

Executive Summary

Direct Investigation into Marine Department's Follow-up Mechanism on Recommendations Made in Marine Incident Investigation Reports

Background

In October 2012, a serious marine incident occurred off Lamma Island (“the Lamma Incident”). After investigation, it was found that one of the vessels involved was not fitted with a watertight door, resulting in water ingress and rapid sinking of the vessel after the collision. Subsequently, the media reported that in 2000, a Government vessel under maintenance at a dockyard sank after water had entered its hull because the watertight bulkheads on board were not intact. While the relevant incident investigation report had already recommended that the Marine Department (“MD”) examine the watertight bulkheads for all vessels of the same type, the occurrence of the Lamma Incident cast doubt on whether MD had fully implemented the recommendations of marine incident investigation reports all along.

2. In this light, The Ombudsman decided to initiate a direct investigation to examine MD’s follow-up mechanism on recommendations made in the investigation reports of local marine incidents. Since the Chief Executive in Council had appointed an independent Commission of Inquiry to inquire into the Lamma Incident (including ascertaining the causes of the incident), and a report was submitted to the Chief Executive upon completion of its inquiry, this direct investigation would not look into the causes of the Lamma Incident and the question of accountability.

Investigation of Marine Incidents

3. Where a Hong Kong registered ocean-going vessel in any waters, or a certificated local vessel or any other non-local vessel within Hong Kong waters is involved in an accident, the owner/master/proprietor of the vessel or their agent(s) shall report the occurrence to the Director of Marine.

4. The Marine Accident Investigation and Shipping Security Policy Branch (“MAI”) under MD is responsible for investigating marine incidents reported in accordance with the provision **above**. The main purpose of investigation is not to affix responsibility or institute any prosecution/disciplinary action, but to determine the circumstances and causes of the incident in order to improve the safety of life at sea. Moreover, by publishing the investigation findings, it is intended to inform the industry of the lessons to be learned and prevent recurrence of similar accidents in future.

5. Upon completion of investigation, MAI will prepare a marine incident investigation report (“incident report”). The incident report, when approved, will be

uploaded to MD's website for public information if it is confirmed that the incident is not involved in any ongoing or pending legal proceedings.

Follow-up Mechanism on Recommendations in Incident Reports

6. Prior to June 2013, it could be said that MD had adopted a "lax" approach in following up on recommendations made in the incident reports. It would mainly rely on the officers of relevant divisions and the related vessel companies/vessel owners to take voluntary actions to rectify the inadequacies, without any specific records of the follow-up actions and monitoring system. In response to Report No. 59 of the Audit Commission issued in October 2012, MD set up a computer system and input into the system all the recommendations made in the incident reports for continued monitoring of the progress of implementation. The computer system began formal operation in June 2013. Furthermore, in December 2014, MD revised its guidelines on marine incident investigation with a new section about following up on recommendations made, with details on the follow-up procedures and the responsible officers. For ease of discussion below, the operational mechanisms before and after MD's setting up of the above computer system are referred to as "the Old Mechanism" and "the New Mechanism" respectively.

"Lax" Approach under the Old Mechanism

7. When the computer system was set up in June 2013, MD did not input into its database the information about implementation of recommendations arising from investigation cases concluded before that time. Upon our request, MD retrieved from different divisions the records between 2005 and 2013 and manually searched the relevant information. It then collated and compiled the information related to its follow-up actions on recommendations made in the incident reports. According to the information so obtained, during the period of more than eight years between January 2005 and May 2013, MD concluded 114 marine incident investigations and made 308 recommendations in total.

8. Under the Old Mechanism, MD would just inform the related agencies and parties of the recommendations made in the incident reports, and then leave it to them to handle the implementation. There was no established mechanism for monitoring whether those related agencies and parties were going to implement the recommendations or not.

9. Regarding MD's follow-up actions on the recommendations made in the above 114 incident reports, we have the following observations.

No Follow-up Actions by MD for Years after Completion of Investigation

10. In five cases, MD had not taken any follow-up actions for years after completing the investigation. For the case with the most serious delay, MD only took “retrospective” action to follow up on the recommendations made in the incident report eight years and seven months after completion of the investigation. In the other three cases, MD only took “retrospective” follow-up actions some seven years after completion of the investigation.

11. As for the remaining case, MD checked the relevant records once again on receipt of our draft investigation report and found that the recommendations made in the incident report had actually been followed up in a timely manner. Nevertheless, MD could not locate any record about the “follow-up action taken” when it collated and compiled the information upon our request in mid-2014, and so it took “retrospective” follow-up action again in July 2014. This showed that MD’s records were indeed muddled and confusing.

