申訴專員公署

主動調查報告

海事處對海上事故調查報告所作建議的跟進機制

2016 年 6 月 14 日

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海事處對海上事故調查報告所作建議的跟進機制

主動調查報告摘要

背景

二〇一二年十月於南丫島附近發生嚴重海上事故（「南丫事故」），經調查後發現，其中一艘肇事船隻沒有設置水密門，令該船隻遭碰撞後入水並迅速沉沒。其後，有報章報道，於二〇〇〇年曾有政府船隻在船塢維修期間入水，由於船上水密艙壁不密封，該船隻最終沉沒。相關的事故調查報告，已建議海事處檢查同類船隻的水密艙壁；南丫事故的發生，令人質疑海事處一向以來有否落實海上事故調查報告的建議。

2. 為此，申訴專員決定就海上事故調查報告所作建議的跟進機制，向海事處展開主動調查。鑑於行政長官會同行政會議委任了獨立調查委員會，就南丫事故進行調查（其中包括確定事故起因），而該調查委員會亦已完成調查並向行政長官提交調查報告。因此，本主動調查不會涵蓋南丫事故的肇事原因及責任誰屬問題。

為海上事故立案調查

3. 在任何水域的香港註冊遠洋船舶，或在香港水域內的本地登記船舶及其他所有非本地船舶，當發生意外時，其船東／船長／船隻擁有人或其代理須向海事處處長報告有關事故。

4. 海事處轄下海事意外調查及船舶保安政策部（「調查部」）負責調查因應**前段**所述的規定而接報的海上事故。調查的主要目的，並不是要追究責任或採取檢控行動／紀律處分，而是要確定事發經過和肇事原因，以期改善海上人命安全，並且藉着公布調查結果，讓業界汲取事故的教訓，避免日後再次發生同類意外事故。

5. 完成海上事故調查後，調查部會撰寫海上事故調查報告(「事故報告」)；通過審批的事故報告，若事故確定不涉及正在進行或將會進行的法律訴訟程序，便會上載於海事處網頁，讓公眾瀏覽。

海上事故調查報告中的建議的跟進機制

6. 海事處於二〇一三年六月以前，在跟進事故報告建議方面可說是採取自由放任模式，主要倚賴相關科別職員和船公司／船主自行糾正不足之處，沒有特定的跟進記錄和監控系統。因應審計署於二〇一二年十月發表的第 59 號審計報告，海事處設立電腦系統，把事故報告中所作建議輸入電腦系統，以便持續監察建議的推行進度；有關電腦系統於二〇一三年六月正式運作。此外，該處於二〇一四年十二月修訂海上事故調查指引，新增有關跟進建議的內容，詳列跟進建議的步驟及負責執行的人員。為方便討論，本報告把該處設立上述電腦系統前後的運作機制分別稱為「舊機制」和「新機制」。

自由放任的「舊機制」

7. 海事處於二〇一三年六月設立的電腦系統，並無將該日期前所完成的調查個案有關落實建議的資料輸入電腦資料庫。因應本署的要求，該處從不同科別彙集二〇〇五年至二〇一三年期間的記錄，並以人手翻查以重新整理及綜合與跟進事故報告建議有關的資料。所得資料顯示，在二〇〇五年一月至二〇一三年五月這八年多期間，海事處共完成 114 宗海上事故調查，合共提出 308 項建議。

8. 在「舊機制」下，海事處只會將事故報告中所作的建議通知相關機構和人士，由他們自行處理和執行，並無既定機制監察有關機構和人士有否落實建議。

9. 就海事處對上述 114 宗事故報告所提出建議的跟進，本署有以下觀察所得：

於調查完成多年後海事處仍沒有任何跟進行動

10. 有五宗個案在海事處完成調查多年後，竟沒有作出任何跟進行動。其中延誤最嚴重的一宗個案，海事處於完成調查八年七個月後才「補回」跟進事故報告中的建議。而另有三宗個案，則於完成調查逾七年後才「補回」跟進。

