CORONERS' REPORT

死因裁判官報告

2018

Contents 目錄

第一部

2018年死因裁判官報告

死亡數字上升趨勢

1. 今年共有 47,479 宗死亡登記，至於曾向死因裁判官報告的死亡個案，則有 10,976 宗。過去 18 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

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 10 年，即 2007 至 2016

年期間，數字反覆向上。2017 年的死亡登記數字及向死因裁判官報告的個案相對 2016 年輕微回落，但於 2018 年又再度回升。2018 年的數目比 2017 年的高出百分之三左右。整體而言，死亡登記數字及向死因裁判官報告的個案均有逐漸上升的趨勢。此趨勢相信可能是因為香港人口不斷增加及人口老化所致。

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，便會根據世界衛生組織所制訂的《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. 如果我們認為有關的死亡個案須予進一步調查，便會通知警方展開進一步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. 下表列出關於過去十八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	須進行研訊的個案	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	1128	117	112	5	96%
2018	10,976	1083	161	152	9	94%

7. 2018年，死因裁判法庭召開的死因研訊個案較2017年大約增加了百分之四十，較2016年更增加了百分之一百一十。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，而所召開的研訊所牽涉的議題亦較過往複雜，因而令這些研訊所需的研訊日較多；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。

<u>內庭申請</u>

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 2018 年，死因裁判官一共處理了 880 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夠找出死亡原因。

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。

自殺個案

15. 今年有955宗自殺個案，其中219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 604:351。青少年自殺組別的個案較上年增加了百分之六，情況令人關注。

意外死亡個案

16. 今年有628宗意外死亡個案，其中197宗須由警方進一步調查並提交更詳盡的死亡調查報告。上述意外死亡人數與去年相若。男性因意外引致死亡的數字遠高於女性，比率為401:227。

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，便包括了所有看來是與職業有關的意外(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 24 宗，包括 22 宗在陸上發生的和 2 宗在海上發生的。24 名死者全是男性。

殺人個案

18. 今年有 10 人死於被殺，其中男性佔 3 人，女性佔 7 人。

車輛導致死亡的個案

19. 今年有 119 宗由車輛導致的死亡。其中 69 名死者是行人，佔去死亡數字約一半。119 名死者中，有 43 名是 70 歲以上的老人家，佔此組別的死亡數字約三分一。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 84:35。

與毒品及藥物有關的個案

20. 今年有 139 宗死亡與毒品或藥物有關，和去年比較增加了百分之八十，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 98: 41。

自然死亡個案

21. 今年因各種疾病而死亡的人數是 9352 人，其中因循環系統疾病而死亡的有 3989 人，佔這個類別的死亡人數五分之二。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 5545: 3807。

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，有些死亡類別甚至高出很多，例如職業死亡個案是 24 與 0 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) 一名患有乙型肝炎的男士因慢性轉急性肺炎離世

醫院管理局及何文翰醫生

(1) 如果病人拒絕接受任何檢查或服用藥物，最好在排版內記錄及註明原因。

(2) 在醫生處方藥物前，最好要求病人簽署他 / 她已知道藥物的副作用及嚴重性。

將軍澳醫院

醫院應該有 24 小時候召專科醫生。

醫院管理局

醫院應該能查閱同一個病人在所有醫院的病歷，而不只是單單該名病人在該醫院的病歷。

何文翰醫生

需嚴格按照藥廠建議讓病人服藥。

(ii) 一名被診斷患有精神分裂症的病人，在住院期間被處方精神科藥物「可致律」，導致其糖尿病酮症酸中毒死亡

青山醫院

(1) 在實驗室報告上，有標示“H”和“L”數值的旁邊加簽。

(2) 醫院要檢討處方可致律之後的評估方法，要跟從國際指引定期檢查血糖血脂，包括在證物 C12 內段落 11D 的要求。

(3) 當需要調整精神病患者精神科藥物的時候，包括加藥或減藥，需要通知病患者家屬或監護人，亦需要派發藥物的小冊子。

(4) 如果病人發生急救情況，醫院通知家屬時要告知急救的過程。

(iii) 一名消防員在執行任務時，遇上氣體爆炸，引致其後腦撞擊硬物令其昏迷，最後因腦部受傷及支氣管肺炎離世

嘉怡物業管理有限公司

(1) 增強員工處理氣體洩漏事故的訓練。

(2) 購置氣體探測器供員工使用及提供相關訓練。

消防處

(1) 改善目前處理氣體洩漏事件的工作指引。

(2) 改善／增強消防處管理職級對處理氣體洩漏事故的培訓。

(iv) 一名初次參加渡海泳的男士在比賽期間遇溺死亡

大埔體育會

(1) 需要求吐露港渡海泳的參加者在參加表格上聲明是否患有慢性疾病或長期病患（如呼吸系統或心臟病等），如有的話參加者必須提供醫生證明以確認他們可以應付渡海泳的途程。

(2) 在每一組泳手下水前，需安排有救護資歷或經驗的人士觀察該些泳手的身體狀況，以確保他們是否適合下水及提醒他們如身體不適不要下水。

(3) 向每一位參加渡海泳的獨木舟救生員提供對講機。

獨木舟總會及香港拯溺總會

盡快就獨木舟救生員的資歷及要求制定互相承認的標準。

(v) 一名患有神經纖維瘤的男士，因血管異常導致出血及破裂，最後因出血及吸入血液死亡

醫院管理局

(1) CT 和 MRI 檢查應該在星期六、日及公眾假期，能夠提供最基本的緊急服務。

(2) 在緊急轉介的個案，所有醫療報告、病歷記錄及轉介信，亦要附於急症室及病房排版中，以供有關醫生參考。

(vi) 一名患有急性心肌梗塞的男士在醫院的急症室接受溶解血栓療法，及後因腦橋出血及急性心肌梗塞死亡

醫院管理局

盡快落實執行每一個聯網有一間醫院可以進行全天候 24 小時通波仔手術。

博愛醫院

(1) 在「溶解血栓療法」錄音中，可以加上有百分之 0.9 腦出血的併發症。

(2) 博愛醫院應該參考瑪嘉烈醫院在給予急症室使用溶解血栓療法清單中，在每一項考慮加上「是」及「否」的格子。

(vii) 再有一名患有急性心肌梗塞的男士，在醫院急症室接受溶解血栓療法後因腦出血死亡

醫院管理局

盡快落實及執行在每一個區域內至少有一間急症醫院提供每星期 7 天，每天 24 小時的緊急經皮冠狀動脈介入療法（即通波仔手術）。

(viii) 一名女士在接受以腹腔鏡移除輸尿管結石的手術過程中，其右總髂動脈被誤當為輸尿管而遭切割，最後她因右總髂動脈裂傷大量出血死亡

醫院管理局

(1) 在以腹腔鏡移除輸尿管結石的手術過程中，主刀醫生應適時因應情況，考慮是否需要將手術轉為傳統開刀方式繼續進行。
(2) 若主刀醫生在以腹腔鏡移除輸尿管結石手術時遇到困難情況，如不能確定病者輸尿管的位置，應尋求資深醫生的協助及意見。

