含「蒟蒻」成份的小杯裝果凍產品。

(x) 病人在接受胸腔引流術(chest drain insertion)期間，肝臟意外地被刺穿，隨後離世

醫院管理局

醫管局應定時向未獲取專科資格的醫生提供胸腔引流術的訓練，訓練內容應包括：(1) 技巧教授； (2) 超聲波的使用；及 (3) 經驗及案例分享。

(xi) 死者在監禁服刑期滿後，被羈留於青山灣入境事務中心等待被遞解出境期間，在羈留倉內以衣物上吊自殺

入境處

所有羈留中心，我們有以下改善建議

1. 訂立更清晰具體員工守則及指引

   例如：培訓入境處職員如何判斷異常行為及制定具體的工作要求。監控室員工要為觀察 CCTV 的頻率作出紀錄。

2. 引入獨立第三方檢查機構提升管理。例如:每半年一次。

3. 每位新入中心羈留人士需接受專業心理醫生評估，及背景調查。不同羈留中心紀錄要互通，將高風險人士納入醫學監察名單。

(xii) 死者在接種新冠病毒病疫苗後翌日死亡。死者冠狀動脈因粥樣硬化造成百分之九十的阻塞，死因是室性心律不正(頑固型心室顫動)，被裁定死於自然

衞生署

1. 注射疫苗前，醫生需收集及索取病人的過往病歷，特別是有長期病患的人士。

2. 如有需要，醫生應建議病人在注射疫苗前，作出相關的檢查。

3. 強烈建議在注射疫苗前，利用醫健通，去查核病人的資料。

(xiii) 一名因自殘行為入院的病人，在接受醫院安排的精神科評估前，在病房洗滌房的窗戶爬出離開時，從高處墮下至多處受傷而死亡，被裁定死於意外

伊利沙伯醫院

1. 建議伊利沙伯醫院應該重新和慎重處理精神科病人的個案及流程，特別是對有自殺風險的病人之緊急處理程序，並作出適當的轉介。
2. 建議伊利沙伯醫院的專業團隊，包括醫生和護士，就精神科人士，提供一些合適「培訓」，例如針對一些對精神科病人的風險評估和緊急應對處理措施。並加強精神科病人入院處理和藥物的使用程序。
3. 建議伊利沙伯醫院應該慎重檢視當值醫療團隊之人手安排。要充份關注人手不足的問題。
4. 建議伊利沙伯醫院應該加強病房出入口，(當中包括洗滌房)，門窗的開關指引及安全措施，並作出定期檢測，以減低意外的風險。

醫院管理局

建議醫管局須重新檢視精神科病人的常規處理的時間，而非局限於使用「工作天」來界定。

(xiv) 死者自行以電鋸移除一棵枯樹時，被樹幹從高處墮下擊中頭部後受傷致死。事發前，地政署已接獲有關該枯樹的投

訴並在處理中，通往該枯樹的通道亦按警方與消防員的指示被繩索欄著。死者被裁定死於意外

地政署

1. 增加投訴個案的透明度，令投訴人可以清楚知道處理的進度，避免投訴人自行處理並構成危險。
2. 由官方提供即時措施避免市民進入高危地方，例如提供明確標語及圍封措施。

(xv) 渠務署外判工程商工人在進行污水處理廠內回流井更換喉管工程時，因廠內離心機被開啟導致釋出有害氣體，令回流井內的工人暈倒。雖然署方成功救出暈倒的工人，但一名在回流井外的工人在署方救援過程中，在未有佩戴任何安全裝備的情況下，自行進入回流井內進行救援，因硫化氫中毒、胸部受傷及溺斃而死亡，被裁定死於不幸

渠務署

1. 向各承建商（主要承建商和分判商）建議:

1.1. 為在回流液泵站的密閉空間工作，制定及維持一個安全而不會危害工人健康的工作系統，當中包括但不限於：

1.1.1. 在承接工程前，對有關的密閉空間內的工作環境進行危險評估，並就工作期間對工人的安全及健康要採取的預防措施作出建議；

1.1.2. 確保執行所有建議的安全措施，例如適當隔離危害性源頭。容許工人進入密閉空間（即回流液泵站的濕井）前，應完全關掉所有不必要的動力來源（例如所有離心機的電源），而在工作之前及進行期間，喉管 A 的閥門應完全關閉。為預防離心機的電力意外啟動，或是喉管 A 的閥門未經許可被打開，應實施“上鎖”及“掛牌”的機制。“上鎖”是指用鎖將喉管 A 鎖上，並使用上鎖工具將離心機的電力鎖在安全模式；而“掛牌”制度是指附上警告牌或標籤以告示他人。實際作業時，所有參與的各方應分別用各自的上鎖工具，將離心機的電掣板鎖在關閉狀態及將喉管 A 的閥門關閉，並展示警告牌；

1.1.3. 發出證明書，註明已採取所有必需的安全預防措施；

1.1.4. 確保工人使用必需的個人防護裝備，例如安全帽、認可呼吸器具、連接救生繩的安全吊帶等，尤其須符合進入密閉空間進行地底喉管工作的法律規定；

1.1.5. 制定及實施合適的應變計劃，以處理工人在濕井內工作時遇到的任何嚴重和逼切的危險情況，包括適當的救援安排及緊急程序。須定期進行演習以測試緊急應變計劃，以及練習有關程序及使用救援裝備。所有有關各方應獲給予足夠資訊、培訓及指示。工地應有救援隊伍，為緊急救援隨時準備就緒；以及

1.1.6. 就有關工作的風險，給予工人清楚及具體的安全指示及健康指示。工人進入濕井進行密閉空間工作前，承建商應至少指示他們，在濕井內工作期間，配戴適當的認可呼吸器具和連接救生繩的安全帶。此外，承建商應指示候命人員，即使發生緊急事故亦不應進入濕井。候命人員應駐留在密閉空間外，並召喚救援隊及公共緊急服務（即警方及消防處）的協助。

1.2. 遵從“工地工作准許證”的條款，例如承建商在到達工地開工及離開工地時，應通知小蠔灣污水處理廠的當值主管。

1.3. 向負責的渠務處人員要求截斷離心設施的電源、及封閉喉管 A 和喉管 B，然後才進入濕井進行密閉空間工作。

1.4. 在工人進入密閉空間前，參照由合資格人士進行的危險評估，並相應地在回流液泵站實施建議的措施。這些措施包括但限於：

1.4.1. 容許工人進入密閉空間工作前，將密閉空間與所有其他連接部分分隔及隔離，以預防任何危險物質進入密閉空間，危害裏面的工人，例如含高濃度硫化氫的離心機廢液從喉管 A 進入濕井，及自由流動的固體或液體湧入濕井；

1.4.2. 截斷離心機的電源，並在離心機設施的控制板執行 “上鎖”及“掛牌”機制；

1.4.3. 封閉喉管 A，其內含物可造成危害，並對離心機大樓裝卸區的喉管 A 閥門實施“上鎖”及“掛牌”機制；

1.4.4. 確保至少有一名候命人員駐留密閉空間外，與在密閉空間內的工人保持聯繫；以及

1.4.5. 確保在密閉空間工作開始前承諾的安全措施在工作進行期間持續有效。

1.5. 在該密閉空間的入口顯眼處展示危險評估報告及根據《工廠及工業經營（密閉空間）規例》發出的有關證明書；及

1.6. 確保逗留在濕井的密閉空間內進行地底喉管工程的工人配戴適當的認可呼吸器具及連接救生繩的安全吊帶。

1.7. 向每名參與工作的工人提供合適及配有下額索帶的安全帽，並確保他們在工作期間恰當戴上。

1.8. 若任何人可從污水井洞口墮下兩米或以上，便須確保污水井所有沒有圍欄的邊緣用圍欄妥善圍封。

1.9. 在工人首次進入密閉空間前，確保已採取有效步驟，預防自由流動的固體或液體湧入該密閉空間內。

1.10. 若工人有從水旁構築物（即濕井內的水泥平台）墮下的風險，須提供鞏固圍攔。

1.11. 若工人在水旁進行建造工程，而有墮下水中遇溺的風險，便須提供合適的救援裝備，並使裝備保持高效狀態。

2. 中期至長期改善措施

(i) 備有影片分析功能的閉路電視／鏡頭

為進一步改善工地監察，應盡快全面採用備有影片分析功能的閉路電視／鏡頭以偵測異常及／或

緊急情況，例如：工人沒有穿上個人防護裝備、工人因有害氣體失去行動能力等。

(ii) 中央電子平台

應盡快全面使用中央電子平台，用以管理、記錄及實行所有相關的工作流程及通訊，包括不同設備的運作、承建商的工作及所遞交的資料、工地監督、工作通知、處理廠進出管制等。平台亦應能整合至數碼工程監督系統（DWSS），並與智能裝置（如：智能頭盔、GPS 手環）相容。

(xvi) 死者在街上行為異常、疑似醉酒，並對警方作出激烈反抗。死者在被警方制服後，於警車上被觀察到身體不適，送院後不治死亡。遺體剖驗顯示死者冠狀動脈達百分之七十五的阻塞。死者的死因是冠狀動脈疾病導致急性心肌梗塞，被裁定死於自然

警務處

警方可建立指引，就被拘捕人士在拘留期間，如發現有關人士身體狀況變壞，應立即上報。

總結

24. 我們非常感謝死因裁判法庭的所有同事，他們在死因裁判官書記的領導下，勤奮盡責，表現卓越。

25. 我們也要感謝終審法院首席法官、總裁判官以及司法機構政務處給予精神上及資源上的支援。我們同時感謝其他政府部門提供的人力及所有其他資源，使我們的死亡個案調查工作得以順利進行。這些部門包括，但不限於律政司、警務處、衞生署的法醫科和政府化驗所等等。

26. 警務處的調查員就死亡事故進行了高水平的調查，也擬備了高水平的死亡調查報告。警務處亦調派了三名高級督察擔任死因研訊主任，負責聯絡工作，並協助處理死因研訊，他們的表現尤為出色。

27. 此外，我們感謝律政司各級別的政府律師，他們在死因裁判法庭上提出證據，協助死因裁判官處理了多宗較爲複雜的死因研訊。

28. 與往年一樣，我們在此感謝一眾曾協助法庭的病理學家，包括衞生署的法醫科醫生及醫院管理局的臨床病理科醫生；他們不但肩負了剖驗屍體的工作，並在法庭上提供證據，協助死因研訊的進行；他們亦協助我們解答公眾對驗屍及死因等一般事宜所作的電話查詢。

29. 一直以來，法庭傳譯主任不論在庭內和庭外，均提供了一流的傳譯和翻譯服務。

30. 勞工處和海事處努力不懈，繼續就陸上和海上的意外展開詳盡的調查，並撰寫報告；該等報告所提出的建議，對死因裁判官及有關業界而言，往往甚有幫助，我們在此謹向勞工處和海事處表示謝意。

死因裁判官　　死因裁判官　　死因裁判官

周至偉　　周慧珠　　林希維

二零二五年八月

Part One

Coroners' Report 2024

Number of Deaths on a Rising Trend

1. A total of 52,366 deaths were registered this year, and a total of 12,281 deaths were reported to the Coroners. Figures for the last 24 years are set out below :

	Deaths registered	Deaths Reported to the Coroners
2001	33,305	7,733
2002	34,316	7,890
2003	36,421	9,315
2004	37,322	9,108
2005	38,683	9,506
2006	37,415	9,025
2007	39,963	9,422
2008	41,530	10,314
2009	41,034	10,070
2010	42,705	9,999
2011	42,188	10,017
2012	43,672	10,472
2013	43,399	10,249
2014	45,710	10,598
2015	46,757	10,767
2016	46,662	10,773
2017	45,883	10,768
2018	47,479	10,976
2019	48,706	11,168
2020	50,653	12,680
2021	51,536	12,694
2022	61,557	17,193
2023	56,776	12,996
2024	52,366	12,281

2. From the list above we can see that the number of deaths registered increased year by year from 2001 to 2005. The trend showed a slight downturn in 2006. The figures in the past 16 years, between 2007 and 2022, show a mixed uptrend. The number of deaths registered and the number of cases reported to Coroners in 2024 have dropped as compared with the figures of 2023, with the number of deaths reported to Coroners decreasing by 5%.

