CORONERS' REPORT

死因裁判官報告

2021

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第一部

2021年死因裁判官報告

死亡數字上升趨勢

1. 今年共有 51,536 宗死亡登記，至於曾向死因裁判官報告的死亡個案，則有 12,694 宗。過去 21 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

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 12 年，即 2007 至 2018 年期間，數字反覆向上。2020 年的死亡登記數字及向死因裁判官報告的個案相對 2019 年持續遞升，更有超過百分之十的升幅。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. 下表列出關於過去二十一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	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%

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 2021 年，死因裁判官一共處理了 603 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。

15. 死因裁判官在此特別感謝所有相關人士及部門在 2019 新型冠狀病毒疫情期間所付出的努力，能讓死因裁判法庭可以無間斷地運作。因應公共衞生情況及維持社交距離及人流管制的措施，我們大部份需要陪審員一同審理的死因研訊需要延期，死因裁判官會盡快安排舉行這些研訊。

自殺個案

16. 今年有 1,010 宗自殺個案，與 2020 年相若。其中 244 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 636:374。青少年自殺組別的個案與去年相若。

意外死亡個案

17. 今年有 727 宗意外死亡個案，其中 211 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 483:244。

職業死亡個案

18. 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 33 宗，包括 27 宗在陸上發生的和 6 宗在海上發生的。男女死者的比率是 31:2。

殺人個案

19. 今年有 20 人死於被殺，其中男性佔 12 人，女性佔 8 人。

車輛導致死亡的個案

20. 今年有 96 宗由車輛導致的死亡，其中 49 名死者是行人，佔去死亡數字約一半。96 名死者中，有 36 名是 70 歲以上的老人家，佔此組別的死亡數字約三分之一。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 63:33。

與毒品及藥物有關的個案

21. 今年有 107 宗死亡與毒品或藥物有關，和去年比較減少了百分之二十，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 73: 34。

自然死亡個案

22. 今年因各種疾病而死亡的人數是 10,890 人，其中因循環系統疾病而死亡的有 4,519 人，佔這個類別的死亡人數約二分之一。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 6,329: 4,561。

23. 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 31 與 2 之比。

建議

24. 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) 一名教師覺得受到校長不公平對待而在學校跳樓身亡

教育局

教育局考慮以下的建議，作出相應的行動，落實建議：

(1) 東華三院李東海小學事件獨立調查委員會 2019 年 7 月報告內的 19 項建議；

(2) 各校每年持份者問卷的結果，呈上法團校董會會議討論。

東華三院教育科

(1) 東華三院教育科應確保完善的交接工作。如有特別的事項，例如，匿名投訴或需跟進的事項，交接時應特別提醒新上任的同事。

(2) 東華三院教育科作出相關的指示給予學校的管理層，要顧及同事的私人空間。

(3) 東華三院教育科在與投訴人或求助人會面之後，明確告知投訴人或求助人，事情將會如何處理，及必須得到投訴人或求助人的同意之下才可以披露投訴人或求助人的身分。

(4) 每年持份者問卷的結果，呈上法團校董會會議討論。

(ii) 死者在越野跑賽事中走錯路線後中暑死亡

勁亞有限公司

香港越野跑步總會

(1) 在越野跑賽事辨別路向宜用顏色明顯且印上賽事資訊之絲帶(如賽事名稱及日期等)。

(2) 在易於混淆的分岔路，增加標示方式：如掛更多絲帶、採用粉筆於不正確路向劃上交叉、派工作人員指示。

(3) 於員工掛絲帶時，記錄絲帶位置 (如拍照或於絲帶加上定位裝置)。

(4) 開賽前派先行跑手(front runner)按絲帶紀錄覆查掛絲帶位置。

(5) 主辦方須保留清楚之賽事員工、崗位、分布位置、當值時間及聯絡方法等紀錄。

(6) 主辦方於賽前須清楚向員工、義工等解釋注意事項，跑手報告事故的應對方法並留下紀錄並即時向大會報告。

(7) 主辦方應提醒參賽者必須攜帶手機參賽，而非只作建議，可於賽事網站、大會廣播作提醒。

(8) 開賽前主辦方以大會廣播及於賽事網站提醒參賽者注意身體狀況、天氣情況、攜帶手機及於酷熱天氣多帶飲用水及補給。

(9) 主辦方如遇家屬或跑手求助或懷疑有人失蹤，應提高危機意識，盡早報警求助，可參考以下準則：

(i) 跑手往績

(ii) 經過 checkpoint 時間

(iii) 賽事當日事故報告(如迷路)

(iv) 跑手是否確認退賽、有否取回行李、是否失去聯絡。

(iii) 因藥物紀錄擺放錯誤而未有給予處方藥物

醫院管理局

(1) 如果醫療程序上出現任何異常情況，病房經理必須即時報上醫院管理局的「早期事故通報系統」(Advanced Incidents Reporting System, AIRS)。

(2) 醫生在接見死者家屬之前應該查看「早期事故通報系統」(AIRS)。

(iv) 死者在引產和真空分娩後死於羊水栓塞

醫院管理局

(1) 醫管局發出指引，醫生應清楚曾考慮的病症並需要寫入排版。

(2) 醫管局應統一使用催生素指引並給予醫管局屬下醫院。

(3) 增加有關羊水栓塞培訓/講座（必須每年參與）。

(4) 檢討通報及上報機制，如發生突發情況，應尋求其他專科協助。

(5) 建議當使用催生素催生時（即第一產程）需使用血氧監察儀持續監察。

(6) 設立緊急程度指引，把緊急程度分級。加快血液樣本運送時間、檢測速度，實驗室需要確認交收時間，當有檢測結果時，需立刻通報，檢測結果要設立時限。特別是當血液樣本有問題時，需要立即通知有關醫生。檢討實驗室人手安排，縮短化驗時間，予醫務人員盡早根據化驗結果分析。