11. 至於餘下的一宗個案，海事處在收到本調查報告的初稿後，再次翻查相關記錄，發現事涉事故報告中的建議其實已獲適時跟進，但該處在二〇一四年中應本署要求重新整理及綜合資料時，卻又未發現該「曾作跟進」的記錄，於是再於同年七月「補回」跟進。其混亂情況，可見一斑。

12. 本署留意到，海事處「補回」跟進工作的日期均為二〇一四年七月之後，即本署要求該處翻查及整理舊記錄之後。由此看來，若非本署進行主動調查，該處未必會發現有遺漏跟進的情況。

海事處遺漏跟進部分建議

13. 一般而言，每宗事故報告會提出多於一項建議，本署留意到，海事處在跟進其中 11 宗個案時，每宗至少遺漏跟進一項建議，並於多年後才「補回」跟進。延誤最嚴重的一宗個案，海事處於二〇〇五年五月完成調查並提出七項建議，該處於同月及翌年一月，只跟進其中三項建議，而其餘四項建議則延至二〇一四年八月，即逾九年後才作跟進。

14. 與上文**第 12 段**提及的情況相若，海事處「補回」跟進工作的日期均為二〇一四年七月後，相信是應本署要求翻查記錄後才發現有遺漏而作出補救跟進行動。

個案資料甩漏、混亂不全

15. 根據海事處在調查期間向本署提供的記錄，在二〇〇五年一月至二〇一三年五月期間完成的事故報告，合共 114 宗（上文**第 7 段**）。然而，本署從海事處網頁發現，除了上述 114 宗外，尚有另外六宗發生於二〇〇九年八月至二〇一二年十一月的海上事故，這些個案只提供了事故報告摘要，其他詳情未明。

16. 與上文**第 11 段**提及的情況相若，海事處在收到本調查報告的初稿後，隨即搜索並翻查出該六宗個案的檔案。該處解釋，最初應本署要求於二〇一四年十月提供個案資料時，事涉六宗個案均涉法律訴訟，故未能公布有關調查報告全文。

17. 然而，本署須指出，在調查期間海事處向本署提供了 191 宗有關海上事故調查的資料，當中不乏未完成法律訴訟的個案，但卻沒有提及上述的六宗個案。此外，由於該處的資料混亂，本署曾於二〇一五年十一月，明確要求海事處確認在調查期間向本署提供的資料及數據是否準確無誤；該處於同年十二月回覆本署，確認有關資料及數據準確無誤，明顯意味該處根本沒有嚴謹翻查記錄，亦反映該處的記錄混亂不全。

「新機制」不無缺失

18. 根據海事處提供的記錄，由二〇一三年六月至二〇一五年十一月的兩年多期間，該處已完成的事故報告共 77 宗，合共提出 215 項建議。在「新機制」下，海事處除了按「舊機制」將事故報告中所作的建議通知相關機構和人士外，並會把有關建議輸入電腦系統，以便相關科別持續跟進，以及由管理層監察跟進進度，直至有關建議得以全面落實為止。

就非香港註冊船舶及非本地登記船舶的建議跟進欠全面

19. 「新機制」實際上只適用於香港註冊船舶及本地登記船舶，對於涉及非香港註冊船舶的調查報告建議，海事處基本上仍是沿用「舊機制」，即將調查結果通知相關船旗國或船公司，再由他們自行處理和執行相關建議，該處一般不會再作跟進。

20. 本署明白，海事處對於監察非香港註冊船舶及非本地登記船舶落實建議，有一定困難，但本署認為，該處最低限度應知悉有關船舶有否作出改善，以評估這些船舶再度進入香港水域時可能出現的海事安全風險。

未有嚴謹處理每宗個案

21. 在「新機制」下，海事處對落實建議的跟進，較「舊機制」有系統，但本署觀察到，大部分在「新機制」下的個案，海事處在收到相關機構回覆，指已經或將會落實有關建議後，跟進工作便告一段落，未有進一步核實落實情況。