Investigation of deaths

3. The Police will investigate every death which has been reported to the Coroners. They will submit an investigation report together with the post mortem report by the clinical pathologist or the forensic pathologist to the Coroners. The Coroners will consider the police report and the post mortem report. If we determine that the investigation carried out by the Police has provided sufficient information to enable us to exercise our power and perform our duties under s.9 of the Coroners Ordinance and that the cause of death and the circumstances of the death are clear and there is no suspicion, we will assign a classification code to the death in accordance with the "International Statistical Classification of Diseases and Related Health Problems" as prescribed by the World Health Organization, so that the Registrar of Births and Deaths is able to register the death.

4. Notwithstanding the preliminary view of the Police on the absence of suspicion in a death, if we consider that further investigation of the death is necessary, we will inform the Police to carry out relevant investigations and to submit a more detailed death investigation report. In this regard, we exercise our judicial discretion taking into account all the circumstances of each individual death, as contained in the Police's first investigation report. The further investigation and submission of a more detailed report by the Police typically takes 6-12 months or longer in some cases. Upon perusal of that report, and upon

considering all the circumstances of the case, we will determine whether to hold an inquest into the death.

5. As to deaths in official custody, the law requires that an inquest must be held. In these cases, the Coroners will ask the Police to further investigate the death and to submit a more detailed death investigation report so that an inquest will be held in due course.

6. The following table sets out the figures for the last 24 years showing how reported deaths were dealt with:

	Deaths Reported to the Coroners	Further Investigations	Inquests Held	With Jury	Without Jury	Percentage of Inquests with Jury
2001	7,733	2,374	158	71	87	45%
2002	7,890	2,451	132	83	49	63%
2003	9,315	2,678	108	67	41	62%
2004	9,108	2,059	141	99	42	70%
2005	9,506	1,351	189	150	39	79%
2006	9,025	1,061	210	181	29	86%
2007	9,422	767	185	155	30	84%
2008	10,314	1,364	145	135	10	93%
2009	10,070	1,260	193	167	26	87%
2010	9,999	1,106	172	131	41	76%
2011	10,017	1,224	182	149	33	82%
2012	10,472	1,420	164	138	26	84%
2013	10,249	1,099	176	140	36	80%
2014	10,598	967	148	139	9	94%
2015	10,767	751	100	93	7	93%
2016	10,773	730	77	63	14	82%

2017	10,768	1,128	117	112	5	96%
2018	10,976	1,083	161	152	9	94%
2019	11,168	1,047	130	114	16	88%
2020	12,680	1,099	74	64	10	86%
2021	12,694	1,120	163	150	13	92%
2022	17,193	1,199	139	122	17	88%
2023	12,996	999	184	172	12	93%
2024	12,281	995	147	128	19	87%

7. In recent years, there has been a growing number of deceased's family members and their legal representatives, as well as other interested parties requesting open inquests. The issues involved have become more complicated than in the past, with most cases concerning medical or post-operative incidents. These requests were often made on a common misconception that the purpose of an inquest is to investigate and determine whether the deceased died as a result of medical or surgical mismanagement. In dealing with such requests, the Coroner has often exercises discretion in favour of the families by ordering the Police to furnish further investigation reports and expert opinion reports from independent medical experts, which will be made available to the families enabling them to better undertsand the cause of death and the circumstances connected with it. Inquests are also held where it appears that useful recommendations may be made.

8. The main purpose of an inquest is to find out the truth of the death through evidence given in open court. This is for the sake of putting forward realistic and practicable recommendations in appropriate cases, in the hope of preventing the occurrence of similar death incidents. There is however another important function, and that is after the family has seen the witnesses and heard their evidence in open court, it is hoped that they will be better able to accept the death of their loved ones.

Chambers Applications

9. In our previous reports we described the procedure for family members to apply to the Coroner for waiver of autopsy. This is a very important and difficult task of the Coroners. It is important for the public to understand this aspect of the Coroner's work, which is why we are explaining the procedure once again here.

10. Typically, a public hospital clinical pathologists or a Department of Health forensic pathologists will have examined the medical records of the deceased and the course of events leading to his death. The pathologists will have also carried out an external examination of the body. If they are still unable to determine a cause of death, they will advise the Coroner that it is necessary to perform an autopsy to ascertain it. Members of the family of the deceased are often deeply upset by this suggestion and will appear before a Coroner to express intense cultural, religious and other reasons why an autopsy should not be performed. In 2024, the Coroners dealt with a total of 486 applications under this category.

11. The Coroner fully appreciates the family members' concern when handling these applications. The family is already coping with intense grief. Their distress is compounded by the need for an autopsy, especially if the deceased had expressed an aversion or abhorrence to surgical intervention or hospital stay, making the procedure feel like a violation and exceptionally difficult to accept.

12. Each such case must be dealt with on its merits but very often the purpose of an autopsy is to find out the cause of death. According to the stipulations of the World Health Organization and the Births and Deaths Registration Ordinance, the Coroners are under statutory duties to find out the cause of death in respect of

every death and to classify the death cases in accordance with the prescribed classification. The Registrar of Births and Deaths is also under a duty to find out the cause of death before he may register the death in the death register. In order to find out the cause of death, the Coroner very often has to call the pathologist or even the ward doctor to see whether on the balance of probabilities, a certain cause of death may be identified. However, in some cases because the deceased has, for instance, limited medical history, there is no satisfactory medical evidence upon which a pathologist may identify a cause of death. In such cases, a detailed explanation to the family as to why an autopsy is required is necessary.

13. In recent years, upon the suggestion of the Coroner, the flow of medical information between public hospitals and the Government Forensic Pathology Service has strengthened. As a result, for public hospital patients who were treated immediately prior to death, forensic pathologists now have more comprehensive medical history of the deceased to enable them to determine the cause of death without having to perform an autopsy.

14. On the one hand, the Coroner has a duty to ascertain the cause of death in every case. On the other hand, we must also consider the emotions and sentiments of family members. The Coroner must therefore exercise judicial power carefully in considering every waiver application, taking into consideration all the relevant factors and circumstances of the matter.

Suicides

15. There were 1,138 suicide cases this year, an increase of 4% compared with 2023. 160 of these were further investigated by the Police, followed by a more detailed death investigation report. In line with the past years, the number of men committing suicide is still much higher than that of women, with the ratio of 762 : 376. The number of juvenile suicide remains relatively unchanged compared to last year.

Accidental Deaths

16. The number of accidental deaths this year is 767. Of these, 272 required further investigation by the Police, followed by a more detailed death investigation report. This year's figures were more or less the same as last year's. The number of men who died as a result of accidents was significantly higher than that of women, with a ratio of 523 : 244.

Occupational Deaths

17. In our reports up to 2009, we only mentioned occupational deaths for which an inquest had been held. After careful consideration, we believe the whole picture had not been adequately presented. Therefore, starting from the 2010 report, the number of deaths referred to includes occupational deaths, both on land and at sea. There were a total of 47 occupational deaths, all of which were on land. 42 of the deceased were men, and 5 were women; the ratio was 42 : 5.

Homicides

18. The number of people unlawfully killed was 14, comprising 9 men and 5 women.

Vehicular Accidents

19. The number of deaths arising from vehicular accidents was 110. Among these, 62 deceased were pedestrians, accounting for about half of the total fatalities. Of the 62 pedestrians deaths fatalities, 29 were aged 70 years or above, representing about half of the total fatalities. It is evident that older individuals are more susceptible to road traffic accidents compared to other age groups. The ratio of men to women was 80 : 30.

Drugs and Poisons related Deaths

20. There were 140 deaths related to drugs and poisons, a 16% decrease from the previous year. Most of them involved dangerous drugs. The figure included suicide, accidental death, and death where the intent was undetermined. The ratio of men to women was 101 : 39.

Deaths from natural causes

21. There were 10,478 deaths due to various diseases, with 4,862, approximately half, classified as diseases of the circulatory system. According to the "International Statistical Classification of Diseases and Related Health Problems", diseases of the circulatory system include hypertensive diseases, various heart diseases and cerebrovascular diseases. The ratio of men to women among the deaths was 6,136 : 4,342.

22. We can see that more men than women died in all the above mentioned classifications of deaths. In some classifications, such as occupational deaths, the gender disparity was particularly pronounced where the ratio of men to women was 42 to 5.

Recommendations

23. As in previous years, a wide variety of recommendations were made during the year, some of which have been accepted and implemented. Here are some of the recommendations made by the Coroners or the Jury: -

(i) Hepatitis B carrier developed fulminant hepatic failure after being placed on high dose immunosuppressive therapy without prophylactic antiviral

To: Hospital Authority

1. Length of time for using high dose steroid

   It is recommended that even patients being placed on the medication for less than 7 days have to be put into the high-risk category, which calls for the prescription of antiviral.

2. Subsidizing hepatitis B carriers, albeit asymptomatic, to undergo regular checkups in private clinic can be considered.

3. Educating hepatitis B carriers to take note of certain matters and symptoms.

4. Medical notes and records have to be clear so much so that other doctors are able to follow.

5. Laboratories have to give an account of the reasons for cancelling a lab test.

(ii) A patient was found with arrhythmia four days before his death but no further examination was conducted on the patient in hospital. The patient eventually died of pneumonia

To: Hospital Authority

If prolonged QTc is shown in patient's electrocardiogram (ECG), the hospital should conduct another ECG examination within the next 24 hours with the provision of cardiac monitoring.

(iii) During a catheter insertion procedure, the catheter accidentally entered the patient's right femoral artery. The patient eventually died of complications

To: Hospital Authority

(1) The Authority should consider issuing internal guidelines, stating clearly the circumstances under which a patient is suitable for haemodialysis.

(2) The Authority should provide training and regular assessments for all doctors who will carry out ultrasound-guided punctures [in particular those in intensive care and anaesthesia].

(3) The Authority should consider requiring doctors to set up a pressure system during puncture procedures to monitor the patient's blood pressure.

(4) The Authority should consider requiring doctors to use an angio catheter for catheter placement during puncture procedures for patients to prevent displacement of the needle tip after puncture.

(5) The Authority should consider issuing guidelines, stating clearly how to deal with misplacement of catheters.

(iv) <u>During the pandemic, medical staff were unable to locate the deceased in the crowded Accident and Emergency (A&E) Department while he was waiting for admission, and he was later found unconscious</u>

To: Hospital Authority/ Kwong Wah Hospital

(1) A&E Departments should make good use of technology to expedite the setting up of a system for tracking and locating patients awaiting admission.

(2) Pending the establishment of such a system, A&E Departments should ensure medical staff and workers have a systematic way to locate patients waiting for admission in A&E Departments.