(7) 建議當發現有胎心異常時，要持續使用超聲波檢測去避免太早或太頻繁使用催生素。

(8) 手術時間要有定義，需要有標準指引，如手術開始及完結時間。

(v) <u>死者在接種克爾來福疫苗兩天後死亡</u>

衞生署

(1) 證物 C1 小冊子內對未控制嚴重慢性病患，提供實際例子，例如糖尿病、心臟病等等。疾病的名稱應是市民知道，不僅是專家用詞。

(2) 解釋清楚甚麼是未受控病患，例如嚴重病情，但正在服用藥物。

(3) 可加上或列出嚴重疾病的選項供市民剔選，讓當值醫生留意到，並即時作建議。

(vi) 死者在支氣管鏡檢查期間死於對鎮靜劑的不良反應

養和醫院

(1) 建議所有醫護人員應定期進行突發醫療事故之演練，例如病人之心臟停頓、停止呼吸的急救程序及工具/器材之應用。

(2) 另外，亦應定期對急救之程序及指引進行檢討及更新。

(vii) 死者被控謀殺其妻兒於等候審訊期間在囚室自縊

懲教署

(1) 我們建議小欖精神病治療中心的精神科醫生服務應基於不同個案增加會面次數，如語言不通、控罪嚴重或家人離世等，提供至少每一個月一次會面。

(2) 建議精神科醫生就不同個案情況，主動向警方申請索取更多資料，例如對疑犯精神健康評估有幫助的紀錄。

(3) 署方亦可加強對前線懲教人員有關了解精神健康的培訓，以助及早識別及轉介有需要的人士作出跟進。

警務處

警方可在合理規範下盡可能向精神科醫生提供有助判定精神健康的資料，如疑犯曾向警方透露自殺的念頭。

(viii) 一名在醫院接受腹膜透析的女士因真菌性腹膜炎死亡

仁濟醫院

(1) 需確保每一名協助病人進行腹膜透析的醫護人員，知悉構成透析導管及用具乾性及濕性污染的成因及補救方法。

(2) 在腹膜透析記錄表格上，加上病人使用腹膜透折系統的名稱，即優卓(Ultrabag) 或家安寶(Andy disc system)。

(ix) 一名男病人在接受冠狀動脈搭橋手術後，由於縫合線鬆脫引致出血離世

醫院管理局/伊利沙伯醫院

伊利沙伯醫院心胸外科應重新檢視，在替病人進行冠狀動脈搭橋手術後，是否有需要：

(1) 將病人的心包膜縫合，以避免出血時引發心包填塞效果；及

(2) 同時開出腎上腺素及去甲腎上腺素，以避免由於血管收窄而引起的心臟問題。

(x) 一名女病人在接受經皮經肝膽汁引流手術期間，肝臟因手術所需而被刺穿，其後引致出血並離世

醫院管理局/廣華醫院

(1) 醫護人員應加強與患者（尤其是年邁、理解力較差的患者）家屬之間的溝通，盡力確保家屬得悉患者的病況及醫護人員打算採取的治療方案，並在適當可行的情況下，讓家屬參與同意書的簽署；及

(2) 在進行經皮經肝膽汁引流手術時，廣華醫院介入放射科的醫護人員應考慮停止使用 16G 的針，以避免增加患者出血的風險；並應採購尺寸較細的引流導管，以備不時之需。

(xi) 一名女病人在接受氟哌啶醇注射後因心律失常離世

醫院管理局/北區醫院內科部

在處方氟哌啶醇時，醫護人員應注意病人身上是否出現了長 QT 綜合症，並加強審閱有關情況。如有需要，應作進一步的心電圖檢查，甚至考慮停止處方氟哌啶醇。另外，在處方氟哌啶醇予年老病人時，亦應考慮採用較低劑量，以減低風險。

(xii) 一名女病人在接受胃部切除手術後離世

葉盛輝醫生

在替病人進行胃部切除手術後，應考慮放置引流管，以便監察；如病人出現不尋常之腎功能受損及驗血指數，應考慮替病人進行

電腦掃瞄，並尋求腎科及／或內科醫生的支援，積極找出原因，及早為病人提供適切治療。

醫院管理局/伊利沙伯醫院

醫管局應盡早制定有關醫護人員檢查接受氣管造口術病人的指引，包括詳細列出檢查間距、監察等方面的要求，以確保病人得到充份照顧。此外，亦應定期提醒醫護人員相關指引的內容，並確保醫護人員切實跟從有關指引，包括就監察所得作出充足紀錄。

(xiii) 一名年老死者在廣華醫院搶救時所拍攝的肺部X光片及驗血檢測沒有給予衞生署病理學醫生作判斷死因之用

醫院管理局/衞生署

建議醫管局及衞生署應建立死者死後之醫療紀錄系統，以方便雙方溝通及查閱所有資料，讓法醫能掌握全面資料，用以判斷及決定應否「豁免遺體剖驗」之申請。

總結

25. 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。

26. 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。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。

27. 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。

28. 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。

29. 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衆對驗屍及死因等一般事宜所作的電話查詢。

30. 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。

31. 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。

署理主任裁判官	死因裁判官	死因裁判官	死因裁判官
高偉雄	何俊堯	周慧珠	林希維

二零二二年五月

Part One

Coroners' Report 2021

Number of Deaths on a Rising Trend

1. A total of 51,536 deaths were registered this year, and a total of 12,694 deaths were reported to the Coroners. Figures for the last 21 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

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 12 years, between 2007 and 2018, show a mixed uptrend. The number of deaths registered and the number of cases reported to Coroners for 2020 continued to increase progressively, which are up more than 10%, as compared with the figures for 2019. 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. 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 required, we shall inform the Police to carry out relevant investigations 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 21 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	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%

7. In recent years, there has been a growing number of deceased's family members and legal representatives of the deceased's family, as well as interested parties requesting for open inquests. The issues involved have been more complicated than in the past, with a majority of the relevant death cases related to medical or post-operative incidents. They 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, discretion was often exercised by the Coroner 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 so that they will 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 2021, the Coroners dealt with a total of 603 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 determine 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.

15. We would like to express our special thanks to the relevant parties and departments for their efforts made during the Covid-19 pandemic to enable the Coroners' Courts to continue to operate. In response to the public health situation and in maintaining social distancing and crowd control measures, most of our inquests to be heard with a jury had to be postponed. The Coroners will arrange to hold those inquests as soon as possible.

Suicides

16. There were 1,010 suicide cases this year. The figures are more or less the same as last year's. 244 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 636 : 374. The number of suicides for juvenile are more or less the same as last year's.