12. We notice that MD’s “retrospective” follow-up actions were all taken after July 2014, subsequent to our request for MD to search and collate its old records. It appeared that had it not been because of our direct investigation, MD might not have discovered its omissions of follow-up actions in those cases.

Omissions in Following up on Some Recommendations

13. In general, more than one recommendation would be made in an incident report. We notice that in following up on 11 cases, MD had omitted follow-up actions on at least one recommendation in each case, and “retrospective” follow-up actions were only taken years later. In the case which involved the most serious delay, MD completed the investigation in May 2005 and made seven recommendations. Only three of those recommendations were followed up in the same month and in January 2006. For the remaining four recommendations, however, it was not until August 2014 (i.e. more than nine years later) that MD took follow-up actions.

14. Similar to the situation described in **para. 12** above, MD only took “retrospective” actions to follow up on its recommendations after July 2014. We believe that it was upon checking of records at our request that MD discovered the omissions and took retrospective follow-up actions.

Case Information Incomplete and Confusing

15. According to the records provided by MD during our investigation, a total of 114 incident reports (**para. 7** above) were completed between January 2005 and March 2013. However, we found from MD’s website that in addition to those 114 incidents, there were another six marine incidents between August 2009 and November 2012. Only the report summaries of those six incidents had been published. No further details about them were available.

16. Similar to the case cited in **para. 11** above, MD searched and found the case files of those six incidents upon receipt of our draft investigation report. The Department explained that when it first provided us with the case information in October 2014, those six cases were involved in legal proceedings. Full incident reports on the cases, therefore, could not be published.

17. Nevertheless, we must point out that during our investigation, MD had provided us with information on 191 marine incident investigations. A number of those cases involved on-going litigations but the six cases just mentioned were not among them. Besides, MD's information were confusing. We, therefore, had specifically asked MD in November 2015 to confirm whether the information and data provided to this Office in the course of our investigation were accurate. MD replied in December and confirmed their accuracy. This clearly implied that the Department had not been rigorous at all in checking its records, and reflected how incomplete and confusing its records had been.

The New Mechanism is Still Inadequate

18. Records provided by MD showed that during the period of more than two years between June 2013 and November 2015, the Department had completed 77 incident reports and made 215 recommendations in total. The New Mechanism requires that in addition to following the Old Mechanism and informing the related agencies and parties of its recommendations made in the incident report, MD should also enter those recommendations into its computer system, so that the relevant divisions can continue to follow up, and senior management can monitor the progress until all the recommendations are implemented.

Inadequate Follow-up Actions on Recommendations Regarding Vessels Not Registered in Hong Kong or Not Certificated Locally

19. In fact, the New Mechanism is only applicable to vessels registered in Hong Kong or certificated locally. For recommendations relating to vessels not registered in Hong Kong, MD would basically follow the Old Mechanism. In other words, after informing the flag states or the ship companies of its investigation findings, MD will leave it to them to handle and implement the recommendations. The Department normally will not follow up any further.

20. We understand that it may be difficult for MD to monitor implementation by vessels not registered in Hong Kong or not certificated locally. Nonetheless, we consider that the Department should at least try to know whether improvements have been made to the vessels in question so that it could assess the possible marine safety hazards should those vessels enter Hong Kong waters again.

Failure to Follow up Rigorously on Each Case

21. MD's follow-up actions on implementation of recommendations are better organised under the New Mechanism than under the Old Mechanism. Nevertheless, we observe that in most cases where the New Mechanism was applicable, follow-up actions would come to an end once MD received replies from the related agencies indicating that the recommendations had been, or were about to be, implemented. No further verification on the implementation process were then made.

22. In a small number of cases which had been handled more rigorously, MD wrapped up its follow-up actions only after it had received documentary proofs from the related agencies, or after MD officers had conducted inspections to confirm implementation of all the recommendations. Of the 77 cases cited in **para. 18** above, only 13 had been handled in such a more rigorous manner.

23. We consider that MD should rigorously follow up on each and every recommendation that involves marine safety to ensure their full implementation, just as what it had done in those 13 cases mentioned above.

Our Comments

Records Incomplete and Confusing under the Old Mechanism, with Inadequate Follow-up Actions and Ineffective Monitoring

24. Before the computer system was set up in June 2013, MD had not established any database for the recommendations, nor any management information system for monitoring the implementation of its recommendations. In response to our request to check the information, MD started collating old case records scattered among its different divisions. It then manually searched all information relating to its follow-up of the recommendations. This took six months to complete. What was even worse, as can be seen in **paras. 11 and 15 to 17** above, MD's records were obviously incomplete and confusing. Monitoring of implementation progress of recommendations could hardly be possible.