(ix) 一名在囚女士在大欖女子懲教院所的醫院病房內洗手間內使用懲教員提供的胸圍上吊

香港懲教署

(1) 所有派給在囚人士衣物必須編配號碼及作出記錄。

(2) 懲教署人員必須提高警覺，多加留意不尋常狀況，例如離開病床太久的病人。

(3) 巡邏讀咭器應該改裝至洗手間較入位置，例如在無障礙洗手間馬桶旁邊。

(4) 更改或增設醫生駐院時間，令新收的病人可即時得到醫生的評估；增設輔導員對新收在囚人士作出輔導。

(5) 加強在職培訓，例如處理緊急事項的反應以及使用醫療儀器的訓練。

(x) 一名工人在混凝土配料廠石粉儲存倉堆積的石粉堆上工作期間，因石粉倉的底部閘門打開，令他墮進倉底，被困在閘門出入口處引致窒息死亡。

珠江船舶貨運有限公司

當船員需下船上岸並在濕滑或凹凸不平工地工作時，必須確保他們穿上安全鞋，以預防他們因穿著不合適的鞋子而滑倒受傷。

(xi) 一名需插鼻胃喉的住院病人自行拔除鼻胃喉，其後因氣管吸入胃液，導致氣管及肺部損傷

醫院管理局

檢討及制定高危病人自行拔鼻胃喉的處理機制及制定指引，加強前線醫護人員的相關培訓。

(xii) 一名煤氣學徒在一個住宅地盤的單位內因一氧化碳中毒死亡

晉業建築有限公司

在住宅地盤初步竣工直至單位交付賣家前，需在每一個工作天完結時檢查每一個單位內是否有人逗留並將單位大門鎖上，以防止有人可以在單位內留宿。

利安煤氣工程有限公司

若安排煤氣技工學徒往工地或處所工作時，在同一工地或處所的所有員工均需獲告知該名學徒的身份，以便作出適當的監管。

(xiii) 一名疑犯在警署的羈留室內上吊

香港警務處處長

(1) 於每個羈留室加設電子拍咭系統，用以記錄巡查狀況，並設定警告系統，如每25分鐘沒有拍咭記錄時，發出訊息通知值日官或相關職員。

(2) 檢視現行的羈留室設計，如減少鐵絲網與其他組件接駁位。

(3) 定期將疑犯轉換不同羈留室，以減少疑犯透過發現羈留室內的設施損毀狀況作出自殘行為的機會。

(xiv) 再有一名疑犯在警署的羈留室內上吊

警務處處長

(1) 考慮在避免拍攝到羈留倉廁格的情況下，加裝閉路電視，以顯示臨時拘留室及正式羈留倉內部情況。

(2) 提升及採納更高規格的科技（以提高監察質素），例如：

i) 全面改裝高解像度，甚至可錄音的閉路電視鏡頭；

ii) 採用 X 光探測儀作「羈留搜查」之用；

iii) 替被拘留人士戴上智能手帶，以檢測其生命跡象，有需要時可馬上施救；

iv) 資訊科技部門於羈留設施內的電腦斷線後，馬上向相關警局發出警示。

(3) 於現行使用的流水簿上：

i) 每頁標注「不可偽造紀錄」警示，並標明相關刑責；

ii) 增設“簽署”欄目，每項巡查紀錄必須由相關警員簽署作實，並註明其警員編號。

(4) 流水簿紀錄，在每間警局內部抽查的基礎上，須交由警方內部第三方小組定期抽查。

(5) 確保每一當值更份內，最少有一名曾接受急救訓練的警員當值，以便有需要時進行初步施救。

(6) 警方內部應有一部門，定期巡查各分區警局，就其保安及安全措施作出報告；提出具體改善建議及跟進。該部門亦應“一站式”向各分區警署提供行政、採購、工程維修方面的支援，除提出工作指引外，亦應提出具體實施方案。

(7) 警方於選用消防及安全設施供應商時，必須於採購標書內標明：

i) 供應商應確保維修技工接受良好訓練及熟知產品知識；

ii) 供應商必須提供產品使用培訓予警方；

iii) 供應商必須提供產品使用手冊。

(8) 就法證科而言，進行案情模擬實驗之人員須親身陪同搜證警員到達案發現場，以便其設計的實驗能更完善地模擬案情。

(9) 警方可考慮就下列兩方面，修改現行的「警察通例」及「程序手冊」：

i) 就「羈留搜查」而言，詳細及清晰列明何時需要進行搜查的等級及條件；

ii) 就「巡查時間」而言，應詳釋字眼的定義，例如「每小時至少巡一次」應列明為「每隔一小時至少巡一次」。

(10) 建築署應就全港警署之設計、建造及施工制訂統一的「標準守則」，並詳列羈留設施的「防自殺」標準，例如所有倉內採用防撞牆設計以避免拘留人士撞牆自殘。

(11) 就使用新推出的「電子羈留巡查系統」而言，應考慮使用「生物特徵」作巡查紀錄，以杜絕「代替拍卡」及或「擅離職守」的情況。

政府化驗所
法證事務科

就法證科而言，進行案情模擬實驗之人員須親身陪同搜證警員到達案發現場，以便其設計的實驗能更完善地模擬案情。

建築署

建築署應就全港警署之設計、建造及施工制訂統一的「標準守則」，並詳列羈留設施的「防自殺」標準，例如所有倉內採用防撞牆設計以避免拘留人士撞牆自殘。

(xv) 一名男士因化膿性鏈球菌感染引致鏈球菌中毒性休克症候群連帶壞死性筋膜炎至死亡

醫院管理局

(1) 如果病人血壓無法量度，應制定更科學指引讓前線醫護人員參考。

(2) 減少醫護人員及病人比例。

(3) 增加市民對壞死性筋膜炎認識，提高大眾對處理傷口的意識。

(xvi) 一名女士因瀰漫性全身性硬化症引致肺高壓導致心臟衰竭死亡

醫院管理局

當不能從 EPR 取出病人資料，醫護人員應從其他途徑索取醫療紀錄，以保障病人能獲得適切治療。

(xvii) 一名女士在其家人替她申請監護令期間被帶離香港，最後此女士在監護令生效時在香港境外離世

監護委員會

當申請監護令期間時，應不讓擬被監護人離開香港，假若需離開香港，要提供足夠理由。

(xviii) 一名在囚人士因肺癌連帶腦部轉移死亡

香港懲教署

應考慮在監獄醫院提供中醫服務供犯人選擇。

(xix) 一名女子從高處墮下引致身體多處受傷死亡

警務處處長

警方在處理「墮樓」事件之調查過程中，可作更仔細及詳盡的調查記錄。

(xx) 一名女子因左下肢深層靜脈血栓引致肺栓塞死亡

香港中醫藥管理委員會

(1) 建議 CMP 執業註冊試範圍加入 DVT 的內容。

(2) CMP 定期進修內容可包括 DVT 的相關知識。

醫院管理局

醫管局轄下中醫部發出的針灸安全指引可根據今次個案作出檢討。

(xxi) 一名沙中線地盤工人移除插鎖時令吊臂屈曲塌下被壓倒導致死亡

勞工處

建造業議會

(1) 勞工處確保總承建商及所有分判商必須制訂詳細的安全施工程序及適當的安全措施，清晰界定彼此間的安全責任，及能有效協調和溝通，使安全工作系統全面實施。

(2) 建造業議會針對起重機操作員考牌課程應加強起重機操作員對工作範疇的認知，及加強相關工作安全意識的培訓，包括起重機拆卸的工作必須在具備足夠經驗的合資格人士直接監督下方可進行安全拆卸。

(xxii) 一名女子因急性心肌梗塞連帶心臟左前方游離壁破裂心包積血死亡

醫院管理局

醫院應完善心臟深切治療部簡稱(CCU)收症政策，增加彈性，即使 CCU 沒有床位，患有高風險心臟疾病的病人也應得到適當的心臟科的治療，相關心臟科醫生也應緊密監察和臨床應診，提供和 CCU 相關的治療和跟進，而非受 CCU 床位所限。

(xxiii) 一名中學生從高處墜下自殺身亡

警衛城有限公司

東華三院甲寅年總理中學

警衛城有限公司

必須有清晰指引，要求保安員在響警鐘時馬上到現場查看情況。

東華三院甲寅年總理中學

(1) 學校需加強教育宣傳，引導學生正向思考及面對逆境能力。

(2) 學校需加強家長與老師的溝通。

(3) 學校的懲罰機制必須透明，讓家長及學生清晰了解被處分的後果。

(4) 學校需向班主任訂出清晰指令，對表現與平時有落差的學生多加關注，有需要時可轉介予社工跟進。

(5) 學校必須對班主任、輔導老師、訓導老師及社工的分工清晰，以讓學生及家長在有需要時可聯絡適當人士求助。

(6) 學校應制訂明文清晰的程序指引去處理學生行為紀律的問題。

(7) 對於學生犯錯的情況，學校必須制訂清晰的懲罰處分機制，並向家長及學生說明進行處分的程序。

(8) 學校需為負責訓導的老師提供專業的培訓指導，而非讓老師以慣常做法去處理學生的問題。

(9) 工作方法：(處理學生問題時)

a) 先向家長通報；

b) 在沒迫切性下，避免向學生說出未被確定的處分；

c) 在家長陪同下，向學生當面了解犯錯的情況及背後的原因。

(xxiv) <u>一名女子因敗血性流產死亡</u>

醫院管理局

(1) 加強孕婦對穿羊水後果及其嚴重性的認知，最嚴重可引致死亡。建議所有產前教育可用動畫方法表達，令孕婦及家屬更容易明白及怎樣處理。

(2) 婦產科於收症時要有註冊助產士負責收症。

(3) 加強負責手術醫生及麻醉科醫生溝通，以便了解手術之急切性。

以上建議應推廣至全醫管局醫院執行。

(xxv) 一名男子於健身中心參加肌肉訓練課程期間因動脈粥樣腫導致冠狀動脈閉塞死亡

國際康體專才培訓學院 (IPTFA)

私人健身教練除了要急救證書外，亦應修讀有關 AED 使用課程。

(xxvi) 一名女子因牽涉肺部，胸膜，脾臟及骨骼的粟粒型結核病連帶彌漫性肺泡損傷及肺炎死亡

醫院管理局

急救能力 / 知識：
定期提供重複急救訓練予病房的前線護士。

文件記錄：
所有主要的維生指數應集中記錄於同一表格以便不同的醫護人員查閱及記錄，並且維生指數檢查後，應記錄讀數及檢查時間，所有記錄的修改必須由修改之醫護人員簽名作實及紀錄修改之時間。

替假醫生安排：
替假醫生應為該病房之本科醫生，如由非本科醫生替假，該醫生作出之醫療決定應由本科醫生覆核。

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從總部給予精神上及資源上的支援。在 2018 年，我們委派了死因裁判官崔美霞前往澳洲堪培拉參加亞太區死因裁判官協會會議，獲益良多。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。他們工作的成果，可見於職業死亡個案的數目在過往數年有減少的趨勢。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

高偉雄　　崔美霞

二零一九年七月

Part One

Coroners' Report 2018

Number of Deaths on a Rising Trend

1. A total of 47,479 deaths were registered this year, and a total of 10,976 deaths were reported to the Coroners. Figures for the last 18 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

2. From the list above we can see that the number of deaths registered increased year by year from 2001 to 2005. The trend has turned downward a little bit in 2006. The figures in the past 10 years, between 2007 and 2016, show a

mixed uptrend. The number of deaths registered and the number of cases reported to coroners for 2017 have slightly dropped as compared with the figure of 2016. However, the figure increases again in 2018, which is about 3% over that of 2017. The number of deaths registered and the number of case reported show a tendency of gradual rise as a whole. It is believed that this trend is due to a continuously rising population and an aging population of Hong Kong.