Accidental Deaths

17. The number of accidental deaths this year is 727, including 211 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 483 : 244.

Occupational Deaths

18. 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 31 occupational deaths, of which 33 are on land and 6 is at sea. The ratio of men to women is 31 : 2.

Homicides

19. The number of people unlawfully killed is 20, including 12 men and 8 women.

Vehicular Accidents

20. The number of deaths arising from vehicular accidents is 96. Of these 96 deaths, 49 deceased are pedestrians, being about half of the total death figure. 36 deceased are 70 years or older, which represents about one third of the total death figure. It is therefore clear that older people are much more vulnerable to road traffic accidents than other age groups. The ratio of men to women is 63 : 33.

Drugs and Poisons related Deaths

21. There are 107 deaths which are related to drugs and poisons, representing a decrease of 20% 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 73 : 34.

Deaths from natural causes

22. There are 10,890 deaths due to various diseases, of which 4,519, i.e. about half 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 6,329 : 4,561.

23. 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 31 to 2.

Recommendations

24. 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) Teacher who felt unjustly treated by the principal jumped to her death at school

To: Education Bureau

The Education Bureau shall consider the following recommendations, and to take corresponding actions to implement the recommendations:

(1) The 19 recommendations made by the Independent Investigation Committee of Tung Wah Group of Hospitals (TWGHs) Leo Tung-hai LEE Primary School in their July 2019 report;

(2) The results of the yearly Stakeholder Survey of every school shall be submitted to the Incorporated Management Committee (IMC) for discussion.

To : Education Division of the TWGHs

(1) The Education Division of the TWGHs shall ensure that there be a better handover procedure. If there are any matters requiring special attention (e.g. anonymous complaints or matters to be followed up), the incoming colleague shall be particularly reminded during the handover.

(2) The Education Division of the TWGHs shall give relevant directions to the management of the school that private spaces of colleagues shall be given due regard.

(3) After meeting a complainant or assistance seeker, the Education Division of the TWGHs shall clearly tell him/her how the matter would be handled, and his/her identity should only be disclosed with his/her consent.

(4) The results of the yearly Stakeholder Survey shall be submitted to the IMC for discussion.

(ii) <u>The deceased died from heat stroke at a trail race after taking a wrong route</u>

To: Power Asia Ltd.
Trail Runners Association of Hong Kong

(1) In a trail racing, to show runners the way to follow, it is preferable to use ribbons with a sharp colour and with information of the race printed on them (e.g. name and date of the race).

(2) At diverging paths where runners may easily get confused, the types of indicators should be increased: more ribbons are to be hung, use chalk to put a cross on an incorrect direction of a path, send along staff to show runners the way.

(3) When staff hang ribbons, the positions of ribbons should be recorded (e.g. take photos or attach positioning devices to ribbons)

(4) Before the race starts, a front runner is to be sent to double check positions where ribbons are hung by referring to record of ribbons.

(5) The organizing body must keep a clear record of race staff, their posts, where they are distributed, duty hours and how to contact them.

(6) Before the race starts, the organizing body must clearly explain the points to note to staff and volunteers, and how to deal with runners making incident reports.

(7) The organizing body should remind participants they must bring mobile phones when taking part in the race, rather than merely suggest them do so. Such a reminder may be put on website of race or through oral announcement by the organizing body.

(8) Before the race starts, the organizing body should, via oral announcement and website of the race, remind participants to pay attention to their own physical conditions and the weather, bring mobile phones and to bring and drink more hot water under very hot weather.

(9) If runners or their family members contact the organizing body for assistance, or if it is suspected that someone has gone missing, the organizing body should stay alert in relation to a sense of danger, and ask for assistance from the Police as soon as possible. Reference can be made to the following criteria:

(i) Past record of runner

(ii) At what time he passed the checkpoint

(iii) Incident reports on race day (e.g. losing one's way)

(iv) Whether it is confirmed the runner has withdrawn from the race: whether he/she has collected his/her luggage and whether he/she could no longer be reached

(iii) <u>Precribed medication not given due to misplaced medication record</u>

To: Hospital Authority

(1) If any abnormalities occur in a medical procedure, the ward manager must report immediately to the Advanced Incidents Reporting System (AIRS) of the Hospital Authority.

(2) The doctor should review the contents in the AIRS prior to interviewing the deceased's family.

(iv) <u>The deceased died from amniotic fluid embolism following an induced labour and vacuum delivery</u>

To: Hospital Authority

(1) The Hospital Authority is to issue guidelines so that doctors should indicate clearly the diagnosis they have considered and are required to write them down in the medical notes.

(2) The Hospital Authority should standardize the guidelines on the use of oxytocin for hospitals under its purview.

(3) To increase the amount of training/lectures in respect of amniotic fluid embolism (must attend annually).

(4) To review the notification and reporting mechanism, and seek assistance from other specialties in case of emergencies.

(5) The use of pulse oximeter is recommended for continuous monitoring when oxytocin is used to induce labour (ie, the first stage of labour).

(6) To establish urgency guidelines so as to grade urgency. To speed up the delivery time and testing speed of blood samples. The laboratory is required to acknowledge the time of delivery. When the test result is available, notification is to be made immediately. Time limit has to be set for the release of test result. Especially when there is a problem with the blood sample, the doctors concerned are to be notified immediately. To review the manpower arrangement of the laboratory so as to shorten the testing time, and allow medical staff to analyze the test results as soon as possible.

(7) It is recommended that when an abnormal fetal heart rate is noticed, continuous use of ultrasonography has to be used to avoid using oxytocin too early or too frequently.

(8) The duration of surgery has to be defined and standard guidelines are required, such as the start and end times of surgery.

(v) <u>The deceased died two days after receiving CoronaVac vaccine</u>

To: Department of Health

(1) Exhibit C1 booklet is to provide practical examples of uncontrolled severe chronic diseases, such as diabetes, heart disease, etc. The name of the diseases should be known to the public, and not only to the experts.

(2) Explain clearly what an uncontrolled illness is, e.g. serious medical conditions in which medication is being taken.

(3) Options for serious diseases can be included or listed out for the patient to choose by ticking it with a pen, so that doctors on duty can take note and make immediate recommendations.