(v) <u>Patient died shortly after being diagnosed with myocardial infarction</u>

To: The Hospital Authority / Tuen Mun Hospital

(1) The Authority should remind frontline medical staff to use clear wording when explaining medical condition to patients and their family.

(2) The Hospital should consider establishing a shock protocol, stating clearly the circumstances under which medical staff should consider setting up Extracorporeal Membrane Oxygenation [ECMO] for patients.

(vi) Patient's condition deteriorated and eventually passed away due to respiratory failure while waiting for chest X-ray report

To: Hospital Authority/ Department of Health

The Department and the Authority should, with the patient's consent, actively explore the sharing of the patient's medical imaging information through e-platforms (including the existing eHealth platform), and the system should automatically send notification to the doctor requesting for the images when they are uploaded, so that the doctor could view the relevant images immediately.

(vii) Patient died of dissection of aorta in the absence of obvious early symptoms

To: Hospital Authority

(1) If a patient complains of tearing pain in the chest that extends to the back, medical staff should be alert and consider whether the patient is suffering from aortic dissection. In addition, a recent chest X-ray should be compared with an old one to determine if the patient's mediastinum is enlarged.

(2) If the doctor suspects the patient is suffering from acute heart disease, medical staff should arrange for the patient to be connected to a cardiac monitor, and to check the patient's

electrocardiogram and arrange blood test for cardiac enzymes every 4 hours.

(3) The doctor should attend the patient as soon as practicable after verbally prescribing medication.

(viii) The patient developed complications after undergoing Endoscopic Retrograde Cholangiopancreatography [ERCP] and subsequently died as a result of these complications

To: Hospital Authority/Queen Mary Hospital

In performing ERCP, doctors should check the patient not only for pneumoperitoneum intra-operatively and post-operatively, but also the presence of any retroperitoneal gas in the patient. In case of any suspicion, doctors should arrange CT scan for the patient as soon as feasible to confirm whether there is bowel perforation.

(ix) A student choked to death on jelly containing konjac at school

To: Chiu Sheung School, Hong Kong

The School shall consider organizing drills or simulation trainings with an emphasis on crisis communication and division of labour to cater for future medical emergency.

To: Centre for Food Safety (Risk Communication Section)

The Centre shall consider imposing a permanent ban on all mini-cup jelly confectionery product containing the ingredient

"konjac" having a height or width of less than or equal to 45mm.

(x) Patient died after his liver was accidentally punctured during chest drain insertion

To: Hospital Authority

The Hospital Authority should provide regular training on chest drain insertion for non-specialist doctors, such training should include: (1) technique instruction; (2) use of ultrasound; and (3) experience and case sharing.

(xi) Having served the full sentence of imprisonment, the deceased committed suicide in the detention cell by hanging herself with clothing while being detained in the Castle Peak Bay Immigration Centre pending deportation

Immigration Department

We have the following recommendations for improvement of all Detention Centres

1. Formulating clearer and more specific code of practice and guidelines for staff

   For example: to provide training to staff of the Immigration Department on abnormal behavior detection and to define specific work requirements. Staff working in the monitor room have to record the frequency of CCTV observation.

2. Bringing in an independent third party to inspect the organization and to enhance the management. For example: once every six months

3. Every newly admitted detainee is required to be assessed and have his/her background checked by a professional psychologist. Records of different Detention Centres have to be shared, for putting high-risk individuals on the Medical Observation List.

(xii) The deceased died the day after receiving the COVID-19 vaccine. The deceased's coronary arteries were 90% occluded due to atherosclerosis, and the cause of death was ventricular arrhythmia (refractory ventricular fibrillation). It was found that the deceased died from natural causes

Department of Health

1. Before giving the vaccine, doctors are required to collect and request the patient's medical history, especially for those with chronic illnesses.

2. If necessary, doctors should advise patients to undergo relevant examinations before vaccination.

3. It is strongly recommended that eHealth be used to verify the patient's information before giving the vaccine.

(xiii) A patient had been admitted for self-harm, before undergoing psychiatric assessment arranged by the hospital, while (attempting to) leave by climbing through a window in the ward's cleaning room, fell

from height and died from multiple injuries, the finding was death by accident

Queen Elizabeth Hospital

1. It is recommended that Queen Elizabeth Hospital should carefully review the processes of handling psychiatric cases, especially the emergency management procedures for patients at risk of suicide, and make appropriate referrals.

2. It is recommended that the professional team at Queen Elizabeth Hospital, including doctors and nurses, regarding psychiatric persons, provide some appropriate "training", such as risk assessment and emergency response measures for psychiatric patients. Furthermore, the hospitalization and medication procedures for psychiatric patients should be strengthened.

3. It is recommended that Queen Elizabeth Hospital should carefully review the manpower arrangements of its on duty medical team and pay full attention to the issue of manpower shortage.

4. It is recommended that Queen Elizabeth Hospital should strengthen the opening and closing instructions and safety measures of ward entrances and exits [including cleaning rooms], doors and windows, and conduct regular inspections to reduce the risk of accidents.

Hospital Authority

It is recommended that the Hospital Authority should review the routine handling time for psychiatric patients, instead of limiting it to be marked by "working days".

(xiv) While removing a dead tree using an electric saw, the deceased was stuck on the head by a trunk that fell from above. He then died of injuries. Prior to the incident, Lands Department had received the complaint about the dead tree and was dealing with it. Access to the dead tree was also blocked by ropes pursuant to the instructions of the police and firemen. The death of the deceased was found to be death by accident

Lands Department

1. Increase the transparency of complaint cases so that the complainant clearly knows the progress of handling to prevent the complainant from handling the problem by himself/herself, posing any danger.

2. Relevant authorities to take immediate measures such as providing conspicuous signs and hoardings to prevent members of the public from entering places of high risk.

(xv) While workers from a Drainage Services Department (DSD) contractor were replacing pipes in a return liquor pump well at a sewage treatment plant, the activation of a centrifuge released,

hazardous gases, causing the workers inside the well to lose conscionsness. Although the affected workers were eventually rescued, a worker outside the return liquor pump well, who was not equipped with any safety equipment, entered the return liquor pump well in an attempt to help. She died as a result of hydrogen sulfide poisoning, chest injuries, and drowning. The incident was determined to be a death by misadventure

Drainage Services Department

1. Recommendations to contractors [main contractors and subcontractors]:

1.1. Develop and maintain a system of work in relation to the confined space works at RLPS that is safe and without risks to the health of workers. It includes, but is not limited to, the following:

1.1.1. Carry out risk assessment for the working conditions in the confined space and make recommendations on measures to be taken in relation to the safety and health of workers while working in that space before undertaking the works;

1.1.2. Ensure that all recommended safety precautions were carried out such as proper isolation of hazardous sources. Before allowing workers to

enter a confined space, i.e. the wet well of RLPS, all unnecessary power sources (such as all centrifuges) should be completely shut off and the gate valves of Pipe A should be fully closed before and throughout the course of work. To prevent the power of the centrifuges from accidentally switching on or the gate valves of Pipe A from being opened without authorization, a lock-out and tag-out system should be implemented. Lock-out refers to physically locking Pipe A and the power of centrifuges in a safe mode using lock-out devices, whereas tag-out system refers to attaching warning signs or labels to alert others. In practice, the power panels of the centrifuges should be locked off and the gate valves of Pipe A should be shut off by all involved parties separately using their own lock-out devices, with warning signs displayed;

1.1.3. Issue a certificate stating that all necessary precautions have been taken;

1.1.4. Ensure the use of necessary personal protective equipment by workers such as safety helmets, approved BA, safety harness connected to lifeline, etc., in particular complying the legal requirements with respect to entering a confined space for underground pipework;

1.1.5. Formulate and implement appropriate response plan to deal with any serious and imminent danger to workers inside the wet well. It includes suitable rescue arrangements and emergency procedures. Emergency drills should be conducted periodically for testing of the emergency response plan, and for practicing the procedures and use of rescue equipment. Adequate information, training and instruction should be given to all parties concerned. A rescue team should be readily available at the site for emergency rescue; and

1.1.6. Provide clear and specific safety and health instructions to workers with respect to the risks of the said work. Before workers entered the wet well to conduct the confined space works, the contractor

should at least instruct them to wear suitable approved BA and safety harness connected to a lifeline while working inside the wet well. Also, the contractor should instruct the standby person not to enter the wet well even in case of emergency. The standby person should remain stationed outside the confined space and summon assistance of the rescue team and public emergency services (i.e. the Police and the Fire Services).

1.2. Comply with the term of the SWAC e.g. informing the Shift-in-charge of SHWSTW when the contractor(s) arrive on site to start work and when they leave the site.

1.3. Make request to the responsible staff of DSD for disconnecting the power sources of the centrifuge facilities, and blanking off Pipe A and Pipe B before entering the wet well for the confined space works,

1.4. Refer to the risk assessment carried out by a competent person and implement the recommended measures at RLPS accordingly before workers enter the confined space. These include, but are not limited to,

1.4.1. Isolation and separation of the confined space from all other connecting parts before allowing workers to enter a confined space for work so as to prevent any dangerous materials entering the confined space to create hazards for the workers inside such is an ingress of centrate which contained a high level of H_2S from Pipe A into the wet well, and an in-rush of free flowing solid or liquid into the wet well;

1.4.2. Disconnection of the centrifuges from the power sources and implement lock-out and tag-out system for the control panel at the centrifuge facilities;

1.4.3. Blanking off Pipe A whose contents are liable to create a hazard and implement lock-out and tag-out system to the gate valves of Pipe A at the loading bay of the Centrifuge Building;

1.4.4. Ensuring at least a standby person is stationed outside the confined space to maintain communication with the workers inside; and

1.4.5. Ensuring the safety precautions undertaken before the confined space works begin to be effective continuously throughout the course of the work.

1.5. Display the risk assessment report and the related certificate issued under FIU(CS)R in a conspicuous place at the entrance of the confined space.

1.6. Ensure the workers remaining inside the confined space of the wet well for underground pipework to wear suitable approved BA and safety harnesses connected to a lifeline.

1.7. Provide each worker involved in the work with a suitable safety helmet equipped with a chin strap and ensure the proper wearing of the same by the worker throughout the work.

1.8. Ensure that all unprotected edges of the manhole openings through which any person is liable to fall a distance of 2 metres or more, are properly fenced off.

1.9. Ensure that effective steps have been taken to prevent an in-rush into the confined space of free flowing solid or

liquid before worker enters the confined space for the first time.

1.10. Provide secure fencing where there is risk of a fall of a workman from the structure adjacent to the water, i.e. the concrete platform inside the wet well,

1.11. Provide suitable rescue equipment and keep it in an efficient state where construction work is carried out on a place adjacent to water into which a workman is liable to fall with the risk of drowning.

2. Medium to Long-Term Enhancement Measures

(i) CCTV/Camera with Video Analytics Function

To further enhance site monitoring, CCTV/Camera with video analytics function should also be deployed to detect any abnormal and/or emergency situations, e.g. workers not wearing PPE, workers being overcome by hazardous gases, etc.

(ii) Centralized Electronic Platform

A centralized electronic platform should be developed to manage, record and implement all relevant workflows and communications, including the operation of the various

equipment, the contractors' works and submissions; the site supervision, notification of works, plant access control, and so forth. This platform should also be able to integrate with the Digital Works Supervision System (DWSS) and work with smart devices, e.g. smart helmet, GPS wrist band, etc.