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 are of the view that the investigation carried out by the Police has come up with 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 is clear and there is no suspicion, we shall assign the death a classification code 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. If we consider that further investigation of the death is required, we shall inform the Police to investigate further and to submit a more detailed death investigation report to us. 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 months to 1 year or sometimes even longer. Upon perusal of that report, and upon considering all the

circumstances of the case, we shall consider 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 shall 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 18 years showing how reported deaths were dealt with :

	Deaths Reported to the Coroners	Further Investigations	Inquests	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	1128	117	112	5	96%
2018	10,976	1083	161	152	9	94%

7. In 2018, the number of death inquests convened in Coroners' Court increases by about 40% as compared with that in 2017 and it even represents an increase of 110% as compared with that in 2016. In recent years, there have been increasing numbers of requests from family members, their legal representatives or interested parties that public inquests be held. Some of the issues involved in the inquests if held are much more complicated as compared with the past, and as a result, more hearing days are required. Most of those requests involved deaths are connected with medical or surgical incidents. They are 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 those requests, discretion is often exercised by the Coroner in favour of the families in ordering the Police to furnish further investigation reports and expert opinion reports from independent medical experts, which will be made available to the families so that they will be able to know more about the cause of death and the circumstances connected with it. In addition, inquests are held where necessary, especially when it appears that useful recommendations might 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 incidences. 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 may be more able to accept the fact of the death of their loved ones.

Chamber Applications

9. In our previous reports we described the procedure by which family members may appear before the Coroners to apply 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 work of the Coroners and we therefore mention the procedure yet again here.

10. Typically a public hospital clinical pathologist or a Department of Health forensic pathologist will have examined the medical records of the deceased and the course of events leading to his death. The pathologist will have also carried out an external examination of the body. If he is still unable to determine a cause of death, he would advise the Coroners that it is necessary to perform an autopsy to ascertain the cause. Members of the family of the deceased are often deeply upset by this suggestion and will come before a Coroner and express intensely cultural, religious, sentimental and other reasons as to why an autopsy should not be performed. In 2018, the Coroners dealt with a total of 880 applications under this category.

11. The Coroners fully appreciate the family members' concern when they handle this kind of applications. These family members themselves are attempting to deal with intense emotional feelings of loss. When on top of this, they have to face the suggested need for autopsy when throughout his life, the deceased had indicated a fear and abhorrence of surgical intervention or even hospital stay, it will be something which is extremely difficult for many family members 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 in 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 in strict 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 careful explanation to the family as to why an autopsy is required is necessary.

13. In recent years, upon the suggestion of the Coroners, the flow of medical information between public hospitals and the Government Forensic Pathology Service has increased. As a result, in regard to Hospital Authority patients who have been treated in the public hospitals in the period immediately prior to death, the forensic pathologists now have more medical history of the deceased to enable them to find the cause of death without having to perform an autopsy.

14. On the one hand, the Coroners have a duty to ascertain the cause of death in respect of every death, on the other hand, we also have to consider the emotion and sentiment of family members. The Coroners therefore have to exercise their judicial powers carefully on every waiver application, taking into consideration all the relevant factors and circumstances of the matter.

Suicides

15. The number of suicides this year is 955, 219 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 604 : 351. It is a cause for concern that the number of suicides for juvenile has increased by 6% as compared with last year.

Accidental Deaths

16. The number of accidental deaths this year is 628, including 197 where further investigation by the Police followed by a more detailed death investigation report is required. This year's figures are more or less the same as last year's . The number of men died as a result of an accident is much higher than that of women, with the ratio of 401 : 227.

Occupational Deaths

17. In our reports up to 2009 we have only mentioned occupational deaths in respect of which an inquest has been held. Having given the matter careful consideration, we think the whole picture has not been fully presented. Therefore, starting from the 2010 report, we refer to the number of deaths which appears to be occupational deaths, including those occurring on land and at sea. There are a total of 24 occupational deaths, of which 22 are on land and 2 is at sea. All of the 24 deceased are men.

Homicides

18. The number of people unlawfully killed is 10, including 3 men and 7 women.

Vehicular Accidents

19. The number of deaths arising from vehicular accidents is 119. Of these 119 deaths, 69 deceased are pedestrians, being about half of the total death figure. 43 deceased are 70 years or older, which represents about a third of the total death figure. It is therefore clear that old people are much more vulnerable to road traffic accidents than other age groups. The ratio of men to women is 84 : 35.

Drugs and Poisons related Deaths

20. There are 139 deaths which are related to drugs and poisons, representing an increase of 80% as compared with last year. Most of them involve dangerous drugs. The figure includes suicides, accidental deaths, and deaths where the intent is undetermined. The ratio of men to women among the deaths is 98 : 41.

Deaths from natural causes

21. There are 9352 deaths due to various diseases, of which 3989, i.e. two fifths of deaths in this categories, are 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, cerebrovascular diseases, etc. The ratio of men to women among the deaths is 5545 : 3807.

22. We can see that more men than women died in all the above mentioned classifications of deaths. In some classifications, the ratio is rather extreme, for example, in occupational deaths, the ratio is 24 to 0.

Recommendations

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

(i) A male who suffered from hepatitis B died of acute on chronic pneumonia

Hospital Authority and Dr Ho Man-hon

(1) If the patient refuses to undergo any examination or take medication, it would be the best to make a record with reasons stated in the medical notes.

(2) Before a doctor prescribes the medicine, it would be the best to ask the patient to sign to acknowledge the side effects and severity of the medicine.

Tseung Kwan O Hospital

There should be a specialist doctor on call for 24 hours in the hospital.

Hospital Authority

The hospital should be able to check the medical records of the same patient in all hospitals, not just the patient's medical history in its hospital.

Dr. Ho Man-Hon

Should prescribe medication in strict accordance with the recommendations of the pharmaceutical manufacturer.

(ii) A patient, being diagnosed of suffering from schizophrenia, was prescribed with Clozapine, an anti-psychotics drug during his stay in hospital, causing him to die of diabetic ketoacidosis

Castle Peak Hospital

(1) To countersign next to the laboratory reports where figures are marked with "H" and "L".

(2) The Hospital should review the way of assessment after prescription of Clozapine, and conduct regular checkup of blood sugar and lipids according to international guidelines, including the requirements of paragraph 11D in exhibit C12.

(3) If it is necessary to titrate anti-psychotics drug, which includes adding or reducing drugs for patients suffering from mental illness, the patients' relatives need to be informed and drug leaflets need to be distributed.

(4) The Hospital should inform the patient's relatives if the patient is under a situation where resuscitation is necessary, and inform the relatives of the course of resuscitation.

(iii) A fireman carrying out his duties met with a gas explosion resulting in a coma due to the back of his head bumping into a hard object and finally succumbed to brain damage and bronchopneumonia

Nice Property Management Ltd

(1) Enhance staff training on the handling of gas leakage incidents.

(2) Procure gas detectors for use by staff and provide relevant training.

Fire Services Department

(1) Improve on the current work guidelines on handling gas leakage incidents

(2) Improve on/enhance the training of management grades of the Fire Services Department on the handling of gas leakage incidents.

(iv) <u>A male who participated in Cross Harbour race for the first time died of drowning during the race</u>

Tai Po Sports Association

(1) Participants of the Cross Tolo Harbour Open Race are required to sign a declaration of any suffering of chronic disease or long term illness (e.g. respiratory disease or cardiac disease), if there is any, such participants must provide a doctor's certificate to confirm that they have the ability to cope with the swimming route of the Cross Harbour race.

(2) Before each group of swimmers start the race, arrangement had to be made for persons with life-saving qualifications or experience to observe the health condition of swimmers, so as to

ensure they are fit to start the race; and to remind them not to participate in the event if they are not feeling well.

(3) To provide each canoe lifeguard participating in the Cross Harbour Swimming Race with communicators.

Hong Kong Canoe Union and Hong Kong Life Saving Society (HKLSS)

To formulate mutually recognizable standards on qualifications and requirements of canoe lifeguards as soon as possible

(v) A male, who suffered from neurofibromatosis, died of hemorrhage and aspiration of blood due to hemorrhage and rupture of abnormal vessels

Hospital Authority

CT scan and MRI examination should be available on Saturdays, Sundays and public holidays to provide the most basic emergency service.