(vi) <u>The deceased died from adverse reaction to sedatives during bronchoscopy</u>

To: Hong Kong Sanatorium & Hospital

(1) It is recommended that all medical and nursing staff should take part in regular rehearsal on sudden medical incidents, eg. first aid procedure and the application of tools/equipment on cardiac and pulmonary arrest.

(2) In addition, regular review and update should be conducted on first aid procedure and guidelines.

(vii) <u>The deceased strangled himself in his cell whilst awaiting trial for murdering his wife and son</u>

To: Correctional Services Department (CSD)

(1) We would suggest the frequency of interviews provided by the psychiatric service of the Siu Lam Psychiatric Centre be increased where the nature of the case so warrants. For cases involving language barriers, serious offences or deaths of family members, for instance, a monthly interview should be arranged at the minimum.

(2) Psychiatrists should be given the liberty to procure from the police further information on cases of a particular nature, for example records that may assist with the assessment of a suspect's mental health.

(3) The Department may also enhance the training of frontline CSD officers on knowledge in mental health in order to help them timely identify and refer those in need for follow-up actions.

To: Police Force

The Police should, in compliance with reasonable regulations, provide as far as possible all such information that may assist a

psychiatrist in making mental health assessments, including suicidal ideation revealed by suspects to the police.

(viii) A female patient undergoing peritoneal dialysis in hospital died of fungal peritonitis

To: Yan Chai Hospital

(1) It is necessary to ensure that each and every medical and nursing staff member who assists patients to undergo peritoneal dialysis knows the causes of the dry and wet contaminations in dialysis catheter and their remedies.

(2) To include the name of the dialysis system the patient uses in the dialysis record form, eg. Ultrabag or Andy Disc system.

(ix) A male patient died of bleeding due to loosening of sutures after a coronary artery bypass surgery

To: Hospital Authority/Queen Elizabeth Hospital

The Cardiothoracic Surgery Department of Queen Elizabeth Hospital should review whether, after coronary artery bypass surgery on a patient, it is necessary to:

(1) suture the patient's pericardium to avoid cardiac tamponade in the event of bleeding; and

(2) simultaneously prescribe epinephrine and norepinephrine to avoid heart problems caused by the narrowing of blood vessels.

(x) A female patient, while undergoing Percutaneous Transhepatic Biliary Drainage (PTBD) procedure, had her liver punctured as necessitated by the procedure, which later caused haemorrhage and death

To: Hospital Authority / Kwong Wah Hospital

(1) Healthcare workers shall improve communication with the family members of patients (in particular, patients of advanced age and with lower level of comprehension), strive to ensure that the family members are aware of the patient's condition and the treatment that the healthcare workers intends to adopt, and, when appropriate and practicable, allow the family members to participate in the signing of consent forms; and,

(2) In performing PTBD procedures, healthcare workers of the Department of Interventional Radiology of the Kwong Wah Hospital shall consider stopping the use of 16G needles, to avoid increasing the risk of haemorrhage in patients; and, catheters of finer gauge shall be procured to meet contingency needs.

(xi) A female patient died of arrhythmia upon the injection of Haloperidol

To: Hospital Authority/ Department of Medicine, North District Hospital

When prescribing Haloperidol, medical staff should take note of whether a patient suffers from Long QT syndrome, and conduct enhanced reviews on the relevant situation. If necessary, further ECG(s) should be carried out, and the stopping of Haloperidol prescription may

even be considered. Also, a lower dosage of Haloperidol should be considered for elderly patients to reduce the risks.

(xii) A female patient died after gastrectomy

To: Dr. Ip Shing Fai

After gastrectomy, the introduction of a drainage tube should be considered for monitoring; if the patient has unusual renal function impairment and blood test figure, a CT scan on the patient should be considered, and consultation with a nephrologist and/or with the support of medical specialist with a view to proactively identifying the cause so as to provide patients with appropriate treatments as soon as possible.

To: Hospital Authority / Queen Elizabeth Hospital

The Hospital Authority should formulate guidelines for medical and nursing staff to examine patients who have undergone tracheostomy as soon as possible, including detailed requirements for time gap in between examinations and monitoring, etc., to ensure that patients receive adequate care. In addition, medical and nursing staff should be regularly reminded of the content of the relevant guidelines and ensure that they actually follow the relevant guidelines, including making adequate records of the monitored findings.

(xiii) The chest X-ray film and blood test taken from an elderly deceased during the resuscitation in Kwong Wah Hospital were not sent to the pathologist of Department of Health for determination of the cause of death

To: Department of Health/ Hospital Authority

It is recommended that the Hospital Authority and Department of Health should build an after-death medical record system in relation to the diseased persons to facilitate the communication between both parties and the access to all data by them. This will enable the forensic pathologist to possess comprehensive data. Based on these data, he will judge and decide whether the application "to waive post-mortem examination" should be approved.

Conclusion

25. 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.

26. 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 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.

27. 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.

28. 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.

29. 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.

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

31. 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	HO Chun-yiu	Monica CHOW	LAM Hei-wei
Ag. Principal Magistrate	Coroner	Coroner	Coroner

May 2022

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 2021 年，死亡登記個案有 51,536 宗，而向死因裁判官呈報的死亡個案有 12,694 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	3,119
命令豁免屍體剖驗	9,575
土葬命令	945
火葬命令	11,749
須作進一步調查的死亡個案	1,120
進行死因研訊	163
死因裁判官或陪審員有提出建議的個案	37

於 2021 年須作進一步調查的 1,120 宗死亡個案中，截至 2021 年 12 月 31 日為止，警方仍未完成死亡調查報告的共有 733 宗。

於 2021 年向死因裁判官呈報的 12,694 宗死亡個案中，截至 2021 年 12 月 31 日仍在等候毒理學報告以決定死因的有 199 宗。

Analysis of Deaths Reported to the Coroners

In 2021 there were 51,536 deaths registered, and there were 12,694 deaths reported to the Coroner.

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

	TOTAL
Autopsy Orders	3,119
Waivers of Autopsy	9,575
Burial Orders	945
Cremation Orders	11,749
Further Death Investigation Reports ordered	1,120
Inquests held	163
Cases where recommendations are made	37

Of the 1,120 further death investigation reports ordered in 2021, 733 of which have not yet been returned from the Police as at 31 December 2021.