(xvi) The deceased was observed behaving abnormally in the street, appeared intoxicated, and resisted the police violently. After being subdued, he was observed to be unwell in the police vehicle and later died in the hospital. Autopsy revealed his coronary arteries were 75% occluded. The cause of death was determined to be acute myocardial infarction due to coronary artery disease, and a finding of death by natural causes was made

Police Force

The police could establish guidelines that if the physical condition of an arrested person deteriorates whilst in custody, the situation should be reported immediately.

Conclusion

24. We are very grateful to the staff of the Coroner's Court for their work. Under the leadership of the Clerk to Coroners, they have carried out their duties deligently and effectively.

25. We would also like to thank the Honourable Chief Justice, the Chief Magistrate, and the Judiciary Administration for their support, both in terms of resources and moral support. We are also grateful to other government departments that have provided immense support, both in terms of manpower and all other resources in assisting us to investigate the deaths. These include, but are not limited to, the Department of Justice, the Hong Kong Police Force, the Forensic Pathology Service of the Department of Health, and the Government Laboratory.

26. The standard of the police investigators and their reports is very high. The Police Force has also deployed three Senior Inspectors of Police to serve as Coroner's Officers. They have performed excellent liaison work and have provided valuable assistance at inquests.

27. We also extend our thanks to Government Counsel of all levels of the Department of Justice who presented the evidence and assisted the Coroners in many of the more complex inquests.

28. As in previous years, we would like to take this opportunity to thank the pathologists from both the Department of Health and the Hospital Authority, who have performed autopsies, assisted us by giving evidence in court, and responded to our general telephone inquiries.

29. The Court Interpreters, as usual, provided first class interpretation and translation, both inside and outside Court.

30. The Labour Department and the Marine Department continued to provide us with investigation reports on accidents which occurred on land and at sea respectively. These reports, which are always prepared following thorough investigations, usually contain recommendations. They are of great assistance to the Coroners and to the industry. We wish to formally express our gratitude to both departments for their continued professionalism and dedication in compiling these reports.

CHOW Chi-wei, Raymund	Monica CHOW	LAM Hei-wei, Arthur
Coroner	Coroner	Coroner

August 2025

第二部

Part Two

統計數字

Statistics

曾向死因裁判官呈報的死亡個案的分析

於 2024 年，死亡登記個案有 52,366 宗，而向死因裁判官呈報的死亡個案有 12,281 宗。

以下是處理曾向死因裁判官呈報的個案的情況：—

	總 計
命令將屍體剖驗	2,836
命令豁免屍體剖驗	9,445
土葬命令	825
火葬命令	11,456
須作進一步調查的死亡個案	995
進行研訊的個案	147
死因裁判官或陪審員有提出建議的個案	26

於 2024 年須作進一步調查的 995 宗死亡個案中，截至 2024 年 12 月 31 日為止，警方仍未完成死亡調查報告的共有 556 宗。

於 2024 年向死因裁判官呈報的 12,281 宗死亡個案中，截至 2024 年 12 月 31 日仍在等候毒理學報告以決定死因的有 293 宗。

Analysis of Deaths Reported to the Coroners

In 2024 there were 52,366 deaths registered, and there were 12,281 deaths reported to the Coroner.

Cases reported to the Coroner were disposed of as follows: -

	TOTAL
Autopsy Orders	2,836
Waivers of Autopsy	9,445
Burial Orders	825
Cremation Orders	11,456
Further Death Investigation Reports ordered	995
Inquests held	147
Cases where recommendations are made	26

Of the 995 further death investigation reports ordered in 2024, 556 of which have not yet been returned from the Police as at 31 December 2024.

Of the 12,281 deaths reported in 2024, there are 293 cases of which the causes of death are still pending over toxicological reports as at 31 December 2024.

向死因裁判官呈報的死亡個案數目 No. of Deaths reported to the Coroners	死因裁判官發出的命令數目 No. of Orders Issued by the Coroners				須警方進一步調查的死亡個案數目 No. of Further Death Investigation Reports ordered	排期死因研訊數目 No. of Death Inquests Set Down		死因研訊數目 No. of Death Inquests Concluded		2024年12月31日當天等候死因研訊的案件數目 No. of Death Inquests Pending Hearing as at 31.12.2024	
	剖驗屍體 Autopsy	豁免屍體剖驗 Waiver	土葬 Burial	火葬 Cremation		會同陪審團 With Jury	沒有會同陪審團 Without Jury	會同陪審團 With Jury	沒有會同陪審團 Without Jury	會同陪審團 With Jury	沒有會同陪審團 Without Jury
12,281	**2,836**	**9,445**	**825**	**11,456**	**995**	**120**	**19**	**128**	**19**	**10**	**1**

數 字 及 百 分 比 **FIGURES AND PERCENTAGE**		總計 TOTAL
命令將屍體剖驗 AUTOPSY ORDERED 2,836 (23.00%)	豁免屍體剖驗 AUTOPSY WAIVED 9,445 (77.00%)	**12,281**
火葬命令 CREMATION ORDER 11,456 (93.00%)	土葬命令 BURIAL ORDER 825 (7.00%)	**12,281**

會同陪審團及沒有會同陪審團的死因研訊數目
Number of Inquests Held With or Without a Jury

會同陪審團研訊 WITH JURY	沒有會同陪審團研訊 WITHOUT JURY	總計 TOTAL
128 (87.00%)	19 (13.00%)	**147**

研訊結論及死因類別分析
Analysis of Conclusions of Inquests and Nature of Deaths

結論 Conclusion	死於自然 Natural Causes	死於意外 Accidental Death	死於不幸 Death by Misadventure	自殺死亡 Suicide	存疑裁決 Open Verdict	總計 TOTAL
總計 TOTAL	**119**	**9**	**12**	**6**	**1**	**147**
腫 瘤 Neoplasms	8					**8**
其他種類的症狀，徵象和異常的臨床及化驗發現 Symptoms, Signs And Abnormal Clinical And Laboratory Findings Not Elsewhere Classified	4					**4**
精神錯亂 Mental And Behavioural Disorders	1					**1**
呼吸系統疾病 Diseases Of The Respiratory System	64					**64**
神經系統疾病 Diseases Of The Nervous System	1					**1**
生殖泌尿系統疾病 Diseases Of The Genitourinary System	6					**6**
消化系統疾病 Diseases of the digestive system	7					**7**
循環系統疾病 Diseases Of The Circulatory System	21					**21**
血液和造血器官疾病 Diseases of blood and blood-forming organs and certain disorders involving the immune mechanism	1					**1**
某些傳染病和寄生蟲病 Certain Infectious And Parasitic Diseases	6					**6**
毒藥 Poisons			1			**1**
由高處跳下 Jumping From Height				1		**1**
吊死 Hanging				5		**5**
內科治療及外科手術 Medical And Surgical Care			7			**7**
藥物 Drugs		1	1			**2**
跌倒 Falls		2	1			**3**
其他 Others		6	2		1	**9**

自殺個案
SUICIDES
（類別、年齡及性別）
(TYPE, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

自殺類別 TYPE OF SUICIDE	年齡組別 AGE GROUPS										小計 SUB TOTAL	**總計 TOTAL**
	性別 SEX	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known		
火器 FIREARMS	男 M								1		1	**1**
	女 F											
藥物 DRUGS	男 M			3	1	2	2	1	2		11	**28**
	女 F		1	5	3	1	3	1	3		17	
毒藥 POISONS	男 M			1		1	1		2		5	**11**
	女 F			1		2		1	2		6	
吊死 HANGING	男 M		2	12	15	21	22	42	52		166	**244**
	女 F		1	3	8	13	7	16	30		78	
由高處跳下 JUMPING FROM HEIGHT	男 M	1	15	41	60	62	41	73	95		388	**590**
	女 F		12	15	32	29	37	30	47		202	
一氧化炭 CARBON MONOXIDE	男 M		1	12	27	35	30	16	7		128	**166**
	女 F			7	6	7	7	6	5		38	
淹死 DROWNING	男 M			2	3	6	11	6	9	1	38	**65**
	女 F		1	2		4	5	5	9	1	27	
利器 SHARP INSTRUMENTS	男 M			2	4	1	2		2		11	**16**
	女 F			1	1	1			2		5	
其他 OTHER	男 M			2	1		3	1	1		8	**11**
	女 F		1						2		3	
小計 SUB TOTAL	男 M	1	18	75	111	128	112	139	171	1	756	**1132**
	女 F		16	34	50	57	59	59	100	1	376	
總計 TOTAL		**1**	**34**	**109**	**161**	**185**	**171**	**198**	**271**	**2**	**1132**	**1132**
受傷類別 TYPE OF INJURY	未確定是意外或故意造成的損傷 INJURY UNDETERMINED WHETHER ACCIDENTALLY OR PURPOSELY INFLICTED											
火器 FIREARMS	男 M											
	女 F											
藥物 DRUGS	男 M											
	女 F											
毒藥 POISONS	男 M					1					1	**1**
	女 F											
吊死 HANGING	男 M											
	女 F											
由高處墮下 FALLING FROM HEIGHT	男 M				1			1			2	**2**
	女 F											
一氧化炭 CARBON MONOXIDE	男 M											
	女 F											
淹死 DROWNING	男 M							1	1	1	3	**3**
	女 F											
利器 SHARP INSTRUMENTS	男 M											
	女 F											
其他 OTHER	男 M											
	女 F											
小計 SUB TOTAL	男 M				1	1		2	1	1	6	**6**
	女 F											
總計 TOTAL					**1**	**1**		**2**	**1**	**1**	**6**	**6**

自殺個案（精神病患者）*
SUICIDES (Mental) *
摘錄自自殺類
EXTRACT FROM SUICIDES
（類別、年齡及性別）
(TYPE, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

自殺類別 TYPE OF SUICIDE	年齡組別 AGE GROUPS										小計 SUB TOTAL	**總計 TOTAL**
	性別 SEX	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known		
火器 FIREARMS	男 M											
	女 F											
藥物 DRUGS	男 M				1	1	1		1		4	**9**
	女 F			1	2		1		1		5	
毒藥 POISONS	男 M			1							1	**4**
	女 F			1		2					3	
吊死 HANGING	男 M				1			3	1		5	**8**
	女 F				1	2					3	
由高處跳下 JUMPING FROM HEIGHT	男 M			6	2	5	1	2	1		17	**27**
	女 F			1	2	2	2	1	2		10	
一氧化炭 CARBON MONOXIDE	男 M				2			1			3	**5**
	女 F				1		1				2	
淹死 DROWNING	男 M				1						1	**3**
	女 F			2							2	
利器 SHARP INSTRUMENTS	男 M				1						1	**1**
	女 F											
其他 OTHER	男 M											**1**
	女 F								1		1	
小計 SUB TOTAL	男 M			7	8	6	2	6	3		32	**58**
	女 F			5	6	6	4	1	4		26	
總計 TOTAL				**12**	**14**	**12**	**6**	**7**	**7**		**58**	**58**
受傷類別 TYPE OF INJURY	未確定是意外或故意造成的損傷 INJURY UNDETERMINED WHETHER ACCIDENTALLY OR PURPOSELY INFLICTED											
火器 FIREARMS	男 M											
	女 F											
藥物 DRUGS	男 M											
	女 F											
毒藥 POISONS	男 M											
	女 F											
吊死 HANGING	男 M											
	女 F											
由高處墮下 FALLING FROM HEIGHT	男 M							1			1	**1**
	女 F											
一氧化炭 CARBON MONOXIDE	男 M											
	女 F											
淹死 DROWNING	男 M							1			1	**1**
	女 F											
利器 SHARP INSTRUMENTS	男 M											
	女 F											
其他 OTHER	男 M											
	女 F											
小計 SUB TOTAL	男 M							2			2	**2**
	女 F											
總計 TOTAL								**2**			**2**	**2**