For referred emergency cases, all medical reports, medical history record and referral letters have to be attached to the notes of A & E and ward as well for reference by doctors.

(vi) A male, who had acute myocardial infarction, received fibrinolytic therapy in the hospital, later died of hemorrhage of pons and acute myocardial infarction

Hospital Authority

To implement the plan of making primary percutaneous coronary intervention available in one hospital of each cluster of hospital on a 24 hour basis as soon as possible.

Pok Oi Hospital

(1) To include the complication of 0.9% cerebral hemorrhage in the voice recording on fibrinolytic therapy.

(2) Pok Oi Hospital should make reference to the checklist of Princess Margaret Hospital on the use of fibrinolytic therapy in the Accident and Emergency Department and consider the addition of a checkbox indicating "Yes" and "No".

(vii) Another male, who had acute myocardial infarction, died of cerebral hemorrhage after receiving fibrinolytic therapy in the accident and emergency department of a hospital

Hospital Authority

To implement and execute the provision of urgent percutaneous coronary intervention (i.e. balloon angioplasty) in at least one accident & emergency hospital within each region 24 hours a day, 7 days a week as soon as possible.

(viii) A female, whose right common iliac artery was resected for it was being mistaken as ureters in the course of receiving transperitoneal laparoscopic ureterolithotomy, eventually died of massive bleeding due to laceration of the right common iliac artery

Hospital Authority

(1) During the surgical procedure of laparoscopic ureterolithotomy, the attending surgeon should timely respond and consider whether the operation needs to be continued by converting to traditional open surgery as the situation deems fit.

(2) If the attending surgeon encounters difficulties in laparoscopic removal of ureteral stones, and cannot determine the position of the ureters, he or she should consult a senior doctor for assistance and advice.

(ix) A female inmate used a brassiere provided by officers of the Correctional Services Department to hang herself in the toilet of the hospital ward of Tai Lam Centre for Women

Correctional Services Department

(1) All clothing distributed to inmates must be marked with numbers and record must be made accordingly.

(2) Correctional Services Department officers should enhance their vigilance by paying more attention to unusual circumstances, for example, in-patients who have left the bed for too long.

(3) PMS reading tag should be installed at a place further inside the toilet, for example, near the water closet in the barrier-free-access toilet.

(4) To change or increase the time of doctors staying in the hospital, so that newly-admitted patients can be instantly assessed by doctors, and to arrange counsellors to provide counselling to new inmates.

(5) To enhance on-the-job training, for example, training on how to respond in case of emergency and the use of medical devices.

(x) A worker working on a stockpile of stone fine aggregates on top of a stone fine storage compartment in a concrete batching plant fell down to the bottom of the storage compartment as the metal gate of the hopper was opened causing his death due to suffocation as a result of his being trapped at the gate access

Zhujiang Shipping Cargo Co Ltd

When seamen need to disembark, go on shore and work on sites of wet, slippery and uneven ground, it must be ensured that they wear safety shoes to prevent them from slipping which results in injuries due to the wearing of unsuitable shoes.

(xi) An in-patient on nasogastric tube pulled off the tube against medical instruction resulted in damage to his trachea and lungs due to aspiration of gastric juice into the trachea

Hospital Authority

Conduct review and devise mechanism for handling the removal of nasogastric tube against medical instruction by high-risk patients and devise guidelines for it, and enhance the relevant training for frontline medical and nursing staff.

(xii) A gas technician apprentice died of carbon monoxide poisoning in a residential unit of a construction site

Chun Yip Construction Company Ltd

From the time of initial completion to delivery of residential units to the sellers, there should be inspection at each unit to be carried out at the end of each working day to see if any one remains in the premises, the door of each unit should be locked to prevent anyone from staying overnight in the premises.

Leon Plumbing & Gas Works Ltd

If a gas technician apprentice is arranged to go and work in the construction site or premises, all staff at the construction site or premises should be informed of the identity of the apprentice so that proper supervision can be made.

(xiii) A suspect hanged himself in a detention cell of a police station

Commissioner of Police

(1) To install an additional electronic card recording system at each cell to record patrolling situation and to set up an alarming system for issuing message to alert the Duty Officer or relevant staff in case there has been no card recording done for 25 minutes.

(2) To review the current design of detention cell, like reducing the metal wire meshes and other connecting components.

(3) To transfer suspects to different detention cell on a regular basis in order to reduce the chances of their hurting themselves through identifying the defective facilities of the cell.

(xiv) One more suspect committed suicide by hanging himself in the detention room of a police station

Commissioner of Police

(1) To consider installing a closed-circuit television to show the interior of the temporary holding area and detention room while avoiding the shooting of the toilet.

(2) To upgrade and adopt more advanced technology (to enhance the quality of monitoring), such as:

i) To fully adopt the use of closed-circuit televisions with high resolution lens, or even with sound-recording function;

ii) To use X-ray detectors for custodial search;

iii) To wear a smart hand strap for detainees to detect their vital signs and to rescue them immediately when needed;

iv) The information technology department to immediately alert the police station in case the computer in the detention facility is disconnected.

(3) Regarding the current use of the occurrence book:

i) To mark each page with a warning sign that "No false record should be made", and to specify the criminal liability concerned;

ii) To add a "Signature" column. Each inspection record must be signed by the relevant police officer and specified with the police officer number.

(4) The occurrence book records should be submitted to a Police internal third party for regular inspection on the basis of random inspections within each police station.

(5) To ensure that for each duty roster, there will be at least one police officer who has received first aid training to be on duty, so that preliminary rescue can be carried out when necessary.

(6) The police should have an internal department to conduct regular inspections of respective district police stations, to report on security and safety measures; to make concrete proposals for improvement and take follow-up actions. The said department should also provide support for administrative, procurement and engineering maintenance for respective district police stations in

a "one-stop" manner. In addition to working guidelines, there should also be concrete plans for implementation.

(7) The police, in selecting any fire and safety facility supplier, must specify in the procurement tender:

i) The supplier should make sure that the repair technician is well trained and familiar with the product;

ii) The supplier must provide training for the police on the use of the product;

iii) The supplier must provide a user manual for the product.

(8) As far as the Forensic Science Division is concerned, the person conducting the case simulation experiment must accompany the police officer to the scene of the investigation so that the designed experiment can better simulate the case.

(9) The police may consider to amend the existing "Police General Orders" and "Procedural Manual" on the following two aspects:

i) in terms of "detained search", specifying the detail and stating clearly the level and condition under which a search is required;

ii) in terms of "inspection time", the definition of the words should be explained in detail. For example, "to inspect at least once every hour" should be stated as "to inspect at least once after every hour".

(10) The Architectural Services Department should formulate a uniform "Standard Code" for the design, construction and work implementation of all the police stations in Hong Kong, with details laid down on standard for “prevention of suicide", for example, to adopt the use of anti-bumping walls in all detention

rooms to prevent detainees from self-mutilation by bumping against the wall.

(11) Regarding the use of the newly introduced "e-Alert Detention Inspection System", "Bio-characteristics" should be considered for inspection records, so as to prevent "replacement of cards" or "absence without leave".

Government Chemist

Forensic Science Division

As far as the Forensic Science Division is concerned, the person conducting the simulation test must accompany police officers who collect evidence to the scene of the investigation, so that the experiments designed can better simulate the case.

The Architectural Services Department

The Architectural Services Department should formulate a uniform "Standard Code" for the design, construction and work implementation of all the police stations in Hong Kong, with details laid down on standard for “prevention of suicide", for example, to adopt the use of anti-bumping walls in all detention rooms to prevent detainees from self-mutilation by bumping against the wall.

(xv) <u>A male died of streptococcal toxic shock syndrome with necrotizing fascitis due to streptococcus pyogenes infection</u>

Hospital Authority

(1) In case the patient's blood pressure cannot be measured, there should be more scientific guidelines laid out for reference by front line medical staff.

(2) To reduce the ratio of medical staff and patients.

(3) To enhance the knowledge of citizens on necrotizing fasciitis and to increase the awareness of general public on dressing of wounds.

(xvi) A female died of pulmonary hypertension leading to heart failure caused by Diffuse systemic sclerosis

Hospital Authority

If patient information cannot be obtained from EPR (electronic patient record), medical and nursing staff should retrieve the medical record through other channels, so as to ensure that the patient can receive prompt and proper treatment.

(xvii) A female, who was being brought away from Hong Kong during the period of time when her family members applied a guardianship order for her, eventually passed away outside the border of Hong Kong while the guardianship order was effective

Guardianship Board

During the period of application for a guardianship order, the person to be subjected to guardianship should not be allowed to leave Hong Kong; if the need to leave Hong Kong arises, there must be sufficient reason provided.

(xviii) An inmate died of lung cancer with brain metastases

Hong Kong Correctional Services Department

The provision of Chinese Medicine service in prison hospitals as an option for inmates should be considered.

(xix) A female fell from a height resulting in death due to multiple injuries

Commissioner of Police

During the course of handling the investigation of a 'falling from a building' incident, the Police may make more detailed and thorough investigation records.