Of the 12,694 deaths reported in 2021, there are 199 cases of which the causes of death are still pending over toxicological reports as at 31 December 2021.

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		2021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 31.12.2021	
	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
12,694	**3,119**	**9,575**	**945**	**11,749**	**1,120**	**138**	**16**	**150**	**13**	**19**	**2**

數 字 及 百 分 比 **FIGURES AND PERCENTAGE**		總計 TOTAL
命令將屍體剖驗 AUTOPSY ORDERED 3,119 (25.00%)	豁免屍體剖驗 AUTOPSY WAIVED 9,575 (75.00%)	**12,694**
火葬命令 CREMATION ORDER 11,749 (92.60%)	土葬命令 BURIAL ORDER 945 (7.40%)	**12,694**

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
150 (92.00%)	13 (8.00%)	**163**

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

結論 Conclusion	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	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	腫瘤 Neoplasms	墮下 Falls	淹死 Drowning	吸入（異物） Aspiration (Foreign Body)	窒息 Suffocation	吊死 Hanging	由高處跳下 Jumping From Height	由高處墮下 Falling From Height	內科治療及外科手術 Medical and surgical care	注射 Injection	不詳 Unknown	毆打兒童 Battered Child	涉及警方的火器 Police Involved Firearms	藥物 Drugs	其他 Others	總計 TOTAL
死於自然 Natural Causes	13	19	5	9	2	75	6	5															**134**
死於意外 Accidental Death									2	1	1	1											**5**
死於不幸 Death by Misadventure									1							8							**9**
自殺死亡 Suicide													2	2									**4**
存疑裁決 Open Verdict															1		1	2					**4**
非法被殺 Unlawful Killing																			1				**1**
合法殺人 Lawful Killing																				1			**1**
死於意外/不幸 Death by Accident/Misadventure																3					1	1	**5**
總計 TOTAL	**13**	**19**	**5**	**9**	**2**	**75**	**6**	**5**	**3**	**1**	**1**	**1**	**2**	**2**	**1**	**11**	**1**	**2**	**1**	**1**	**1**	**1**	**163**

自殺個案
SUICIDES
（類別、年齡及性別）
(TYPE, AGE & SEX)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

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		1	2		3	1	2	2		11	**26**
	女 F			1	3	2	5	1	3		15	
毒藥 POISONS	男 M								2		2	**5**
	女 F								3		3	
吊死 HANGING	男 M		3	13	16	21	16	35	44		148	**236**
	女 F		1	1	8	10	11	21	36		88	
由高處跳下 JUMPING FROM HEIGHT	男 M	1	18	39	41	46	46	69	85		345	**562**
	女 F		16	16	27	35	31	44	48		217	
一氧化炭 CARBON MONOXIDE	男 M			6	15	16	26	9	2		74	**95**
	女 F			3	5	7	3	2	1		21	
淹死 DROWNING	男 M			3	3	5	5	9	8		33	**58**
	女 F			1	1	5	7	3	8		25	
利器 SHARP INSTRUMENTS	男 M					2		2			4	**4**
	女 F											
其他 OTHER	男 M			2	1			2	2		7	**11**
	女 F			1	1		1		1		4	
小計 SUB TOTAL	男 M	1	22	65	76	93	95	128	145		625	**998**
	女 F		17	23	45	59	58	71	100		373	
總計 TOTAL		**1**	**39**	**88**	**121**	**152**	**153**	**199**	**245**		**998**	**998**
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					1					1	**1**
	女 F											
毒藥 POISONS	男 M											
	女 F											
吊死 HANGING	男 M								1		1	**1**
	女 F											
由高處墮下 FALLING FROM HEIGHT	男 M			2	1	2	1	1			7	**8**
	女 F			1							1	
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				1						1	**1**
	女 F											
小計 SUB TOTAL	男 M			2	2	4	1	1	1		11	**12**
	女 F			1							1	
總計 TOTAL				**3**	**2**	**4**	**1**	**1**	**1**		**12**	**12**

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)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

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				3	**10**
	女 F			1	1	2	2	1			7	
毒藥 POISONS	男 M											**1**
	女 F								1		1	
吊死 HANGING	男 M					1		1	2		4	**8**
	女 F				1		1		2		4	
由高處跳下 JUMPING FROM HEIGHT	男 M		1	3	6	7	5	2	1		25	**43**
	女 F		1	3	2	6	3	1	2		18	
一氧化炭 CARBON MONOXIDE	男 M					1	1				2	**6**
	女 F			1		1	2				4	
淹死 DROWNING	男 M			1	1	2	1	3	1		9	**13**
	女 F						1	2	1		4	
利器 SHARP INSTRUMENTS	男 M											
	女 F											
其他 OTHER	男 M								1		1	**1**
	女 F											
小計 SUB TOTAL	男 M		2	5	7	11	8	6	5		44	**82**
	女 F		1	5	4	9	9	4	6		38	
總計 TOTAL			**3**	**10**	**11**	**20**	**17**	**10**	**11**		**82**	**82**
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				1	1					2	**2**
	女 F											
總計 TOTAL					**1**	**1**					**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)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

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							1			1	**1**
	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			1	**1**
	女 F											
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)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

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		5	1							6	**10**
	女 F		4								4	
教師 TEACHER	男 M											**6**
	女 F				2	2	2				6	
沒有職業 NOT EMPLOYED	男 M			6	6	11	13	10	4		50	**77**
	女 F			4	4	6	6	6	1		27	
家庭主婦 HOUSEWIFE	男 M											**5**
	女 F						2		3		5	
藍領 BLUE COLLAR	男 M		2	5	13	8	10	3	2		43	**56**
	女 F		1	1	3	5	1	1	1		13	
白領 WHITE COLLAR	男 M			3	1	10	2				16	**26**
	女 F			2	6	1	1				10	
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					4	2	3			9	**14**
	女 F				2	1	2				5	
退休人士 RETIRED PERSON	男 M						1	4	17		22	**36**
	女 F							5	9		14	
其他 OTHER	男 M					1					1	**1**
	女 F											
小計 SUB TOTAL	男 M		7	15	20	34	29	20	23		148	**232**
	女 F		5	7	17	15	14	12	14		84	
總計 TOTAL			**12**	**22**	**37**	**49**	**43**	**32**	**37**		**232**	**232**