* 有進一步調查及更詳盡的死亡調查報告
with further investigation and more detailed death investigation reports

自殺個案（醫院）*
SUICIDES (Hospital) *
摘錄自自殺類
EXTRACT FROM SUICIDES
（類別、年齡及性別）
(TYPE, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

自殺類別 TYPE OF SUICIDE	年齡組別 AGE GROUPS										小計 SUB TOTAL	**總計 TOTAL**
	性別 SEX	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known		
火器 FIREARMS	男 M											
	女 F											
藥物 DRUGS	男 M											**1**
	女 F				1						1	
毒藥 POISONS	男 M											
	女 F											
吊死 HANGING	男 M											
	女 F											
由高處跳下 JUMPING FROM HEIGHT	男 M											
	女 F											
一氧化炭 CARBON MONOXIDE	男 M											
	女 F											
淹死 DROWNING	男 M											
	女 F											
利器 SHARP INSTRUMENTS	男 M											
	女 F											
其他 OTHER	男 M											
	女 F											
小計 SUB TOTAL	男 M											**1**
	女 F				1						1	
總計 TOTAL					**1**						**1**	**1**
受傷類別 TYPE OF INJURY	未確定是意外或故意造成的損傷 INJURY UNDETERMINED WHETHER ACCIDENTALLY OR PURPOSELY INFLICTED											
火器 FIREARMS	男 M											
	女 F											
藥物 DRUGS	男 M											
	女 F											
毒藥 POISONS	男 M											
	女 F											
吊死 HANGING	男 M											
	女 F											
由高處墮下 FALLING FROM HEIGHT	男 M											
	女 F											
一氧化炭 CARBON MONOXIDE	男 M											
	女 F											
淹死 DROWNING	男 M											
	女 F											
利器 SHARP INSTRUMENTS	男 M											
	女 F											
其他 OTHER	男 M											
	女 F											
小計 SUB TOTAL	男 M											
	女 F											
總計 TOTAL												**0**

* 有進一步調查及更詳盡的死亡調查報告
with further investigation and more detailed death investigation reports

自殺個案（職業）*
SUICIDES (OCCUPATION) *
摘錄自自殺類
EXTRACT FROM SUICIDES
（類別、年齡及性別）
(TYPE, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

職業 OCCUPATION	年齡組別 AGE GROUPS											
	性別 SEX	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known	小計 SUB TOTAL	**總計 TOTAL**
學生 STUDENT	男 M	1	3		1						5	**10**
	女 F		2	3							5	
教師 TEACHER	男 M			1							1	**1**
	女 F											
沒有職業 NOT EMPLOYED	男 M			5	6	8	9	8	4		40	**58**
	女 F		1	2	7	6	2				18	
家庭主婦 HOUSEWIFE	男 M											**8**
	女 F					3	2	1	2		8	
藍領 BLUE COLLAR	男 M			7	5	14	5	3	1		35	**44**
	女 F			2	3	3	1				9	
白領 WHITE COLLAR	男 M				1	3	1				5	**11**
	女 F			2	2		2				6	
病人 PATIENT	男 M											
	女 F											
紀律部隊 DISCIPLINARIES	男 M											
	女 F											
商人 BUSINESS MAN	男 M			1			1				2	**2**
	女 F											
退休人士 RETIRED PERSON	男 M						2	5	9		16	**20**
	女 F							1	3		4	
其他 OTHER	男 M											**1**
	女 F						1				1	
小計 SUB TOTAL	男 M	1	3	14	13	25	18	16	14		104	**155**
	女 F		3	9	12	12	8	2	5		51	
總計 TOTAL		**1**	**6**	**23**	**25**	**37**	**26**	**18**	**19**		**155**	**155**
職業 OCCUPATION	未確定是意外或故意造成的損傷 INJURY UNDETERMINED WHETHER ACCIDENTALLY OR PURPOSELY INFLICTED											
學生 STUDENT	男 M											
	女 F											
教師 TEACHER	男 M											
	女 F											
沒有職業 NOT EMPLOYED	男 M							2			2	**2**
	女 F											
家庭主婦 HOUSEWIFE	男 M											
	女 F											
藍領 BLUE COLLAR	男 M					1					1	**1**
	女 F											
白領 WHITE COLLAR	男 M											
	女 F											
病人 PATIENT	男 M											
	女 F											
紀律部隊 DISCIPLINARIES	男 M											
	女 F											
商人 BUSINESS MAN	男 M											
	女 F											
退休人士 RETIRED PERSON	男 M								1		1	**1**
	女 F											
其他 OTHER	男 M									1	1	**1**
	女 F											
小計 SUB TOTAL	男 M					1		2	1	1	5	**5**
	女 F											
總計 TOTAL						**1**		**2**	**1**	**1**	**5**	**5**

* 有進一步調查及更詳盡的死亡調查報告
with further investigation and more detailed death investigation reports

意外死亡個案
ACCIDENTAL DEATHS
（類別、年齡及性別）
(TYPE, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

意外類別 TYPE OF ACCIDENT	年齡組別 AGE GROUPS										小計 SUB TOTAL	**總計 TOTAL**
	性別 SEX	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known		
吸入（胃容物） ASPIRATION (GASTRIC CONTENTS)	男 M	1					1		5		7	**14**
	女 F							1	6		7	
吸入（食物） ASPIRATION (FOOD)	男 M				1		5	9	26		41	**80**
	女 F	1		1	1	2	3	4	27		39	
吸入（異物） ASPIRATION (FOREIGN BODY)	男 M											**1**
	女 F							1			1	
吸入（其他） ASPIRATION (OTHER)	男 M				1			1	4		6	**11**
	女 F							1	4		5	
窒息 SUFFOCATION	男 M											**1**
	女 F							1			1	
吊死 HANGING	男 M			1							1	**1**
	女 F											
被物件擊中 STRUCK BY OBJECT	男 M			1		4	3	2	2		12	**12**
	女 F											
被升降機壓死 CRUSHED BY LIFT	男 M											
	女 F											
被物件壓死 CRUSHED BY OBJECT	男 M					3	2	4			9	**9**
	女 F											
燒灼 BURNS	男 M	1		1	4				1		7	**25**
	女 F	1	3	3	3	4	1	2	1		18	
一氧化炭（浴室） CARBON MONOXIDE (BATHROOM)	男 M											
	女 F											
一氧化炭（火災） CARBON MONOXIDE (FIRE)	男 M					1					1	**3**
	女 F							2			2	
一氧化炭（其他） CARBON MONOXIDE (OTHER)	男 M											
	女 F											
跌倒 FALLS	男 M		1	6	4	8	14	35	149		217	**320**
	女 F	1		1	1	2	8	10	80		103	
淹死 DROWNING	男 M	1	1	1	4	7	7	13	11		45	**62**
	女 F	1		1	1		2	2	10		17	
觸電 ELECTROCUTION	男 M			1	2						3	**4**
	女 F					1					1	
割或刺 CUT OR PUNCTURE	男 M					1	1		1		3	**4**
	女 F							1			1	
火器 FIREARMS	男 M											
	女 F											
鈍器撞擊 BLUNT FORCE	男 M				1	2		1			4	**6**
	女 F						2				2	
藥物 DRUGS	男 M		1	6	21	30	33	23	5		119	**152**
	女 F				8	11	9	4	1		33	
毒藥 POISONS	男 M											**1**
	女 F					1					1	
中毒（酒精） POISON (ALCOHOL)	男 M				3	2	3	1			9	**11**
	女 F							1	1		2	
內科治療及外科手術 MEDICAL AND SURGICAL CARE	男 M					3	2	6	10		21	**30**
	女 F				1	1	2	2	3		9	
其他 OTHERS	男 M			1	1	6	4	2	4		18	**20**
	女 F						1		1		2	
小計 SUB TOTAL	男 M	3	3	18	42	67	75	97	218		523	**767**
	女 F	4	3	6	15	22	28	32	134		244	
總計 TOTAL		**7**	**6**	**24**	**57**	**89**	**103**	**129**	**352**		**767**	**767**

意外死亡個案（淹死）*
ACCIDENTAL DEATHS (Drowning) *
摘錄自意外死亡類
EXTRACT FROM ACCIDENTAL DEATHS
（類別、年齡及性別）
(TYPE, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

意外類別 TYPE OF ACCIDENT	年齡組別 AGE GROUPS										小計 SUB TOTAL	**總計 TOTAL**
	性別 SEX	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known		
泳池 POOL	男 M	1							2		3	**6**
	女 F	1						1	1		3	
海灘/海 BEACH/SEA	男 M			1	1	3	1	3	2		11	**11**
	女 F											
水庫 RESERVOIR	男 M											
	女 F											
農場 FARM	男 M											
	女 F											
建築地盤 CONSTRUCTION SITE	男 M											
	女 F											
大海（船民） SEA (BOAT PEOPLE)	男 M											
	女 F											
避風塘（船民） TYPHOON SHELTER (BOAT PEOPLE)	男 M											
	女 F											
魚塘 FISH POND	男 M							1			1	**1**
	女 F											
浴室 BATHROOM	男 M											**2**
	女 F						1		1		2	
河流 RIVER	男 M				1						1	**1**
	女 F											
自流井 ARTESIAN WELL	男 M											
	女 F											
其他 OTHERS	男 M						1		1		2	**2**
	女 F											
小計 SUB TOTAL	男 M	1		1	2	3	2	4	5		18	**23**
	女 F	1					1	1	2		5	
總計 TOTAL		**2**		**1**	**2**	**3**	**3**	**5**	**7**		**23**	**23**

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with further investigation and more detailed death investigation reports

意外死亡個案（家居）*
ACCIDENTAL DEATHS (Home) *
摘錄自意外死亡類
EXTRACT FROM ACCIDENTAL DEATHS
（類別、年齡及性別）
(TYPE, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

意外類別 TYPE OF ACCIDENT	年齡組別 AGE GROUPS										小計 SUB TOTAL	**總計 TOTAL**
	性別 SEX	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known		
吸入（胃容物） ASPIRATION (GASTRIC CONTENTS)	男 M											
	女 F											
吸入（食物） ASPIRATION (FOOD)	男 M											**1**
	女 F								1		1	
吸入（異物） ASPIRATION (FOREIGN BODY)	男 M											
	女 F											
吸入（其他） ASPIRATION (OTHER)	男 M											
	女 F											
窒息 SUFFOCATION	男 M											**1**
	女 F							1			1	
吊死 HANGING	男 M			1							1	**1**
	女 F											
被物件擊中 STRUCK BY OBJECT	男 M											
	女 F											
被升降機壓死 CRUSHED BY LIFT	男 M											
	女 F											
被物件壓死 CRUSHED BY OBJECT	男 M											
	女 F											
燒灼 BURNS	男 M			1	1				1		3	**15**
	女 F	1	1	3	2	2	1	2			12	
一氧化炭（浴室） CARBON MONOXIDE (BATHROOM)	男 M											
	女 F											
一氧化炭（火災） CARBON MONOXIDE (FIRE)	男 M											**2**
	女 F							2			2	
一氧化炭（其他） CARBON MONOXIDE (OTHER)	男 M											
	女 F											
跌倒 FALLS	男 M			1				1	2		4	**6**
	女 F			1				1			2	
淹死 DROWNING	男 M											**1**
	女 F								1		1	
觸電 ELECTROCUTION	男 M											
	女 F											
割或刺 CUT OR PUNCTURE	男 M											
	女 F											
火器 FIREARMS	男 M											
	女 F											
鈍器撞擊 BLUNT FORCE	男 M											**1**
	女 F						1				1	
藥物 DRUGS	男 M			1	3	1	4	4	1		14	**27**
	女 F				2	5	2	3	1		13	
毒藥 POISONS	男 M											
	女 F											
中毒（酒精） POISON (ALCOHOL)	男 M				1						1	**1**
	女 F											
內科治療及外科手術 MEDICAL AND SURGICAL CARE	男 M											
	女 F											
其他 OTHERS	男 M				1				2		3	**3**
	女 F											
小計 SUB TOTAL	男 M			4	6	1	4	5	6		26	**59**
	女 F	1	1	4	4	7	4	9	3		33	
總計 TOTAL		**1**	**1**	**8**	**10**	**8**	**8**	**14**	**9**		**59**	**59**