(xx) A female died of pulmonary embolism due to deep vein thrombosis in her left lower limb

Chinese Medicine Council of Hong Kong

(1) It is recommended that the subject of deep vein thrombosis (DVT) be included in the syllabus of the Chinese Medicine Practitioners Licensing Examination.

(2) Regular refresher courses for Chinese Medicine Practitioners may include knowledge pertaining to DVT.

Hospital Authority

Guidelines on Safety in Acupuncture issued by the Chinese Medicine Department under the Hospital Authority may be reviewed based on the present case.

(xxi) A construction site worker in the Shatin-Central Link project was crushed to death by the collapse of the bent lattice boom while removing a connector pin

Labour Department

Construction Industry Council

(1) Labour Department is to ensure that the main contractor and all sub-contractors must devise detailed safe work procedure and proper safety measures, to define the safety responsibilities of various parties, and to be able to effectively liaise and communicate so as to comprehensively implement a safe work system.

(2) In respect of the licensing course for crane operators, Construction Industry Council should enhance crane operators' awareness on their scope of work and the training on the awareness of relevant work safety, including the compulsory

requirement of the crane dismantling work under the direct supervision of a competent person having sufficient experience.

(xxii) A female died of acute myocardial infarction with ruptured left anterior free wall of the heart and haemopericardium

Hospital Authority

Hospitals should perfect the admission policy of Cardiac Care Unit (CCU) to increase its flexibility so that high-risk patients having heart conditions should also get proper cardiological treatment even if no bed space is available in CCU. The relevant cardiologists should also conduct close monitor and perform clinical consultation in order to provide CCU related treatment and follow-up for patients without being constrained by the availability of CCU bed space.

(xxiii) A secondary school student died of falling from a height by committing suicide

Guard City Ltd
TWGHs Kap Yan Directors' College

Guard City Ltd.

There have to be clear guidelines requiring security guard(s) to attend the scene immediately to check out the situation once the alarm rings.

TWGHs Kap Yan Directors' College

(1) The School needs to strengthen education and promotion, guiding students to think positively and strengthen their abilities in facing adversity.

(2) The School needs to strengthen the communication among parents and teachers.

(3) The School must have a transparent punishment mechanism to allow parents and students to clearly understand the consequences of punishment.

(4) The School needs to formulate clear directions to class teachers, (requiring them) to pay more attention to those students who perform below their usual performance, and if necessary, refer them to the social worker for follow-up.

(5) The School must have a clear division of labour among class teachers, counselling teachers, discipline teachers and social workers so that the students and parents can contact the appropriate person for assistance when necessary.

(6) The School should formulate clear procedures and guidelines in writing for handling matters relating to students' behaviours and discipline.

(7) Regarding situations where students have made mistakes, the School must formulate a clear punishment mechanism and explain clearly the punishment procedures to be taken to the parents and students.

(8) The School need to provide the discipline teachers concerned with professional training and guidance rather than letting them deal with students' matters with usual practice.

(9) Ways to be taken: (When dealing with students' matters)

a) Inform the parents first;

b) If there is no urgency, avoid telling the students undecided punishments;

c) In the presence of the parents, understand from the students face to face the circumstances under which the mistakes were made and the reasons behind.

(xxiv) <u>A female died of septic abortion</u>

Hospital Authority

(1) Enhance the awareness of expectant mothers in the consequences and seriousness of breaking of water, which may be fatal in the most serious situation. It is suggested that animations can be used in all antenatal education so that expectant mothers and their family can understand the situation more easily and know how to handle it.

(2) Registered midwives shall be responsible for the admission of patients to the Department of Obstetrics and Gynaecology.

(3) Enhance communications between responsible surgeons and anesthesiologists in order to evaluate the urgency of the surgery.

The above suggestions should take effect in all hospitals under the Hospital Authority.

(xxv) A male died of coronary occlusion due to atheroma in a fitness centre during a muscle training course

International Personal Trainers and Fitness Academy (IPTFA)

Apart from meeting the requirement of first aid certificate, personal fitness trainers should also take up the course related to the use of AED.

(xxvi) A female died of miliary tuberculosis involving the lung, pleura, spleen and bone with diffuse aveolar damage and pneumonia

Hospital Authority

First Aid Capability/Knowledge：

Regular provision of routine first-aid training to frontline ward nurses.

Documentation：

All major vital signs should be collectively documented in the same form for ease of reference and documentation to be made by various medical staff. Moreover, both the readings and the time at which the vital signs are taken should be documented. All amendments to record entry must be signed against by the medical staff making the amendments for confirmation with time of amendment documented.

Arrangement for relieving doctors：

Relieving doctor should be the one specialized in the same medical field as the ward he works in. If the relieving doctor is not specialized in the same field, the medical decision he makes should be reviewed by the doctor specialized in the respective field of the ward.

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 worked hard to fulfill their duties, and have fulfilled their duties well.

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. In 2018, we appointed Coroners, Ms Stephanie Tsui to attend the Asia Pacific Coroners' Society Conference in Canberra, Australia and she benefited a lot from the conference. We are also grateful to other government departments who have given us immense support in terms of manpower and all other resources to help 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 is very high, as is their reports. The Police Force has also deployed three Senior Inspectors of Police to serve as Coroner's Officers. They have performed excellent liaison work and they also assist in the inquests.

27. Thanks are also due to Government Counsel of all levels of the Department of Justice who presented the evidence and assisted the Coroner in many of the more complicated and difficult inquests.

28. Like previous years, we would like to take this opportunity to thank the pathologists both of the Department of Health, and of the Hospital Authority, who

performed autopsies and assisted us with evidence in court as well as with responses to our more general telephone inquiries.

29. The Court Interpreters, as usual, provide first class interpretation and translations, both inside and outside Court.

30. The Labour Department and the Marine Department continue to provide us with investigation reports on accidents which occur on land and at sea, respectively. These reports are always prepared after thorough investigations, and usually contain recommendations. They are of great assistance to the Coroners and to the industry. The number of occupational deaths showing a decreasing trend in the past few years is the best proof. Both departments deserve a thank you from us.

KO Wai-hung
Coroner

Stephanie Tsui
Coroner

July 2019

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 2018 年，死亡登記個案有 47,479 宗，而向死因裁判官呈報的死亡個案有 10,976 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	3093
命令豁免屍體剖驗	7883
土葬命令	981
火葬命令	9995
須作進一步調查的死亡個案	1083
進行死因研訊	161
死因裁判官或陪審員有提出建議的個案	31

於 2018 年須作進一步調查的 1083 宗死亡個案中，截至 2018 年 12 月 31 日為止，警方仍未完成死亡調查報告的共有 914 宗。

於 2018 年向死因裁判官呈報的 10,976 宗死亡個案中，截至 2018 年 12 月 31 日仍在等候毒理學報告以決定死因的有 149 宗。

1. Analysis of Deaths Reported to the Coroners

In 2018 there were 47,479 deaths registered, and there were 10,976 deaths reported to the Coroner.

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

	TOTAL
Autopsy Orders	3093
Waivers of Autopsy	7883
Burial Orders	981
Cremation Orders	9995
Further Death Investigation Reports ordered	1083
Inquests held	161
Cases where recommendations are made	31

Of the 1083 further death investigation reports ordered in 2018, 914 of which have not yet been returned from the Police as at 31 December 2018.

Of the 10,976 deaths reported in 2018, there are 149 cases of which the causes of death are still pending over toxicological reports as at 31 December 2018.

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		2018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 31.12.2018	
	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
10976	**3093**	**7883**	**981**	**9995**	**1083**	**155**	**12**	**152**	**9**	**21**	**6**

數 字 及 百 分 比 **FIGURES AND PERCENTAGE**		總計 TOTAL
命令將屍體剖驗 AUTOPSY ORDERED 3093 (28.18%)	豁免屍體剖驗 AUTOPSY WAIVED 7883 (71.82%)	**10976**
火葬命令 CREMATION ORDER 9995 (91.06%)	土葬命令 BURIAL ORDER 981 (8.94%)	**10976**
須進一步死亡調查報告 FURTHER DEATH INVESTIGATION REPORT 1083 (9.87%)	無須進一步死亡調查報告 NO FURTHER DEATH INVESTIGATION REPORT 9893 (90.13%)	**10976**

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
152 (94.40%)	9 (5.60%)	**161**