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					2					2	**2**
	女 F											
家庭主婦 HOUSEWIFE	男 M											
	女 F											
藍領 BLUE COLLAR	男 M				2	1		1			4	**4**
	女 F											
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					1	1		1		3	**3**
	女 F											
其他 OTHER	男 M											
	女 F											
小計 SUB TOTAL	男 M			2	2	4	1	1	1		11	**12**
	女 F			1							1	
總計 TOTAL				**3**	**2**	**4**	**1**	**1**	**1**		**12**	**12**

* 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)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

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						5		9		14	**19**
	女 F							1	4		5	
吸入（食物） ASPIRATION (FOOD)	男 M		1		1	1	2	10	43		58	**107**
	女 F					2	4	1	42		49	
吸入（異物） ASPIRATION (FOREIGN BODY)	男 M								1		1	**3**
	女 F								2		2	
吸入（其他） ASPIRATION (OTHER)	男 M	1			1	2		2	6		12	**16**
	女 F							1	3		4	
窒息 SUFFOCATION	男 M	1							1		2	**4**
	女 F	1							1		2	
吊死 HANGING	男 M											
	女 F											
被物件擊中 STRUCK BY OBJECT	男 M				3	1	1	2	3		10	**13**
	女 F			1			1		1		3	
被升降機壓死 CRUSHED BY LIFT	男 M							2			2	**2**
	女 F											
被物件壓死 CRUSHED BY OBJECT	男 M					1	1	2			4	**4**
	女 F											
燒灼 BURNS	男 M						1	1			2	**2**
	女 F											
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							2	**3**
	女 F			1							1	
一氧化炭（其他） CARBON MONOXIDE (OTHER)	男 M											
	女 F											
墮下 FALLS	男 M	1	1	6	7	6	16	32	148		217	**332**
	女 F	1	1		1	3	5	8	96		115	
淹死 DROWNING	男 M	1	1	5	8	5	3	16	13		52	**66**
	女 F			1	1		5	2	4	1	14	
觸電 ELECTROCUTION	男 M						2				2	**2**
	女 F											
割或刺 CUT OR PUNCTURE	男 M							1			1	**1**
	女 F											
火器 FIREARMS	男 M											
	女 F											
鈍器撞擊 BLUNT FORCE	男 M											**2**
	女 F					1		1			2	
藥物 DRUGS	男 M			3	10	26	12	17	2		70	**84**
	女 F				6	2	5		1		14	
毒藥 POISONS	男 M					1		1			2	**5**
	女 F				1	1	1				3	
中毒（酒精） POISON (ALCOHOL)	男 M				1		2	2			5	**5**
	女 F											
內科治療及外科手術 MEDICAL AND SURGICAL CARE	男 M					1	4	7	8		20	**48**
	女 F	2		1	2	2	2	3	16		28	
其他 OTHERS	男 M				2	2	1		2		7	**9**
	女 F								2		2	
小計 SUB TOTAL	男 M	4	4	15	33	46	50	95	236		483	**727**
	女 F	4	1	4	11	11	23	17	172	1	244	
總計 TOTAL		**8**	**5**	**19**	**44**	**57**	**73**	**112**	**408**	**1**	**727**	**727**

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)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

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	1		2						4	**5**
	女 F						1				1	
海灘/海 BEACH/SEA	男 M			3	4	1	2	3	4		17	**23**
	女 F				1		3	1		1	6	
水庫 RESERVOIR	男 M											
	女 F											
農場 FARM	男 M											
	女 F											
建築地盤 CONSTRUCTION SITE	男 M			1		2					3	**3**
	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**
	女 F			1							1	
河流 RIVER	男 M							2			2	**2**
	女 F											
自流井 ARTESIAN WELL	男 M											
	女 F											
其他 OTHERS	男 M											
	女 F											
小計 SUB TOTAL	男 M	1	1	4	6	3	2	5	4		26	**34**
	女 F			1	1		4	1		1	8	
總計 TOTAL		**1**	**1**	**5**	**7**	**3**	**6**	**6**	**4**	**1**	**34**	**34**

* 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)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

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											
	女 F											
吸入（異物） ASPIRATION (FOREIGN BODY)	男 M											**2**
	女 F								2		2	
吸入（其他） ASPIRATION (OTHER)	男 M											
	女 F											
窒息 SUFFOCATION	男 M	1									1	**2**
	女 F	1									1	
吊死 HANGING	男 M											
	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	**2**
	女 F											
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											
墮下 FALLS	男 M					1		1	1		3	**8**
	女 F	1	1			1	1		1		5	
淹死 DROWNING	男 M	1									1	**1**
	女 F											
觸電 ELECTROCUTION	男 M						1				1	**1**
	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			1	2	2	4	3			12	**17**
	女 F					2	2		1		5	
毒藥 POISONS	男 M					1		1			2	**2**
	女 F											
中毒（酒精） POISON (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											
	女 F											
小計 SUB TOTAL	男 M	2		1	2	4	6	6	1		22	**35**
	女 F	2	1			3	3		4		13	
總計 TOTAL		**4**	**1**	**1**	**2**	**7**	**9**	**6**	**5**		**35**	**35**

* 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)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

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											**1**
	女 F								1		1	
吸入（其他） ASPIRATION (OTHER)	男 M											
	女 F											
窒息 SUFFOCATION	男 M											
	女 F											
吊死 HANGING	男 M											
	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											
	女 F											
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											
墮下 FALLS	男 M			1	1	1	1	1	1		6	**6**
	女 F											
淹死 DROWNING	男 M						1	1			2	**2**
	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	2	2	1		11	**16**
	女 F				1	2	2				5	
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											
	女 F											
小計 SUB TOTAL	男 M			1	3	5	5	4	2		20	**28**
	女 F				1	2	2	1	2		8	
總計 TOTAL				**1**	**4**	**7**	**7**	**5**	**4**		**28**	**28**

* 有進一步調查及更詳盡的死亡調查報告
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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)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