* 有進一步調查及更詳盡的死亡調查報告
with further investigation and more detailed death investigation reports

意外死亡個案（精神病患者）*
ACCIDENTAL DEATHS (Mental) *
摘錄自意外死亡類
EXTRACT FROM ACCIDENTAL DEATHS
（類別、年齡及性別）
(TYPE, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

意外類別 TYPE OF ACCIDENT	年齡組別 AGE GROUPS										小計 SUB TOTAL	**總計 TOTAL**
	性別 SEX	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known		
吸入（胃容物） ASPIRATION (GASTRIC CONTENTS)	男 M											
	女 F											
吸入（食物） ASPIRATION (FOOD)	男 M						1				1	**3**
	女 F						1	1			2	
吸入（異物） ASPIRATION (FOREIGN BODY)	男 M											
	女 F											
吸入（其他） ASPIRATION (OTHER)	男 M				1						1	**1**
	女 F											
窒息 SUFFOCATION	男 M											
	女 F											
吊死 HANGING	男 M			1							1	**1**
	女 F											
被物件擊中 STRUCK BY OBJECT	男 M											
	女 F											
被升降機壓死 CRUSHED BY LIFT	男 M											
	女 F											
被物件壓死 CRUSHED BY OBJECT	男 M											
	女 F											
燒灼 BURNS	男 M				1						1	**2**
	女 F				1						1	
一氧化炭（浴室） CARBON MONOXIDE (BATHROOM)	男 M											
	女 F											
一氧化炭（火災） CARBON MONOXIDE (FIRE)	男 M											
	女 F											
一氧化炭（其他） CARBON MONOXIDE (OTHER)	男 M											
	女 F											
跌倒 FALLS	男 M			1					3		4	**4**
	女 F											
淹死 DROWNING	男 M							1			1	**1**
	女 F											
觸電 ELECTROCUTION	男 M											
	女 F											
割或刺 CUT OR PUNCTURE	男 M											
	女 F											
火器 FIREARMS	男 M											
	女 F											
鈍器撞擊 BLUNT FORCE	男 M											
	女 F											
藥物 DRUGS	男 M				2	4	8	6	1		21	**34**
	女 F				3	6	2	2			13	
毒藥 POISONS	男 M											
	女 F											
中毒（酒精） POISONS (ALCOHOL)	男 M											
	女 F											
內科治療及外科手術 MEDICAL AND SURGICAL CARE	男 M											
	女 F											
其他 OTHERS	男 M					1	1				2	**3**
	女 F						1				1	
小計 SUB TOTAL	男 M			2	4	5	10	7	4		32	**49**
	女 F				4	6	4	3			17	
總計 TOTAL				**2**	**8**	**11**	**14**	**10**	**4**		**49**	**49**

* 有進一步調查及更詳盡的死亡調查報告
with further investigation and more detailed death investigation reports

意外死亡個案（戶外活動）*
ACCIDENTAL DEATHS (Outdoor Activity) *
摘錄自意外死亡類
EXTRACT FROM ACCIDENTAL DEATHS
（類別、年齡及性別）
(TYPE, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

意外類別 TYPE OF ACCIDENT	年齡組別 AGE GROUPS										小計 SUB TOTAL	**總計 TOTAL**
	性別 SEX	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known		
游泳 SWIMMING	男 M	1				1		2	3		7	**10**
	女 F	1						1	1		3	
獨木舟 CANOEING	男 M											
	女 F											
籃球 BASKET BALL	男 M											
	女 F											
足球 FOOTBALL	男 M											
	女 F											
排球 VOLLEY BALL	男 M											
	女 F											
潛水 DIVING	男 M			1		1	1				3	**3**
	女 F											
羽毛球 BADMINTON	男 M											
	女 F											
板球 CRICKET	男 M											
	女 F											
跳高 HIGH JUMP	男 M											
	女 F											
單槓 HORIZONTAL BAR	男 M											
	女 F											
標槍 JAVELIN	男 M											
	女 F											
高爾夫球 GOLF	男 M											
	女 F											
棒球 BASEBALL	男 M											
	女 F											
欖球 RUGBY	男 M											
	女 F											
擲鐵餅 DISCUS THROWING	男 M											
	女 F											
滾軸溜冰 ROLLER-SKATING	男 M											
	女 F											
划艇 ROWING	男 M											
	女 F											
遠足 EXCURSION	男 M				1		2	1			4	**4**
	女 F											
登山運動 MOUNTAINEERING	男 M											
	女 F											
水上體育活動 WATER SPORTS	男 M											
	女 F											
釣魚 FISHING	男 M											
	女 F											
騎馬 HORSE RIDING	男 M											
	女 F											
遊船河 BOAT EXCURSION	男 M				1						1	**1**
	女 F											
滑浪風帆運動 WINDSURFING	男 M											
	女 F											
其他 OTHERS	男 M		1			1					2	**2**
	女 F											
小計 SUB TOTAL	男 M	1	1	1	2	3	3	3	3		17	**20**
	女 F	1						1	1		3	
總計 TOTAL		**2**	**1**	**1**	**2**	**3**	**3**	**4**	**4**		**20**	**20**

* 有進一步調查及更詳盡的死亡調查報告
with further investigation and more detailed death investigation reports

意外死亡個案（被下墜物擊中）*
ACCIDENTAL DEATHS (Hit by Falling Object) *
摘錄自意外死亡類
EXTRACT FROM ACCIDENTAL DEATHS
（類別、年齡及性別）
(TYPE, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

意外類別 TYPE OF ACCIDENT	年齡組別 AGE GROUPS										小計 SUB TOTAL	**總計 TOTAL**
	性別 SEX	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known		
磚塊 BRICK	男 M			1							1	**1**
	女 F											
石塊 STONE	男 M											
	女 F											
木板 WOODEN PLANK	男 M											
	女 F											
花盆 FLOWER POT	男 M											
	女 F											
冷氣機 AIR CONDITIONER	男 M											
	女 F											
瓶子 BOTTLE	男 M											
	女 F											
傢具 FURNITURE	男 M											
	女 F											
器具 / 工具 INSTRUMENT/TOOL	男 M											
	女 F											
窗框 WINDOW FRAME	男 M											
	女 F											
竹杆 BAMBOO POLE	男 M											
	女 F											
批盪（水泥） CEMENT PLASTER	男 M											
	女 F											
批盪（紙皮石） MOSAIC PLASTER	男 M											
	女 F											
招牌 SIGNBOARD	男 M											
	女 F											
升降機 LIFT	男 M											
	女 F											
建築圍板 HOARDING	男 M											
	女 F											
其他 OTHERS	男 M						1		1		2	**2**
	女 F											
小計 SUB TOTAL	男 M			1			1		1		3	**3**
	女 F											
總計 TOTAL				**1**			**1**		**1**		**3**	**3**

* 有進一步調查及更詳盡的死亡調查報告
with further investigation and more detailed death investigation reports

職業死亡個案
OCCUPATIONAL DEATHS
（類別、年齡及性別）
(TYPE, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

意外類別 TYPE OF ACCIDENT	年齡組別 AGE GROUPS									小計 SUB TOTAL	**總計 TOTAL**
	性別 SEX	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known		
被物件擊中 STRUCK BY OBJECT	男 M		1		4	3	1	2		11	**11**
	女 F										
被物件壓死 CRUSHED BY OBJECT	男 M				3	2	3			8	**8**
	女 F										
燒灼 BURNS	男 M										
	女 F										
一氧化炭（火災） CARBON MONOXIDE (FIRE)	男 M				1					1	**1**
	女 F										
跌倒 FALLS	男 M		1		1	4	6	3		15	**18**
	女 F				1	2				3	
觸電 ELECTROCUTION	男 M		1	2						3	**3**
	女 F										
淹死 DROWNING	男 M										
	女 F										
車輛 VEHICLE	男 M										
	女 F										
升降機 LIFT	男 M										
	女 F										
其他 OTHERS	男 M			1	2			1		4	**6**
	女 F				1		1			2	
小計 SUB TOTAL	男 M		3	3	11	9	10	6		42	**47**
	女 F				2	2	1			5	
總計 TOTAL			**3**	**3**	**13**	**11**	**11**	**6**		**47**	**47**

殺人個案 *
HOMICIDES *
（類別、年齡及性別）
(TYPE, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

殺人罪行類別 TYPE OF HOMICIDE	年齡組別 AGE GROUPS										小計 SUB TOTAL	**總計 TOTAL**
	性別 SEX	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un- known		
火器 FIREARMS	男 M											
	女 F											
涉及警方的火器 POLICE INVOLVED FIREARMS	男 M											
	女 F											
被人用銳利物襲擊 SHARP OBJECT ASSAULT	男 M		1		1			1	1		4	**5**
	女 F						1				1	
被人用鈍器襲擊 BLUNT FORCE ASSAULT	男 M						1	1	1		3	**5**
	女 F				2						2	
絞縊 STRANGULATION	男 M											
	女 F											
火燒、有毒物質、氣體、腐蝕性物質 FIRE, NOXIOUS SUBSTANCE, GASES, CORROSIVE SUBSTANCE	男 M							1			1	**1**
	女 F											
窒息 SUFFOCATION	男 M											**1**
	女 F				1						1	
涉及車輛 VEHICLE INVOLVED	男 M											
	女 F											
淹死 DROWNING	男 M											
	女 F											
毆打兒童 BATTERED CHILD	男 M											
	女 F											
藥物 DRUGS	男 M											
	女 F											
中毒 POISONING	男 M											
	女 F											
由高處被推下 PUSHED FROM HIGH PLACE	男 M	1									1	**2**
	女 F									1	1	
其他 OTHERS	男 M											
	女 F											
小計 SUB TOTAL	男 M	1	1		1		1	3	2		9	**14**
	女 F				3		1			1	5	
總計 TOTAL		**1**	**1**		**4**		**2**	**3**	**2**	**1**	**14**	**14**

* 有進一步調查及更詳盡的死亡調查報告
with further investigation and more detailed death investigation reports

車輛導致死亡的個案
VEHICULAR ACCIDENTS
（類別、年齡及性別）
(TYPE, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