研訊結論及死因類別分析

Analysis of Conclusions of Inquests and Nature of Deaths

結論 Conclusion	循環系統疾病 Diseases Of The Circulatory System	呼吸系統疾病 Diseases Of The Respiratory System	某些傳染病和寄生蟲病 Certain infectious and parasitic diseases	循環系統疾病 Diseases of the circulatory system	消化系統疾病 Diseases of the digestive system	生殖泌尿系統疾病 Diseases of the genitourinary system	肌肉與骨骼系統和結締組織疾病 Diseases Of The Musculoskeletal System And Connective Tissue	呼吸系統疾病 Diseases of the respiratory system	腫瘤 Neoplasms	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	外意業工 Industrial Accident		鈍器撞擊 Blunt Force	一氧化炭 Carbon Monoxide	由高處跳下 Jumping From Height	吊死 Hanging	從高處墮下 Falling From Height	吸入（胃容物） Aspiration (Gastric Contents)	淹死 Drowning	墮下 Falls	藥物 Drugs	內科治療及外科手術 Medical and surgical care	雜項 Miscellaneous	其他 Others	總計 TOTAL
											被物件壓死 Crushed By Object	窒息 Suffocation														
死於自然 Natural Causes	1	1	6	35	8	5	1	67	6	8																**138**
死於意外 Accidental Death											1	1	1						1	2						**6**
死於不幸 Death by Misadventure																		1		1		5				**7**
自殺死亡 Suicide															1	4					1					**6**
存疑裁決 Open Verdict														1			1						1			**3**
非法殺人 Unlawful Killing																									1	**1**
總計 TOTAL	**1**	**1**	**6**	**35**	**8**	**5**	**1**	**67**	**6**	**8**	**1**	**1**	**1**	**1**	**1**	**4**	**1**	**1**	**1**	**3**	**1**	**5**	**1**	**1**	**161**

自殺個案
SUICIDES
（類別、年齡及性別）
(TYPE, AGE & SEX)
2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

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	2	5	4		1	1		14	**31**
	女 F				2	4	3	7	1		17	
毒藥 POISONS	男 M					1					1	**6**
	女 F		1			1	1		2		5	
吊死 HANGING	男 M		4	10	18	15	29	21	36		133	**204**
	女 F			10	5	10	13	15	18		71	
由高處跳下 JUMPING FROM HEIGHT	男 M		11	50	35	49	39	53	59	1	297	**478**
	女 F		9	14	20	29	31	34	44		181	
一氧化炭 CARBON MONOXIDE	男 M		1	15	17	28	14	12	4		91	**129**
	女 F		1	5	9	8	10	3	2		38	
淹死 DROWNING	男 M			3	3	4	5	4	6		25	**39**
	女 F			2	1	1	2	5	3		14	
利器 SHARP INSTRUMENTS	男 M					1	1	1	1		4	**8**
	女 F							1	3		4	
其他 OTHER	男 M			4	2	5	4	1	2		18	**26**
	女 F			1			4	1	2		8	
小計 SUB TOTAL	男 M		17	84	80	107	92	93	109	1	583	**921**
	女 F		11	32	37	53	64	66	75		338	
總計 TOTAL			**28**	**116**	**117**	**160**	**156**	**159**	**184**	**1**	**921**	**921**
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					2			1		3	**12**
	女 F					2	3	2	2		9	
毒藥 POISONS	男 M											**1**
	女 F							1			1	
吊死 HANGING	男 M											
	女 F											
由高處墮下 FALLING FROM HEIGHT	男 M			4	4				1		9	**12**
	女 F				1	2					3	
一氧化炭 CARBON MONOXIDE	男 M			1							1	**1**
	女 F											
淹死 DROWNING	男 M			1	2			2			5	**5**
	女 F											
利器 SHARP INSTRUMENTS	男 M											
	女 F											
其他 OTHER	男 M				1		1	1			3	**3**
	女 F											
小計 SUB TOTAL	男 M			6	7	2	1	3	2		21	**34**
	女 F				1	4	3	3	2		13	
總計 TOTAL				**6**	**8**	**6**	**4**	**6**	**4**		**34**	**34**

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)
2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

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	2	1					5	**11**
	女 F				1	1	1	3			6	
毒藥 POISONS	男 M											**3**
	女 F		1				1		1		3	
吊死 HANGING	男 M					1	2	1			4	**5**
	女 F							1			1	
由高處跳下 JUMPING FROM HEIGHT	男 M		2	2	4	8	4	3	2		25	**36**
	女 F			2	2	1	4	2			11	
一氧化炭 CARBON MONOXIDE	男 M				1	1					2	**4**
	女 F				1		1				2	
淹死 DROWNING	男 M											**4**
	女 F			1	1	1			1		4	
利器 SHARP INSTRUMENTS	男 M											
	女 F											
其他 OTHER	男 M											**1**
	女 F						1				1	
小計 SUB TOTAL	男 M		3	3	7	11	6	4	2		36	**64**
	女 F		1	3	5	3	8	6	2		28	
總計 TOTAL			**4**	**6**	**12**	**14**	**14**	**10**	**4**		**64**	**64**
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					2			1		3	**6**
	女 F					1			2		3	
毒藥 POISONS	男 M											**1**
	女 F							1			1	
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											
	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		5	**9**
	女 F					1		1	2		4	
總計 TOTAL				**1**	**1**	**3**		**1**	**3**		**9**	**9**

* 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)
2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

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											
	女 F											
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											
	女 F											
總計 TOTAL												**0**
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)
2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

職業 OCCUPATION	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		
學生 STUDENT	男 M		6	6							12	**20**
	女 F		5	3							8	
教師 TEACHER	男 M			2			1				3	**4**
	女 F						1				1	
沒有職業 NOT EMPLOYED	男 M			5	9	10	9	4	2	1	40	**67**
	女 F			2	2	6	8	5	4		27	
家庭主婦 HOUSEWIFE	男 M											**8**
	女 F					3	3	1	1		8	
藍領 BLUE COLLAR	男 M			7	7	11	8	6			39	**46**
	女 F			1	1	2	1	2			7	
白領 WHITE COLLAR	男 M			3	4	4	1				12	**19**
	女 F			2	2		3				7	
病人 PATIENT	男 M											
	女 F											
紀律部隊 DISCIPLINARIES	男 M					1					1	**1**
	女 F											
商人 BUSINESS MAN	男 M				2	3	1	1			7	**8**
	女 F					1					1	
退休人士 RETIRED PERSON	男 M						1	3	6		10	**17**
	女 F						1	3	3		7	
其他 OTHER	男 M					1					1	**2**
	女 F				1						1	
小計 SUB TOTAL	男 M		6	23	22	30	21	14	8	1	125	**192**
	女 F		5	8	6	12	17	11	8		67	
總計 TOTAL			**11**	**31**	**28**	**42**	**38**	**25**	**16**	**1**	**192**	**192**

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			1							1	**1**
	女 F											
教師 TEACHER	男 M											
	女 F											
沒有職業 NOT EMPLOYED	男 M			3	2	2					7	**13**
	女 F					1	1	2	2		6	
家庭主婦 HOUSEWIFE	男 M											
	女 F											
藍領 BLUE COLLAR	男 M			2	3			1			6	**8**
	女 F				1		1				2	
白領 WHITE COLLAR	男 M				1						1	**2**
	女 F					1					1	
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							2	1		3	**3**
	女 F											
其他 OTHER	男 M											
	女 F											
小計 SUB TOTAL	男 M			6	6	2		3	1		18	**27**
	女 F				1	2	2	2	2		9	
總計 TOTAL				**6**	**7**	**4**	**2**	**5**	**3**		**27**	**27**

* 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)
2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

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	2		4		8	**13**
	女 F			1					4		5	
吸入（食物） ASPIRATION (FOOD)	男 M			1		2	1	5	42		51	**98**
	女 F	1					1	9	36		47	
吸入（異物） ASPIRATION (FOREIGN BODY)	男 M								1		1	**1**
	女 F											
吸入（其他） ASPIRATION (OTHER)	男 M						3	3	7		13	**23**
	女 F						1		9		10	
窒息 SUFFOCATION	男 M					1	1				2	**3**
	女 F	1									1	
吊死 HANGING	男 M						2				2	**2**
	女 F											
被物件擊中 STRUCK BY OBJECT	男 M						1	2			3	**7**
	女 F							1	3		4	
被升降機壓死 CRUSHED BY LIFT	男 M							1			1	**1**
	女 F											
被物件壓死 CRUSHED BY OBJECT	男 M					1	2	2			5	**5**
	女 F											
燒灼 BURNS	男 M			1				1	3		5	**9**
	女 F		1						3		4	
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											
墮下 FALLS	男 M			3	4	3	13	26	113		162	**265**
	女 F					1	2	12	87	1	103	
淹死 DROWNING	男 M			2	2	1	8	4	5		22	**35**
	女 F		1		2	4	1	2	3		13	
觸電 ELECTROCUTION	男 M											**1**
	女 F							1			1	
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		1					2	**2**
	女 F											
藥物 DRUGS	男 M			7	13	29	20	12	1	3	85	**105**
	女 F			2	4	9	4	1			20	
毒藥 POISONS	男 M				1		1				2	**2**
	女 F											
中毒（酒精） POISON (ALCOHOL)	男 M			1	1	2	4	2			10	**13**
	女 F				1	2					3	
內科治療及外科手術 MEDICAL AND SURGICAL CARE	男 M		1		1	1	5	4	8		20	**34**
	女 F				3		1	2	8		14	
其他 OTHERS	男 M		1	1			1	1	3		7	**7**
	女 F											
小計 SUB TOTAL	男 M		2	17	23	42	64	63	187	3	401	**628**
	女 F	2	2	3	10	16	12	28	153	1	227	
總計 TOTAL		**2**	**4**	**20**	**33**	**58**	**76**	**91**	**340**	**4**	**628**	**628**