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			2			1	1		5	**8**
	女 F						2	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				2				1		3	**4**
	女 F						1				1	
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						2	2	1		5	**7**
	女 F					1			1		2	
登山運動 MOUNTAINEERING	男 M											
	女 F											
水上體育活動 WATER SPORTS	男 M											**1**
	女 F				1						1	
釣魚 FISHING	男 M			1	1			1	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				1		1				2	**2**
	女 F											
小計 SUB TOTAL	男 M	1		1	6		3	4	4		19	**26**
	女 F				1	1	3	1	1		7	
總計 TOTAL		**1**		**1**	**7**	**1**	**6**	**5**	**5**		**26**	**26**

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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)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

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						1				1	**1**
	女 F											
木板 WOODEN PLANK	男 M					1					1	**1**
	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											**1**
	女 F			1							1	
竹杆 BAMBOO POLE	男 M											
	女 F											
批盪（水泥） CEMENT PLASTER	男 M				1			1			2	**3**
	女 F						1				1	
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	**1**
	女 F											
小計 SUB TOTAL	男 M				1	1	1	2			5	**7**
	女 F			1			1				2	
總計 TOTAL				**1**	**1**	**1**	**2**	**2**			**7**	**7**

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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)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

意外類別 TYPE OF ACCIDENT	年齡組別 AGE GROUPS 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	小計 SUB TOTAL	**總計 TOTAL**
被物件擊中 STRUCK BY OBJECT	男 M			3	1	1	1			6	**6**
	女 F										
被物件壓死 CRUSHED BY OBJECT	男 M				1		2			3	**3**
	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		3	7			12	**14**
	女 F					1	1			2	
觸電 ELECTROCUTION	男 M					1				1	**1**
	女 F										
淹死 DROWNING	男 M		2	1	3					6	**6**
	女 F										
車輛 VEHICLE	男 M										
	女 F										
升降機 LIFT	男 M						2			2	**2**
	女 F										
其他 OTHERS	男 M						1			1	**1**
	女 F										
小計 SUB TOTAL	男 M		2	6	5	5	13			31	**33**
	女 F					1	1			2	
總計 TOTAL			**2**	**6**	**5**	**6**	**14**			**33**	**33**

殺人個案 *
HOMICIDES *
（類別、年齡及性別）
(TYPE, AGE & SEX)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

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							1			1	**2**
	女 F								1		1	
涉及警方的火器 POLICE INVOLVED FIREARMS	男 M						1				1	**1**
	女 F											
被人用銳利物襲擊 SHARP OBJECT ASSAULT	男 M			2		2	2		1		7	**7**
	女 F											
被人用鈍器襲擊 BLUNT FORCE ASSAULT	男 M				1						1	**3**
	女 F	2									2	
絞縊 STRANGULATION	男 M											**1**
	女 F						1				1	
火燒、有毒物質、氣體、腐蝕性物質 FIRE, NOXIOUS SUBSTANCE, GASES, CORROSIVE SUBSTANCE	男 M											
	女 F											
窒息 SUFFOCATION	男 M											**2**
	女 F	1				1					2	
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	1									1	**2**
	女 F	1									1	
藥物 DRUGS	男 M							1			1	**1**
	女 F											
中毒 POISONING	男 M											
	女 F											
由高處被推下 PUSHED FROM HIGH PLACE	男 M											
	女 F											
其他 OTHERS	男 M											**1**
	女 F	1									1	
小計 SUB TOTAL	男 M	1		2	1	2	3	2	1		12	**20**
	女 F	5				1	1		1		8	
總計 TOTAL		**6**		**2**	**1**	**3**	**4**	**2**	**2**		**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

車輛導致死亡的個案
VEHICULAR ACCIDENTS
（類別、年齡及性別）
(TYPE, AGE & SEX)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

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											**2**
	女 F					1			1		2	
行人與汽車 / 輕型貨車 / 客貨車 PEDESTRIAN v. CAR/PICK-UP TRUCK/VAN	男 M			1			3	5	10		19	**35**
	女 F				2			3	11		16	
行人與貨車 / 巴士 PEDESTRIAN v. TRUCK/BUS	男 M				2			1	3		6	**12**
	女 F			1			1		4		6	
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		1		3		5	**5**
	女 F											
單車與貨車 / 巴士 BICYCLE v. TRUCK/BUS	男 M			1				1	1		3	**3**
	女 F											
單車失去控制 BICYCLE OUT OF CONTROL	男 M							2			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			2	1	1					4	**5**
	女 F					1					1	
電單車與貨車 / 巴士 MOTORCYCLE v. TRUCK/BUS	男 M				1	1	2				4	**4**
	女 F											
電單車失去控制 MOTOR CYCLE OUT OF CONTROL	男 M				1			1			2	**2**
	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	**3**
	女 F				1			1			2	
汽車 / 輕型貨車 / 客貨車與貨車 / 巴士 CAR/PICK-UP TRUCK/VAN v. TRUCK/BUS	男 M											
	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	2	1	1				5	**5**
	女 F											
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				3		1				4	**7**
	女 F					1	2				3	
其他組合 OTHER COMBINATIONS	男 M					2	1	4	1		8	**11**
	女 F							1	2		3	
小計 SUB TOTAL	男 M			6	11	5	9	14	18		63	**96**
	女 F			1	3	3	3	5	18		33	
總計 TOTAL				**7**	**14**	**8**	**12**	**19**	**36**		**96**	**96**

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)
2021 年 1 月 1 日 - 2021 年 12 月 31 日
1ST JANUARY 2021 - 31ST DECEMBER 2021

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								
	女 F								
20 to 29	男 M	2	2	1		1		6	**7**
	女 F					1		1	
30 to 39	男 M	2	3	1	2	2		10	**13**
	女 F				1	2		3	
40 to 49	男 M		2		2		1	5	**7**
	女 F				1	1		2	
50 to 59	男 M	1	1	1	1	3	1	8	**11**
	女 F				2	1		3	
60 to 69	男 M	1	1	5		6		13	**18**
	女 F				1	4		5	
70 to	男 M			4		13	1	18	**36**
	女 F				2	16		18	
UNKNOWN	男 M								
	女 F								
小計 SUB TOTAL	男 M	6	9	12	5	25	3	60	**92**
	女 F				7	25		32	
個案總數 TOTAL DEATHS		**6**	**9**	**12**	**12**	**50**	**3**	**92**	**92**