意外類別 TYPE OF ACCIDENT	年齡組別 AGE GROUPS										小計 SUB TOTAL	**總計 TOTAL**
	性別 SEX	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known		
行人與電單車 PEDESTRIAN v. MOTORCYCLE	男 M								1		1	**2**
	女 F								1		1	
行人與汽車 / 輕型貨車 / 客貨車 PEDESTRIAN v. CAR/PICK-UP TRUCK/VAN	男 M				1	1	5	5	2		14	**26**
	女 F						1	5	6		12	
行人與貨車 / 巴士 PEDESTRIAN v. TRUCK/BUS	男 M					1	4	5	12		22	**32**
	女 F				1		1	1	7		10	
行人與火車 / 電車 PEDESTRIAN v. TRAIN/TRAM	男 M			1		1					2	**2**
	女 F											
行人與單車 PEDESTRIAN v. BICYCLE	男 M											
	女 F											
單車與汽車 / 輕型貨車 / 客貨車 BICYCLE v. CAR/PICK-UP TRUCK/VAN	男 M					1		1	2		4	**4**
	女 F											
單車與貨車 / 巴士 BICYCLE v. TRUCK/BUS	男 M						1	2			3	**3**
	女 F											
單車失去控制 BICYCLE OUT OF CONTROL	男 M			1			1				2	**3**
	女 F				1						1	
電單車與汽車 / 輕型貨車 / 客貨車 MOTORCYCLE v. CAR/PICK-UP TRUCK/VAN	男 M			1		1					2	**3**
	女 F			1							1	
電單車與貨車 / 巴士 MOTORCYCLE v. TRUCK/BUS	男 M			1			1	1			3	**3**
	女 F											
電單車失去控制 MOTOR CYCLE OUT OF CONTROL	男 M			1	2	5			1		9	**9**
	女 F											
汽車 / 輕型貨車 / 客貨車與汽車 / 輕型貨車 / 客貨車 CAR/PICK-UP TRUCK/VAN v. CAR/PICK-UP TRUCK/VAN	男 M				1				2		3	**4**
	女 F						1				1	
汽車 / 輕型貨車 / 客貨車與貨車 / 巴士 CAR/PICK-UP TRUCK/VAN v. TRUCK/BUS	男 M						1	1			2	**3**
	女 F					1					1	
汽車 / 輕型貨車 / 客貨車與火車 / 電車 CAR/PICK-UP TRUCK/VAN v. TRAIN/TRAM	男 M											
	女 F											
汽車 / 輕型貨車 / 客貨車失去控制 CAR/PICK-UP TRUCK/VAN OUT OF CONTROL	男 M			3	2			1	1		7	**9**
	女 F		1	1							2	
貨車 / 巴士與汽車 / 輕型貨車 / 客貨車 TRUCK/BUS v. CAR/PICK-UP TRUCK/VAN	男 M											
	女 F											
貨車 / 巴士與貨車 / 巴士 TRUCK/BUS v. TRUCK/BUS	男 M											
	女 F											
貨車 / 巴士失去控制 TRUCK/BUS OUT OF CONTROL	男 M							1	1		2	**2**
	女 F											
其他組合 OTHER COMBINATIONS	男 M			1	1			1	1		4	**5**
	女 F							1			1	
小計 SUB TOTAL	男 M			9	7	10	13	18	23		80	**110**
	女 F		1	2	2	1	3	7	14		30	
總計 TOTAL			**1**	**11**	**9**	**11**	**16**	**25**	**37**		**110**	**110**

車輛導致死亡的個案 *
VEHICULAR ACCIDENTS *
（死者位置、年齡及性別）
(POSITION OF THE DECEASED, AGE & SEX)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

年齡 AGE	性別 SEX	司機 DRIVER	騎電單車者 MOTOR CYCLIST	騎單車者 PEDAL CYCLIST	乘客 PASSEN-GER	行人 PEDES-TRIAN	其他位置 OTHER POSITION	小計 SUB TOTAL	**總計 TOTAL**
0 to 9	男 M								
	女 F								
10 to 19	男 M								**1**
	女 F				1			1	
20 to 29	男 M	2	4	1	1	1		9	**11**
	女 F				2			2	
30 to 39	男 M	3	2			1	1	7	**8**
	女 F					1		1	
40 to 49	男 M		3	1	1	3		8	**9**
	女 F				1			1	
50 to 59	男 M		1	1	1	9		12	**15**
	女 F	1				2		3	
60 to 69	男 M	3	1	3		10	1	18	**25**
	女 F					7		7	
70 to	男 M	4	1	2		15		22	**36**
	女 F					14		14	
UNKNOWN	男 M								
	女 F								
小計 SUB TOTAL	男 M	12	12	8	3	39	2	76	**105**
	女 F	1			4	24		29	
個案總數 TOTAL DEATHS		**13**	**12**	**8**	**7**	**63**	**2**	**105**	**105**

* 有進一步調查及更詳盡的死亡調查報告
with further investigation and more detailed death investigation reports

車輛導致死亡個案死者的血液酒精含量 *

BLOOD ALCOHOL LEVEL OF DECEASED IN VEHICULAR ACCIDENTS *

2024 年 1 月 1 日 - 2024 年 12 月 31 日

1ST JANUARY 2024 - 31ST DECEMBER 2024

血液酒精含量水平 BLOOD ALCOHOL LEVEL	司機 DRIVER	騎電單車者 MOTOR CYCLIST	騎單車者 PEDAL CYCLIST	乘客 PASSEN-GER	行人 PEDES-TRIAN	其他位置 OTHER POSITION	**總計 TOTAL**
沒有數據 NO FIGURES	**1**	**1**	**1**	**1**	**11**	**1**	**16**
陰性 NEGATIVE	9	9	5	3	43		**69**
陽性 （每 100 毫升血） POSITIVE (per 100ml blood)							
0 - 50 毫克 0 - 50 mg	2		1	2	5		**10**
51 - 100 毫克 51 - 100 mg				1			**1**
101 - 150 毫克 101 - 150 mg	1	2			1		**4**
151 - 200 毫克 151 - 200 mg							
201 - 250 毫克 201 - 250 mg	2				2		**4**
251 - 300 毫克 251 - 300 mg					1		**1**
301 - 350 毫克 301 - 350 mg							
351 毫克或以上 351 and over							
個案總數 TOTAL DEATHS	**15**	**12**	**7**	**7**	**63**	**1**	**105**

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with further investigation and more detailed death investigation reports

車輛導致死亡個案死者的血液酒精含量 *
BLOOD ALCOHOL LEVEL OF DECEASED IN VEHICULAR ACCIDENTS *
（不同年齡的數字）
(As to Ages)
2024 年 1 月 1 日 - 2024 年 12 月 31 日
1ST JANUARY 2024 - 31ST DECEMBER 2024

血液酒精含量水平 BLOOD ALCOHOL LEVEL	受害者年齡 AGE OF VICTIM									**總計 TOTAL**
	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un- known	
沒有數據 NO FIGURES			**1**	**1**	**3**	**1**	**4**	**6**		**16**
陰性 NEGATIVE		1	1	7	6	10	18	26		**69**
陽性 （每 100 毫升血） POSITIVE (per 100ml blood)										
0 - 50 毫克 0 - 50 mg			3			3	1	3		**10**
51 - 100 毫克 51 - 100 mg			1							**1**
101 - 150 毫克 101 - 150 mg			3				1			**4**
151 - 200 毫克 151 - 200 mg										
201 - 250 毫克 201 - 250 mg			2			1	1			**4**
251 - 300 毫克 251 - 300 mg								1		**1**
301 - 350 毫克 301 - 350 mg										
351 毫克或以上 351 and over										
個案總數 TOTAL DEATHS		**1**	**11**	**8**	**9**	**15**	**25**	**36**		**105**

* 有進一步調查及更詳盡的死亡調查報告
with further investigation and more detailed death investigation reports

與藥物及毒品有關的死亡個案 *
DRUGS AND POISONS RELATED DEATHS *
摘錄自意外死亡、自殺及意圖不確定類
EXTRACT FROM ACCIDENTAL DEATHS, SUICIDES AND UNDETERMINED INTENT
01/01/2024 - 31/12/2024

死亡類別 CLASSIFICATION OF DEATH	年齡組別 Age Groups										小計 SUB TOTAL	總計 TOTAL
	性別 Sex	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known		
X40 非類鴉片鎮痛藥、退熱藥和抗風濕藥的意外中毒及暴露於該類藥物	男 M											
Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics	女 F											
X60 非類鴉片鎮痛藥、退熱藥和抗風濕藥的故意自毒及暴露於該類藥物	男 M											
Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics	女 F											
Y10 非類鴉片鎮痛藥、退熱藥和抗風濕藥的中毒及暴露於該類藥物，意圖不確定的	男 M											
Poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, undetermined intent (e.g. 水楊酸鹽類 Salicylates)	女 F											
X41 鎮癲痛藥、鎮靜-催眠劑、抗震顫麻痺藥和對精神有影響的藥物的意外中毒及暴露於該類藥物，不可歸類在他處者	男 M			1	3	5	4	4			17	
Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	女 F				2	3	2	2			9	**26**
X61 鎮癲痛藥、鎮靜-催眠劑、抗震顫麻痺藥和對精神有影響的藥物的故意自毒及暴露於該類藥物，不可歸類在他處者	男 M				1	1	1				3	
Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	女 F			1	2		1				4	**7**
Y11 鎮癲痛藥、鎮靜-催眠劑、抗震顫麻痺藥和對精神有影響的藥物的中毒及暴露於該類藥物，不可歸類在他處者，意圖不確定的	男 M											
Poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	女 F											
X42 麻醉劑和致幻藥[致幻劑]意外中毒及暴露於該類藥物，不可歸類在他處者	男 M		1	2	9	10	17	13	2		54	
Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	女 F					3	3	1			7	**61**
X62 麻醉劑和致幻藥[致幻劑]故意自毒及暴露於該類藥物，不可歸類在他處者	男 M											
Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	女 F											

Y12	麻醉劑和致幻藥[致幻劑]的中毒及暴露於該類藥物，不可歸類在他處，意圖不確定的 Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent	男 M											
		女 F											
X43	作用於自主神經系統的其他藥物的意外中毒及暴露於該類藥物 Accidental poisoning by and exposure to other drugs acting on the autonomic nervous system	男 M						2				2	**3**
		女 F					1					1	
X63	作用於自主神經系統的其他藥物的故意自毒及暴露於該類藥物 Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system	男 M								1		1	**1**
		女 F											
Y13	作用於自主神經系統的其他藥物的中毒及暴露於該類藥物，意圖不確定的 Poisoning by and exposure to other drugs acting on the autonomic nervous system, undetermined intent	男 M											
		女 F											
X44	其他和未特指的藥物、藥劑和生物製品的意外中毒及暴露於該類物質 Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances	男 M					1			1		2	**6**
		女 F				2	1			1		4	
X64	其他和未特指的藥物、藥劑和生物製品的故意自毒及暴露於該類物質 Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances	男 M											**7**
		女 F			3	1	1		1	1		7	
Y14	其他和未特指的藥物、藥劑和生物製品的中毒及暴露於該類藥物，意圖不確定的 Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent	男 M											
		女 F											
X45	酒精的意外中毒及暴露於酒精 Accidental poisoning by and exposure to alcohol	男 M				1						1	**1**
		女 F											
X65	酒精的故意自毒及暴露於酒精 Intentional self-poisoning by and exposure to alcohol	男 M											
		女 F											
Y15	酒精的中毒及暴露於該類藥物，意圖不確定的 Poisoning by and exposure to alcohol, undetermined intent	男 M					1					1	**1**
		女 F											
X46	有機溶劑和鹵化烴及此兩類物質的汽體的意外中毒及暴露於該類物質／汽體 Accidental poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours	男 M											
		女 F											
X66	有機溶劑和鹵化烴及此兩類物質的汽體的故意自毒及暴露於該類物質／汽體 Intentional self-poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours	男 M											
		女 F											