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)
2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

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											
	女 F											
海灘/海 BEACH/SEA	男 M				1	1	3	3	1		9	**14**
	女 F		1		1	1			2		5	
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											
	女 F											
浴室 BATHROOM	男 M								1		1	**2**
	女 F						1				1	
河流 RIVER	男 M											
	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	1	4	3	2		12	**18**
	女 F		1		1	1	1		2		6	
總計 TOTAL			**1**	**1**	**2**	**2**	**5**	**3**	**4**		**18**	**18**

* 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（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)
2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

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）	男 M											**1**
ASPIRATION (GASTRIC CONTENTS)	女 F			1							1	
吸入（食物）	男 M											
ASPIRATION (FOOD)	女 F											
吸入（異物）	男 M											
ASPIRATION (FOREIGN BODY)	女 F											
吸入（其他）	男 M											
ASPIRATION (OTHER)	女 F											
窒息	男 M											**1**
SUFFOCATION	女 F	1									1	
吊死	男 M						2				2	**2**
HANGING	女 F											
被物件擊中	男 M											
STRUCK BY OBJECT	女 F											
被升降機壓死	男 M											
CRUSHED BY LIFT	女 F											
被物件壓死	男 M											
CRUSHED BY OBJECT	女 F											
燒灼	男 M							1			1	**2**
BURNS	女 F								1		1	
一氧化炭（浴室）	男 M											
CARBON MONOXIDE (BATHROOM)	女 F											
一氧化炭（火災）	男 M											**1**
CARBON MONOXIDE (FIRE)	女 F						1				1	
一氧化炭（其他）	男 M											
CARBON MONOXIDE (OTHER)	女 F											
墮下	男 M			1			1	1	2		5	**8**
FALLS	女 F							2		1	3	
淹死	男 M								1		1	**2**
DROWNING	女 F						1				1	
觸電	男 M											
ELECTROCUTION	女 F											
割或刺	男 M											
CUT OR PUNCTURE	女 F											
火器	男 M											
FIREARMS	女 F											
鈍器撞擊	男 M					1					1	**1**
BLUNT FORCE	女 F											
藥物	男 M				4	6	8	2			20	**27**
DRUGS	女 F			1		4	1	1			7	
毒藥	男 M											
POISONS	女 F											
中毒（酒精）	男 M				1	1	1				3	**4**
POISON (ALCOHOL)	女 F				1						1	
內科治療及外科手術	男 M											
MEDICAL AND SURGICAL CARE	女 F											
其他	男 M								1		1	**1**
OTHERS	女 F											
小計	男 M			1	5	8	12	4	4		34	**50**
SUB TOTAL	女 F	1		2	1	4	3	3	1	1	16	
總計 TOTAL		**1**		**3**	**6**	**12**	**15**	**7**	**5**	**1**	**50**	**50**

* 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)

2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

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）	男 M											
ASPIRATION (GASTRIC CONTENTS)	女 F											
吸入（食物）	男 M								1		1	**4**
ASPIRATION (FOOD)	女 F						1		2		3	
吸入（異物）	男 M											
ASPIRATION (FOREIGN BODY)	女 F											
吸入（其他）	男 M											
ASPIRATION (OTHER)	女 F											
窒息	男 M											
SUFFOCATION	女 F											
吊死	男 M											
HANGING	女 F											
被物件擊中	男 M											
STRUCK BY OBJECT	女 F											
被升降機壓死	男 M											
CRUSHED BY LIFT	女 F											
被物件壓死	男 M											
CRUSHED BY OBJECT	女 F											
燒灼	男 M											
BURNS	女 F											
一氧化炭（浴室）	男 M											
CARBON MONOXIDE (BATHROOM)	女 F											
一氧化炭（火災）	男 M											
CARBON MONOXIDE (FIRE)	女 F											
一氧化炭（其他）	男 M											
CARBON MONOXIDE (OTHER)	女 F											
墮下	男 M				2				2		4	**5**
FALLS	女 F					1					1	
淹死	男 M			1			1				2	**3**
DROWNING	女 F		1								1	
觸電	男 M											
ELECTROCUTION	女 F											
割或刺	男 M											
CUT OR PUNCTURE	女 F											
火器	男 M											
FIREARMS	女 F											
鈍器撞擊	男 M											
BLUNT FORCE	女 F											
藥物	男 M			2	4	6	9				21	**31**
DRUGS	女 F			1	2	4	2	1			10	
毒藥	男 M											
POISONS	女 F											
中毒（酒精）	男 M					1	1				2	**2**
POISONS (ALCOHOL)	女 F											
內科治療及外科手術	男 M				1						1	**2**
MEDICAL AND SURGICAL CARE	女 F								1		1	
其他	男 M											
OTHERS	女 F											
小計	男 M			3	7	7	11		3		31	**47**
SUB TOTAL	女 F		1	1	2	5	3	1	3		16	
總計 TOTAL			**1**	**4**	**9**	**12**	**14**	**1**	**6**		**47**	**47**

* 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)
2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

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							2			2	**6**
	女 F		1		1	1			1		4	
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											
	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							1	**1**
	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						3	1			4	**4**
	女 F											
騎馬 HORSE RIDING	男 M											
	女 F											
遊船河 BOAT EXCURSION	男 M											
	女 F											
滑浪風帆運動 WINDSURFING	男 M											
	女 F											
其他 OTHERS	男 M											
	女 F											
小計 SUB TOTAL	男 M			1			3	3			7	**11**
	女 F		1		1	1			1		4	
總計 TOTAL			**1**	**1**	**1**	**1**	**3**	**3**	**1**		**11**	**11**

* 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)
2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

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											
	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							1			1	**1**
	女 F											
批盪（水泥） CEMENT PLASTER	男 M							1			1	**1**
	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											
	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

職業死亡個案
OCCUPATIONAL DEATHS
（類別、年齡及性別）
(TYPE, AGE & SEX)
2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

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				1	**1**
	女 F										
被物件壓死 CRUSHED BY OBJECT	男 M				1	2	2			5	**5**
	女 F										
燒灼 BURNS	男 M										
	女 F										
一氧化炭（火災） CARBON MONOXIDE (FIRE)	男 M										
	女 F										
墮下 FALLS	男 M		2		2	2	6			12	**12**
	女 F										
觸電 ELECTROCUTION	男 M				1					1	**1**
	女 F										
淹死 DROWNING	男 M				1					1	**1**
	女 F										
車輛 VEHICLE	男 M										
	女 F										
升降機 LIFT	男 M						1			1	**1**
	女 F										
其他 OTHERS	男 M		1		1	1				3	**3**
	女 F										
小計 SUB TOTAL	男 M		3		6	6	9			24	**24**
	女 F										
總計 TOTAL			**3**		**6**	**6**	**9**			**24**	**24**

殺人個案 *
HOMICIDES *
（類別、年齡及性別）
(TYPE, AGE & SEX)
2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

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											**2**
	女 F						1	1			2	
被人用鈍器襲擊 BLUNT FORCE ASSAULT	男 M							1		1	2	**2**
	女 F											
絞縊 STRANGULATION	男 M	1									1	**3**
	女 F	1					1				2	
火燒、有毒物質、氣體、腐蝕性物質 FIRE, NOXIOUS SUBSTANCE, GASES, CORROSIVE SUBSTANCE	男 M											**2**
	女 F		1			1					2	
窒息 SUFFOCATION	男 M											
	女 F											
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**
	女 F			1							1	
其他 OTHERS	男 M											
	女 F											
小計 SUB TOTAL	男 M	1						1		1	3	**10**
	女 F	1	1	1		1	2	1			7	
總計 TOTAL		**2**	**1**	**1**		**1**	**2**	**2**		**1**	**10**	**10**

* 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)
2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

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	**1**
	女 F											
行人與汽車 / 輕型貨車 / 客貨車 PEDESTRIAN v. CAR/PICK-UP TRUCK/VAN	男 M		1	1	2		1	4	15	1	25	**41**
	女 F	1			1	2	1	3	8		16	
行人與貨車 / 巴士 PEDESTRIAN v. TRUCK/BUS	男 M					2	3	2	2		9	**27**
	女 F			1		1	1	4	11		18	
行人與火車 / 電車 PEDESTRIAN v. TRAIN/TRAM	男 M											
	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				2	2		5	**5**
	女 F											
單車與貨車 / 巴士 BICYCLE v. TRUCK/BUS	男 M							1			1	**1**
	女 F											
單車失去控制 BICYCLE OUT OF CONTROL	男 M						1		1		2	**2**
	女 F											
電單車與汽車 / 輕型貨車 / 客貨車 MOTORCYCLE v. CAR/PICK-UP TRUCK/VAN	男 M			3			5				8	**8**
	女 F											
電單車與貨車 / 巴士 MOTORCYCLE v. TRUCK/BUS	男 M											
	女 F											
電單車失去控制 MOTOR CYCLE OUT OF CONTROL	男 M			2		2	2				6	**6**
	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		1				2	**2**
	女 F											
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			1		3	**3**
	女 F											
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			1	1	1					3	**4**
	女 F	1									1	
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						1	1			2	**2**
	女 F											
貨車 / 巴士失去控制 TRUCK/BUS OUT OF CONTROL	男 M				1		1	1			3	**3**
	女 F											
其他組合 OTHER COMBINATIONS	男 M				1	3	4	4	2		14	**14**
	女 F											
小計 SUB TOTAL	男 M		1	9	6	9	19	15	24	1	84	**119**
	女 F	2		1	1	3	2	7	19		35	
總計 TOTAL		**2**	**1**	**10**	**7**	**12**	**21**	**22**	**43**	**1**	**119**	**119**