* 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 *

2021 年 1 月 1 日 - 2021 年 12 月 31 日

1ST JANUARY 2021 - 31ST DECEMBER 2021

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	2	3	3	14	1	**24**
陰性 NEGATIVE	2	7	7	9	31	1	**57**
陽性 （每 100 毫升血） POSITIVE (per 100ml blood)							
0 - 50 毫克 0 - 50 mg	2		2		4	1	**9**
51 - 100 毫克 51 - 100 mg							
101 - 150 毫克 101 - 150 mg	1						**1**
151 - 200 毫克 151 - 200 mg							
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	**6**	**9**	**12**	**12**	**50**	**3**	**92**

* 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)

2021 年 1 月 1 日 - 2021 年 12 月 31 日

1ST JANUARY 2021 - 31ST DECEMBER 2021

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			2	1	1		6	14		**24**
陰性 NEGATIVE			3	11	5	10	11	17		**57**
陽性 （每 100 毫升血） POSITIVE (per 100ml blood)										
0 - 50 毫克 0 - 50 mg			1		1	1	1	5		**9**
51 - 100 毫克 51 - 100 mg										
101 - 150 毫克 101 - 150 mg				1						**1**
151 - 200 毫克 151 - 200 mg										
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			**7**	**13**	**7**	**11**	**18**	**36**		**92**

* 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
01/01/2021 - 31/12/2021

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	3	4	2			13	
Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	女 F				1		1				2	**15**
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	1	2				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					1					1	
Poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified	女 F											**1**
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	12	5	7			27	
Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	女 F				2	3	3				8	**35**
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	
Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	女 F											**1**

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	1					3	**5**
		女 F				1				1		2	
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	**2**
		女 F			1							1	
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	**1**
		女 F											
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	**6**
		女 F					1	3	1			5	
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											
		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		1			2	**3**
	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			1	5	4	8	1			19	**28**
	女 F			1	2	3	3				9	
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											**1**
	女 F								1		1	
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											
	女 F											
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**
	女 F						1				1	
小計 SUB-TOTAL	男 M		1	5	13	22	18	12	2		73	**107**
	女 F			2	7	8	14	1	2		34	
總計 TOTAL			**1**	**7**	**20**	**30**	**32**	**13**	**4**		**107**	**107**

* 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)

2021 年 1 月 1 日 - 2021 年 12 月 31 日

1ST JANUARY 2021 - 31ST DECEMBER 2021

疾病類別 TYPE OF DISEASES	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**
某些傳染病和寄生蟲病 Certain infectious and parasitic diseases A00 - B99	男 M			3	2	10	34	58	126		233	**419**
	女 F	1	2	3	3	6	14	24	133		186	
腫 瘤 Neoplasms C00 - D48	男 M		1	2	9	28	76	198	446		760	**1294**
	女 F	1			5	21	84	108	315		534	
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	3	3		7	**18**
	女 F			1		1	1	1	7		11	
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	3	2	8	20	33	49		116	**190**
	女 F			1	1	3	9	14	46		74	
精神錯亂 Mental and behavioural disorders F00 - F99	男 M				1	1		1	21		24	**95**
	女 F					1	2	2	66		71	
神經系統疾病 Diseases of the nervous system G00 - G99	男 M		2	3	3	8	8	15	31		70	**137**
	女 F		2	3	6	6	6	16	28		67	
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			9	36	136	430	587	1615		2813	**4519**
	女 F	2	1	6	17	63	104	200	1313		1706	
呼吸系統疾病 Diseases of the respiratory system J00 - J99	男 M	1	1		9	18	63	154	564		810	**1177**
	女 F	1			6	6	26	48	280		367	
消化系統疾病 Diseases of the digestive system K00 - K93	男 M	2	2		4	13	41	59	142		263	**428**
	女 F	1		2	6	4	14	21	117		165	
皮膚和皮下組織疾病 Diseases of the skin and subcutaneous tissue L00 - L99	男 M							2	1		3	**8**
	女 F			1	1				3		5	
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				1	1	2	2	6		12	**28**
	女 F	1		1		2	3	1	8		16	
生殖泌尿系統疾病 Diseases of the genitourinary system N00 - N99	男 M				2	5	14	44	78		143	**253**
	女 F					2	9	21	78		110	
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	3								1	4	**7**
	女 F	3									3	
先天畸形 Congenital malformations, deformations and chromosomal abnormalities Q00 - Q99	男 M	4	3	2	1	1	1		1		13	**22**
	女 F	1	1			1	4	1	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	1	3	8	13	20	54	110	837	12	1058	**2294**
	女 F	4		2	9	8	23	36	1153	1	1236	
小計 SUB TOTAL	男 M	11	13	30	83	249	744	1266	3920	13	6329	**10890**
	女 F	15	6	20	54	125	299	493	3548	1	4561	
總計 TOTAL		**26**	**19**	**50**	**137**	**374**	**1043**	**1759**	**7468**	**14**	**10890**	**10890**

2021 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) 2021

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	50
2. 騎腳踏車者在交通意外中受傷 (V10-V19) Pedal cyclist injured in transport accident	12
3. 騎摩托車者在交通意外中受傷 (V20-V29) Motorcycle rider injured in transport accident	9
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	7
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	3
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	7
9. 其他陸上交通意外 (V80-V89) Other land transport accidents	3
10. 水上交通意外 (V90-V94) Water transport accidents	5
11. 航空及太空交通意外 (V95-V97) Air and space transport accidents	1
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	55
2. 暴露於無生命的外物物力 (W20-W49) Exposure to inanimate mechanical forces	19

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	34
5. 其他危及呼吸的意外情況 (W75-W84) Other accidental threats to breathing	15
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	2
7. 暴露於煙、火及火焰 (X00-X09) Exposure to smoke, fire and flames	5
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	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	60
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**	232
III. 襲擊 (X85-Y09) **Assault**	20
IV. 未確定意圖的事件 (Y10-Y34) **Event of undetermined intent**	12
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	5
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	9
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	2

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	3
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**	
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**	73
自然死因 **Natural Cause**	505
[Total 總數]	**1,151**