25. Without proper records, it was difficult for MD's senior management to monitor the implementation of recommendations or check whether there were any omissions. This undesirable situation continued until the Audit Commission published a report on it in October 2012. The Department then conducted a review and took follow-up action. This showed that MD had not attached much importance to monitoring the progress of implementation.

26. Under the Old Mechanism, MD's follow-up actions would just mean informing the related agencies and parties of its recommendations and then leaving it to them to handle the implementation (**para. 8** above). The Department had not exercised due diligence to monitor the progress of implementation and ensure our marine safety.

New Mechanism Neither Comprehensive Nor Rigorous

27. In June 2013, MD set up a computer system so that timely reminder would be issued to the responsible officers while senior management could regularly monitor outstanding cases. We consider this system to be the first step towards effective monitoring.

28. Nevertheless, we notice that apart from a small number of cases (see **para. 22** above), MD still relies mainly on progress reports from vessel companies and related agencies to monitor the implementation of recommendations. When a reply about the implementation progress is received, MD will end its follow-up action and will not make further verification. We stress that to ensure marine safety, MD must rigorously follow up on each recommendation made. MD should end its follow-up actions only after obtaining relevant information to confirm that all the recommendations are implemented. Moreover, where the subject is a vessel not registered in Hong Kong, MD will only notify the related parties but will not monitor the implementation of recommendations. Such practice is not desirable because the vessel may still present a certain hazard when entering Hong Kong waters again (**para. 20** above).

MD Would Not Apply the New Mechanism to Old Cases

29. According to MD, it has completed its follow-up actions on 308 recommendations made under the Old Mechanism (**para. 7** above). In response to our enquiries, however, MD clarified that if the New Mechanism were to apply to the aforesaid 308 recommendations, then 20 cases involving 22 recommendations would require continued follow-up actions.

30. We actually asked MD to consider applying the New Mechanism to all the cases investigated before the computer system was set up in June 2013. However, MD explained that because of manpower and resource constraints, and as its review on the 20 cases mentioned above had confirmed that there were no similar incidents recurring in the same vessels, MD did not see any need to apply the New Mechanism and follow up on those 22 recommendations.

31. In our view, the purpose of investigating marine accidents is to find out the facts and the causes, and to avoid recurrence of similar accidents that would endanger lives and property. This is the way to learn lessons from past experiences. We find it quite unacceptable that MD has decided not to apply the New Mechanism to follow up on those 22 recommendations on grounds of manpower and resource constraints, and simply because there were no similar incidents recurring in the same vessels. This may put our marine safety at risk.

Question on Whether There are Still Outstanding Recommendations Unnoticed

32. MD had spent six months checking the old records upon our request to verify its past follow-up actions on implementation of the recommendations made in the

incident reports. Subsequent to our later enquiries, MD confirmed that those records were accurate but we still found the six “missing” cases (**para. 15** above). Obviously MD’s records are rather confusing. After we sent our draft investigation report to MD for comments, MD checked its records again and then provided us with the information of those six cases (**paras. 16 and 17** above). Under the Old Mechanism, there was no guidelines on how MD officers should follow up on implementation of recommendations. Nor was there a management information system for monitoring the progress of implementation. As a result, it is questionable whether there are still outstanding cases unnoticed and whether manual checks on records are comprehensive and accurate.

Our Recommendations

33. In the light of the above, The Ombudsman urges MD:

- (1) to actively verify whether all the recommendations in incident reports are implemented, instead of relying on reports by the related agencies or parties, and to include this procedure in the regular routines for following up on implementation of recommendations (**para. 23** above);
- (2) to take appropriate follow-up actions on implementation of recommendations regarding cases involving vessels not registered in Hong Kong or not certificated locally (**para. 20** above);
- (3) to reconsider applying the New Mechanism to follow up on those 22 recommendations in the incident reports cited in **para. 29**, with a view to ensure marine safety (**para. 31** above);
- (4) to consider reviewing the information on cases under the Old Mechanism to prevent the problem of confusing records as shown in **paras. 11 and 15 to 17** above, and to ensure that appropriate actions will be taken to follow up on recommendations made in the incident reports; and
- (5) to review regularly the follow-up actions on all recommendations made in incident reports under the New Mechanism and ensure the achievement of expected results.

34. MD has accepted our recommendations and started taking follow-up actions. We thank the Department for its cooperation in our investigation and are pleased to note that all our recommendations have been accepted. We will continue to monitor the progress until all the recommendations are implemented.

**Office of The Ombudsman
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