22. 在處理較為嚴謹的小部分個案中，海事處會在收到相關機構提交的證明文件，又或派員進行審查以確定建議已落實後，才會結束跟進工作。在上文**第 18 段**提及的 77 宗個案中，這類處理較為嚴謹的個案只有 13 宗。

23. 本署認為，海事處應如上述 13 宗個案般，嚴謹地處理每一項涉及海上航行安全的建議，確保該些建議全面落實。

本署的評論

「舊機制」記錄混亂不全、海事處跟進不足、監察不力

24. 在二〇一三年六月設立電腦系統以前，海事處並無設立建議資料庫和監察建議落實的資訊管理系統。為回應本署查核資料的

要求，該處整理分散於轄下不同科別的舊個案，再以人手翻查與跟進建議有關部分的資料，耗時半年才完成。更甚的是，從上文**第 11、15 至 17 段**所述的情況可見，該處的記錄明顯混亂不全，更遑論監察進度。

25. 在沒有妥善記錄的情況下，海事處的管理層實難以監察改善建議有否得以落實，又或跟進是否有遺漏情況。這差劣的情況一直延至審計署於二〇一二年十月發表審計報告，該處才作檢討跟進，顯示該處一直以來不重視監察跟進工作的進展。

26. 即使有跟進建議，在「舊機制」下，海事處亦只是將事故報告中所作的建議通知相關機構和人士，任由他們自行處理和執行（上文**第 8 段**），海事處並無盡責去監督建議的推行，確保本港的海上安全。

「新機制」欠全面和嚴謹

27. 海事處在二〇一三年六月設立電腦系統，以適時向負責職員作出提示，而該處管理層又會定期監察仍未結束跟進的個案。本署認為，設立這系統是邁向有效監管的第一步。

28. 不過，本署留意到，除小部分個案外（見上文**第 22 段**），海事處主要仍是依賴船公司和相關機構匯報，以監察推行建議的情況。當收到回覆指已落實建議，跟進工作便告一段落，亦不會進一步核實。本署重申，要確保海上安全，該處必須嚴謹跟進每項建議，於取得確切資料顯示建議已獲全面落實後才終結跟進工作。再者，該處對於涉及非香港註冊船舶的建議，仍只作通知，並無監察落實情形，如問題船舶再進入香港水域，會造成一定風險，有欠理想（見上文**第 20 段**）。

海事處不將「新機制」用於舊個案

29. 海事處表示，已完成跟進「舊機制」下的 308 項建議（上文**第 7 段**）。在本署查詢下，該處澄清，若套用「新機制」的運作模式於上述 308 項建議，則有 20 宗個案涉及 22 項建議需持續跟進。

30. 本署曾建議海事處，應一併把「新機制」用於二〇一三年六月電腦化以前完成調查的個案。然而，該處表示基於人手及資源所限，加上經逐一翻查事涉 20 宗個案後，確認沒有發現同類事故重複發生於相關船隻，因此，該處認為無需以「新機制」跟進該 22 項建議。

31. 本署認為，海事意外調查的目的，除了確定事發經過和肇事原因，亦是為避免同類意外再發生而危害生命財產安全，所謂「前事不忘，後事之師」；本署難以接納該處以人手及資源所限，以及沒有發現同類事故重複發生於相關船隻為由，便決定不以「新機制」跟進該 22 項建議，這對本港海事安全可能構成風險。

有否「漏網之魚」未獲海事處跟進建議的個案存疑

32. 為回應本署要求查核以往跟進事故報告建議的情況，海事處耗時半年去整理舊記錄，並再應本署其後的詢問，確認有關記錄準確無誤。儘管如此，本署仍發現有六宗遺漏個案（見上文**第 15 段**），顯示該處的記錄明顯混亂。直至本署將調查報告的初稿送交該處評論後，該處方再次翻查記錄並向本署提供該六宗個案的資料（上文**第 16 段**）。在「舊機制」下，海事處並無制定跟進建議的工作指引，也沒有監控跟進進度的資訊管理系統，故此，是否仍有「漏網之魚」的個案未獲適切的跟進，以及以人手翻查所得記錄是否齊全和準確等，頓成疑問。