Y16 有機溶劑和鹵化烴及此兩類物質的汽體的中毒及暴露於該類物質／汽體，意圖不確定的 Poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours, undetermined intent	男 M											
	女 F											
X47 其他氣體及蒸氣的意外中毒及暴露於該類氣體 Accidental poisoning by and exposure to other gases and vapours	男 M											**1**
	女 F					1					1	
X67 其他氣體及蒸氣的故意自毒及暴露於該類氣體 Intentional self-poisoning by and exposure to other gases and vapours	男 M			2	3	6	2	3	1		17	**22**
	女 F			1	2	1	1				5	
Y17 其他氣體及蒸氣的中毒及暴露於該類氣體，意圖不確定的 Poisoning by and exposure to other gases and vapours, undetermined intent	男 M											
	女 F											
X48 除害劑的意外中毒及暴露於該類物質 Accidental poisoning by and exposure to pesticides	男 M											
	女 F											
X68 除害劑的故意自毒及暴露於該類物質 Intentional self-poisoning by and exposure to pesticides	男 M											
	女 F											
Y18 除害劑的中毒及暴露於該類物質，意圖不確定的 Poisoning by and exposure to pesticides, undetermined intent	男 M											
	女 F											
X49 其他和未特指的化學品及有害物品的意外中毒及及暴露於該類物品 Accidental poisoning by and exposure to other and unspecified chemicals and noxious substances	男 M											
	女 F											
X69 其他和未特指的化學品及有害物品的故意自毒及暴露於該類物品 Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances	男 M			1			1				2	**3**
	女 F					1					1	
Y19 其他和未特指的化學品及有害物品的中毒及暴露於該類物品，意圖不確定的 Poisoning by and exposure to other and unspecified chemicals and noxious substances, undetermined intent	男 M											
	女 F											
Y47 鎮靜劑、 安眠藥及抗焦慮藥物 Sedatives, hypnotics and antianxiety drugs	男 M						1				1	**1**
	女 F											
小計 SUB-TOTAL	男 M		1	6	17	24	28	20	5		101	**140**
	女 F			5	9	12	7	4	2		39	
總計 TOTAL			**1**	**11**	**26**	**36**	**35**	**24**	**7**		**140**	**140**

* 有進一步調查及更詳盡的死亡調查報告
with further investigation and more detailed death investigation reports

自然原因導致死亡個案

DEATHS FROM NATURAL CAUSES

（類別、年齡及性別）

(TYPE, AGE & SEX) (New Code)

2024 年 1 月 1 日 - 2024 年 12 月 31 日

1ST JANUARY 2024 - 31ST DECEMBER 2024

疾病類別 TYPE OF DISEASES	年齡組別 AGE GROUPS										小計 SUB TOTAL	**總計 TOTAL**
	性別 SEX	0 to 9	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to	不詳 Un-known		
某些傳染病和寄生蟲病 Certain infectious and parasitic diseases A00 - B99	男 M	1			3	9	17	57	144		231	**409**
	女 F	5		1	3	6	16	26	121		178	
腫 瘤 Neoplasms C00 - D48	男 M	2		1	2	18	47	190	344	1	605	**1019**
	女 F			1	6	15	42	99	251		414	
血液和造血器官疾病 Diseases of blood and blood-forming organs and certain disorders involving the immune mechanism D50 - D89	男 M				1		2	3	5		11	**16**
	女 F						1		4		5	
內分泌、營養和新陳代謝有關的疾病和免疫失調 Endocrine, nutritional and metabolic diseases E00 - E90	男 M		1		2	7	22	30	38		100	**187**
	女 F			1	1	5	11	23	46		87	
精神錯亂 Mental and behavioural disorders F00 - F99	男 M				1		3	1	25		30	**94**
	女 F					1		1	62		64	
神經系統疾病 Diseases of the nervous system G00 - G99	男 M	1		3	7	3	6	19	30		69	**132**
	女 F	1	1		1	5	9	14	32		63	
眼部和屬眼的疾病 Diseases of the eye and adnexa H00 - H59	男 M											
	女 F											
耳部和屬耳的疾病 Diseases of the ear and mastoid process H60 - H95	男 M											
	女 F											
循環系統疾病 Diseases of the circulatory system I00 - I99	男 M	4		11	47	159	362	730	1634		2947	**4862**
	女 F	2	1	4	9	53	90	235	1520	1	1915	
呼吸系統疾病 Diseases of the respiratory system J00 - J99	男 M	5	1	6	11	28	56	152	611	1	871	**1277**
	女 F	4		3	8	18	31	66	276		406	
消化系統疾病 Diseases of the digestive system K00 - K93	男 M	3		1	1	15	27	57	122	1	227	**366**
	女 F		1		2	4	7	20	105		139	
皮膚和皮下組織疾病 Diseases of the skin and subcutaneous tissue L00 - L99	男 M					2	1		1		4	**6**
	女 F								2		2	
肌肉與骨骼系統和結締組織疾病 Diseases of the musculoskeletal system and connective tissue M00 - M99	男 M						2	2	7		11	**28**
	女 F				1	4	3	1	8		17	
生殖泌尿系統疾病 Diseases of the genitourinary system N00 - N99	男 M	1		2		9	17	27	73		129	**227**
	女 F			1	5	2	7	17	66		98	
懷孕期、分娩和產後併發症 Pregnancy, childbirth and the puerperium O00 - O99	男 M											**1**
	女 F				1						1	
一些始於出生前後嬰兒時期的狀況 Certain conditions originating in the perinatal period P00 - P96	男 M	1								2	3	**11**
	女 F	4								4	8	
先天畸形 Congenital malformations, deformations and chromosomal abnormalities Q00 - Q99	男 M	1			1	1	3		1		7	**16**
	女 F	3	2				1	2	1		9	
其他種類的症狀，徵象和異常的臨床及化驗發現 Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified R00 - R99	男 M	5		9	11	23	63	114	654	12	891	**1827**
	女 F	3			8	11	24	40	848	2	936	
小計 SUB TOTAL	男 M	24	2	33	87	274	628	1382	3689	17	6136	**10478**
	女 F	22	5	11	45	124	242	544	3342	7	4342	
總計 TOTAL		**46**	**7**	**44**	**132**	**398**	**870**	**1926**	**7031**	**24**	**10478**	**10478**

2024 年造成死亡的外在原因的國際疾病分類編碼週年報表
（有進一步調查及更詳盡的死亡調查報告的死亡個案）
Annual Return of International Classification of Diseases Code for External Causes of Deaths (deaths requiring further investigation and more detailed death investigation reports) in 2024

標題/代碼編號　SUBJECT /CODE NO.

I. 意外	
Accidents	
i) 交通意外	
Transport accidents	
1. 行人在交通意外中受傷 (V01-V09)	
Pedestrian injured in transport accident	62
2. 騎腳踏車者在交通意外中受傷 (V10-V19)	
Pedal cyclist injured in transport accident	8
3. 騎摩托車者在交通意外中受傷 (V20-V29)	
Motorcycle rider injured in transport accident	14
4. 三輪汽車使用者在交通意外中受傷 (V30-V39)	
Three-wheeled motor vehicle occupant injured in transport accident	
5. 私家車使用者在交通意外中受傷 (V40-V49)	
Car occupant injured in transport accident	14
6. 輕型貨車或客貨車使用者在交通意外中受傷 (V50-V59)	
Occupant of pick-up truck or van injured in transport accident	2
7. 重型運輸車使用者在交通意外中受傷 (V60-V69)	
Occupant of heavy transport vehicle injured in transport accident	1
8. 巴士使用者在交通意外中受傷 (V70-V79)	
Bus occupant injured in transport accident	1
9. 其他陸上交通意外 (V80-V89)	
Other land transport accidents	2
10. 水上交通意外 (V90-V94)	
Water transport accidents	1
11. 航空及太空交通意外 (V95-V97)	
Air and space transport accidents	2
12. 其他及未指明性質的交通意外 (V98-V99)	
Other and unspecified transport accidents	
ii) 意外受傷的其他外在成因	
Other external causes of accidental injury	
1. 跌倒 (W00-W19)	
Falls	50
2. 暴露於無生命的外物物力 (W20-W49)	
Exposure to inanimate mechanical forces	29

3. 暴露於有生命的外物物力 (W50-W64) Exposure to animate mechanical forces	1
4. 意外淹死及淹沒 (W65-W74) Accidental drowning and submersion	23
5. 其他危及呼吸的意外情況 (W75-W84) Other accidental threats to breathing	12
6. 暴露於電流、輻射及極端的環境氣溫及氣壓 (W85-W99) Exposure to electric current, radiation and extreme ambient air temperature and pressure	3
7. 暴露於煙、火及火焰 (X00-X09) Exposure to smoke, fire and flames	27
8. 接觸熱力及熱的物質 (X10-X19) Contact with heat and hot substances	1
9. 接觸分泌毒液的動植物 (X20-X29) Contact with venomous animals and plants	
10. 暴露於大自然力量 (X30-X39) Exposure to forces of nature	1
11. 由有害物質及暴露於有害物質的情況下所導致的意外中毒 (X40-X49) Accidental poisoning by and exposure to noxious substances	98
12. 勞累過份用力、出行及缺乏生活必需品 (X50-X57) Overexertion, travel and privation	
13. 意外地暴露於屬其他類別及未指明的因素 (X58-X59) Accidental exposure to other and unspecified factors	
II. 故意使自己受到傷害 (X60-X84) **Intentional self-harm**	155
III. 襲擊 (X85-Y09) **Assault**	14
IV. 未確定意圖的事件 (Y10-Y34) **Event of undetermined intent**	5
V. 合法干預及戰爭行動 (Y35-Y36) **Legal intervention and operations of war**	
VI. 接受醫療及外科護理後出現各類併發症的情況 **Complications of medical and surgical care**	
i) 藥物、藥劑及生物質於治療用途中導致不良效應 (Y40-Y59) Drugs, medicaments and biological substances causing adverse effects in therapeutic use	3
ii) 病人在接受外科及醫療護理期間遇到不幸 (Y60-Y69) Misadventures to patients during surgical and medical care	3
iii) 與在診斷及治療用途中發生的各類負面事故相關的醫療設備 (Y70-Y82) Medical devices associated with adverse incidents in diagnostic and therapeutic use	1

iv) 外科及其他醫療程序導致病人出現異常反應或後期出現併發症（在有關程序進行期間並無提及發生不幸）(Y83-Y84) Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure	8
VII. 患病及死亡的外在成因的後發病 (Y85-Y89) **Sequelae of external causes of morbidity and mortality**	1
VIII. 與分類於他處的患病及死亡的各種成因有關的輔助因素 (Y90-Y98) **Supplementary factors related to causes of morbidity and mortality classified elsewhere**	10
IX. 影響健康狀態和與保健機構接觸的因素 (Z00-Z99) **Factors influencing health status and contact with health services**	
死因不明的死亡個案 **Unknown Causes of Mortality**	135
自然死因 **Natural Causes**	563
[Total 總數]	**1,250**