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)
2018 年 1 月 1 日 - 2018 年 12 月 31 日
1ST JANUARY 2018 - 31ST DECEMBER 2018

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								**2**
	女 F				1	1		2	
10 to 19	男 M					1		1	**1**
	女 F								
20 to 29	男 M	1	4	1	1	1		8	**9**
	女 F					1		1	
30 to 39	男 M	3				2	1	6	**7**
	女 F					1		1	
40 to 49	男 M	3	2			2	2	9	**12**
	女 F					3		3	
50 to 59	男 M	3	6			4	2	15	**17**
	女 F					2		2	
60 to 69	男 M	4	1	2		6		13	**20**
	女 F					7		7	
70 to	男 M	1		2	1	18		22	**40**
	女 F					18		18	
UNKNOWN	男 M					1		1	**1**
	女 F								
小計 SUB TOTAL	男 M	15	13	5	2	35	5	75	**109**
	女 F				1	33		34	
個案總數 TOTAL DEATHS		**15**	**13**	**5**	**3**	**68**	**5**	**109**	**109**

* 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 *

2018 年 1 月 1 日 - 2018 年 12 月 31 日

1ST JANUARY 2018 - 31ST DECEMBER 2018

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**	**2**	**2**	**2**	**4**	**20**		**32**
陰性 NEGATIVE	1	1	7	5	9	13	13	15		**64**
陽性 （每 100 毫升血） POSITIVE (per 100ml blood)										
0 - 50 毫克 0 - 50 mg							2	5		**7**
51 - 100 毫克 51 - 100 mg							1			**1**
101 - 150 毫克 101 - 150 mg					1	1			1	**3**
151 - 200 毫克 151 - 200 mg						1				**1**
201 - 250 毫克 201 - 250 mg			1							**1**
251 - 300 毫克 251 - 300 mg										
301 - 350 毫克 301 - 350 mg										
351 毫克或以上 351 and over										
個案總數 TOTAL DEATHS	**2**	**1**	**9**	**7**	**12**	**17**	**20**	**40**	**1**	**109**

* 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 *

（不同年齡的數字）

(As to Ages)

2018 年 1 月 1 日 - 2018 年 12 月 31 日

1ST JANUARY 2018 - 31ST DECEMBER 2018

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	**3**		**3**	**2**	**23**	**1**	**32**
陰性 NEGATIVE	11	11	1	1	36	4	**64**
陽性 （每 100 毫升血） POSITIVE (per 100ml blood)							
0 - 50 毫克 0 - 50 mg			1		6		**7**
51 - 100 毫克 51 - 100 mg					1		**1**
101 - 150 毫克 101 - 150 mg		2			1		**3**
151 - 200 毫克 151 - 200 mg					1		**1**
201 - 250 毫克 201 - 250 mg	1						**1**
251 - 300 毫克 251 - 300 mg							
301 - 350 毫克 301 - 350 mg							
351 毫克或以上 351 and over							
個案總數 TOTAL DEATHS	**15**	**13**	**5**	**3**	**68**	**5**	**109**

* 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
01/01/2018 - 31/12/2018

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				2	2	4		1		9	
Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	女 F			1		1	1				3	**12**
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	2					4	
Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	女 F					3	1	3			7	**11**
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								1		1	
Poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	女 F							2	2		4	**5**
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			5	9	15	12	6			47	
Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	女 F			1	1	5	1	1			9	**56**
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				1	1					2	
Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	女 F											**2**

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					2					2	**3**
		女 F					1					1	
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											
		女 F											
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	**4**
		女 F				2						2	
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			1	1			1			3	**4**
		女 F				1						1	
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											**2**
		女 F						2				2	
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	2				4	**5**
		女 F				1						1	
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											
		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											
	女 F											
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			5	7	4	4	1			21	**31**
	女 F		1	1	1	1	6				10	
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			1							1	**1**
	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**
	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	14	23	28	22	8	2		98	**139**
	女 F		1	3	6	11	11	6	3		41	
總計 TOTAL			**2**	**17**	**29**	**39**	**33**	**14**	**5**		**139**	**139**

* 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)

2018 年 1 月 1 日 - 2018 年 12 月 31 日

1ST JANUARY 2018 - 31ST DECEMBER 2018

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	3	13	17	58	123	1	219	**374**
	女 F	2		2	5	13	11	23	99		155	
腫 瘤 Neoplasms C00 - D48	男 M	1		2	3	17	81	143	329		576	**943**
	女 F			5	6	19	61	73	203		367	
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	1		7	**13**
	女 F				2				4		6	
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		12	11	31	43		98	**163**
	女 F	1			1	4	9	12	38		65	
精神錯亂 Mental and behavioural disorders F00 - F99	男 M							1	27		28	**86**
	女 F		1		1			1	55		58	
神經系統疾病 Diseases of the nervous system G00 - G99	男 M	3	2	3	2	2	12	13	18		55	**114**
	女 F	2	3	3		4	6	8	32	1	59	
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			1							1	**1**
	女 F											
循環系統疾病 Diseases of the circulatory system I00 - I99	男 M	5	2	3	50	128	375	524	1336	2	2425	**3989**
	女 F		2	5	17	43	93	184	1220		1564	
呼吸系統疾病 Diseases of the respiratory system J00 - J99	男 M	2	1	5	10	23	75	138	575		829	**1165**
	女 F	3		2	6	11	24	43	247		336	
消化系統疾病 Diseases of the digestive system K00 - K93	男 M	2		1	4	16	30	58	130		241	**372**
	女 F		1	1	5	4	9	20	91		131	
皮膚和皮下組織疾病 Diseases of the skin and subcutaneous tissue L00 - L99	男 M				1				3		4	**7**
	女 F						1		2		3	
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				3	3	5	6	7		24	**41**
	女 F			1		2	1	4	9		17	
生殖泌尿系統疾病 Diseases of the genitourinary system N00 - N99	男 M				2	10	17	27	72		128	**218**
	女 F				1	3	8	14	64		90	
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	2									2	**7**
	女 F	2								3	5	
先天畸形 Congenital malformations, deformations and chromosomal abnormalities Q00 - Q99	男 M	2	3	2	2	1	1		2		13	**24**
	女 F	1		2	2	2	1	3			11	
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	3		10	8	31	59	113	661	10	895	**1834**
	女 F	6	1	1	5	14	22	30	855	5	939	
小計 SUB TOTAL	男 M	21	8	31	88	257	685	1115	3327	13	5545	**9352**
	女 F	17	8	23	51	119	246	415	2919	9	3807	
總計 TOTAL		**38**	**16**	**54**	**139**	**376**	**931**	**1530**	**6246**	**22**	**9352**	**9352**

2018 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) 2018

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	68
2. 騎腳踏車者在交通意外中受傷 (V10-V19) Pedal cyclist injured in transport accident	5
3. 騎摩托車者在交通意外中受傷 (V20-V29) Motorcycle rider injured in transport accident	13
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	6
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	4
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	7
8. 巴士使用者在交通意外中受傷 (V70-V79) Bus occupant injured in transport accident	2
9. 其他陸上交通意外 (V80-V89) Other land transport accidents	4
10. 水上交通意外 (V90-V94) Water transport accidents	7
11. 航空及太空交通意外 (V95-V97) Air and space transport accidents	
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. 墮下 (W00-W19) Falls	41
2. 暴露於無生命的外物物力 (W20-W49) Exposure to inanimate mechanical forces	12

3. 暴露於有生命的外物物力 (W50-W64) Exposure to animate mechanical forces	
4. 意外淹死及淹沒 (W65-W74) Accidental drowning and submersion	18
5. 其他危及呼吸的意外情況 (W75-W84) Other accidental threats to breathing	20
6. 暴露於電流、幅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	
7. 暴露於烟、火及火焰 (X00-X09) Exposure to smoke, fire and flames	3
8. 接觸熱力及熱的物質 (X10-X19) Contact with heat and hot substances	
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	3
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	77
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**	192
III. 襲擊 (X85-Y09) **Assault**	10
IV. 未確定意圖的事件 (Y10-Y34) **Event of undetermined intent**	27
V. 合法干預及戰爭行動 (Y35-Y36) **Legal intervention and operations of war**	1
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	

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	16
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**	
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**	
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 Cause of Mortality**	38
自然死因 **Natural Cause**	334
[Total 總數]	**914**