本署的建議

33. 鑑於以上所述，申訴專員敦促海事處：

（一） 主動核查事故報告建議是否已獲全面落實，而非只依賴相關機構或人士的匯報，並將此程序加入為跟進建議的常規步驟（見上文**第 23 段**）。

（二） 適當跟進非香港註冊船舶及非本地登記船隻落實建議的情況（見上文**第 20 段**）。

（三） 在保障海上人命安全的前提下，重新考慮以「新機制」跟進上文**第 29 段**所述的 22 項事故報告建議（見上文**第 31 段**）。

（四） 考慮再次覆核「舊機制」下的個案資料，避免**第 11**、**15 至 17 段**所顯示的記錄混亂情況重演，並確保有關事故報告的建議獲適當跟進。

（五） 定時檢討「新機制」下跟進事故報告所作建議的情況，確保達到預期的效果。

34. 海事處接納本署的建議，並已着手跟進。本署感謝該處在調查過程中予以合作，亦欣悉該處接納本署的所有建議。本署會繼續監察，直至該處全面落實建議。

申訴專員公署

二〇一六年六月

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
June 2016

1

引言

背景

1.1 二〇一二年十月於南丫島附近發生嚴重海上事故（「南丫事故」），經調查後發現，其中一艘肇事船隻沒有設置水密門，令該船隻遭碰撞後入水並迅速沉沒。其後，有報章報道，於二〇〇〇年曾有政府船隻在船塢維修期間入水，由於船上水密艙壁不密封，該船隻最終沉沒。相關的事故調查報告，已建議海事處檢查同類船隻的水密艙壁；南丫事故的發生，令人質疑海事處一向以來有否落實海上事故調查報告的建議。

1.2 為此，申訴專員於二〇一三年五月二十八日向海事處展開初步查訊，並於二〇一五年十一月二日決定根據《申訴專員條例》（第 397 章）第 7(1)(a)(ii)條就海上事故調查報告所作建議的跟進機制，向海事處展開主動調查。由於行政長官會同行政會議委任了獨立調查委員會，就南丫事故進行調查（其中包括確定事故起因），而該調查委員會已於二〇一三年四月十九日完成調查並向行政長官提交調查報告。因此，本主動調查不會涵蓋南丫事故的肇事原因及責任誰屬問題。

調查範圍

1.3 這項主動調查的審研範圍包括：

- 長久以來海事處對海上事故調查報告所作建議的跟進機制是否全面及適切。
- 可予改善及加強之處。

調查過程

1.4 這項主動調查的工作主要包括以下幾方面：

- 向海事處索取海上事故的相關資料和數據；
- 實地視察海事處電腦系統的運作；
- 審研有關海事處工作成效的報告，包括審計報告，以及「海事處制度改革督導委員會」的調查報告相關部分。

1.5 二〇一六年四月十一日，本署將調查報告的初稿送交海事處評論。應海事處要求，本署職員於五月三日與該處職員會面，聆聽該處對調查報告的初稿的意見。會後，本署於五月十六日收到該處的書面回應。經考慮及適當納入他們的意見後，本署於二〇一六年六月八日完成這份報告。

2

有關海上事故調查的背景資料

報告海上事故的法例規定

2.1 根據《商船（安全）條例》（第 369 章）第 80 條、《商船（本地船隻）條例》（第 548 章）第 57 條，以及《船舶及港口管制條例》（第 313 章）第 67 條，在任何水域的香港註冊遠洋船舶，或在香港水域內的本地登記船舶及其他所有非本地船舶，當發生意外時，其船東／船長／船隻擁有人或其代理須向海事處處長報告有關事故。

海上事故的分類

2.2 海上事故大致分為以下三類：

(1) 船舶意外—即坊間常說的海事意外，與船舶有關，例如碰撞、傾斜、擱淺／沉沒、火警／爆炸等。

(2) 海上職業意外—主要涉及船員或船上其他人員因工受傷，例如滑倒、從高處墮下、燒傷等。

(3) 海上工業意外—主要涉及因船隻的修理／拆卸、貨物處理或海上建造工程等導致的意外。

為海上事故立案調查的目的和指引

2.3 海事處轄下海事意外調查及船舶保安政策部（「調查部」）負責調查因應上文**第 2.1 段**所述的規定而接報的海上事故。調查的主要目的，並不是要追究責任或採取檢控行動／紀律處

分，而是要確定事發經過和肇事原因，以期改善海上人命安全，並且藉着公布調查結果，讓業界汲取事故的教訓，避免日後再次發生同類意外事故。

2.4 並非所有海上事故都會立案調查，調查部需視乎有關事故的嚴重程度而決定。根據海事處的海上事故調查指引（二〇一四年十二月修訂版本），調查部的高級驗船主任負責為接報的海上事故的嚴重性作評估及分類。所有被歸類為非常嚴重的事故，調查部均須立案調查；其他不太嚴重的事故，則視乎個案性質，再決定是否立案調查，但若決定不立案調查，必須先得到調查部主管（即總海事意外調查及船舶保安政策主任）的批准。至於無需立案調查的輕微事故，調查部須作一般評估以確定肇事原因，並將結果存檔作統計之用。

海上事故調查報告的公布

2.5 完成海上事故調查後，調查部會撰寫海上事故調查報告（「事故報告」）；若事故的嚴重程度屬非常嚴重，事故報告會交海事處處長審批，其餘事故報告，則會交總海事意外調查及船舶保安政策主任審批。通過審批的事故報告，若事故確定不涉及正在進行或將會進行的法律訴訟程序，有關事故報告便會上載於海事處網頁，讓公眾瀏覽。

涉及政府船隻的海上事故

2.6 根據海事處的內部指引，當海上事故只涉及政府船隻（即沒有涉及非政府船隻），其所屬政府部門須負責撰寫意外報告，並提交海事處轄下政府船隊科（「船隊科」），以便其對有關事故提供意見或進行初步調查及提供建議。

2.7 若事故屬重大程度，船隊科須將初步調查結果送交調查部；調查部再評估從有關事故中所汲取的教訓，並在有需要時提出建議或發出海事處佈告。若事故同時涉及政府船隻及非政府船隻，船隊科於整合初步調查結果後，會交予調查部作評估或進一步調查；調查部的處理程序與上文**第 2.4 至 2.5 段**相同。

2.8 船隊科所撰寫的初步調查報告，只會用作內部討論及參考，並不會上載於海事處網頁供公眾瀏覽。調查報告中所提出的建議，會由船隊科自行跟進，並於船隊科的定期維修會議（每兩

星期舉行）和定期管理會議（每星期舉行）中檢視落實建議的進度。

2.9 根據海事處提供的資料，上文**第 1.1 段**提及的二〇〇〇年政府船隻意外，並非在航行期間發生。而是在停泊於政府船塢進行修理時，因承辦商工人疏忽導致機房入水，其後海水再滲進毗連兩櫃艙，最終導致沉船。該意外於二〇〇〇年三月發生後，海事處處長隨即指示當時的政府船塢工業安全主任展開調查，報告於同年四月完成，並針對船隊科轄下維修組及政府船塢的承辦商提出了改善建議，當中包括詳細檢查事涉船隻及同類政府船隻的水密艙壁；相關建議已於二〇〇〇年內落實。

2.10 海事處續指，**前段**提及的意外，並無涉及非政府船隻，亦不屬於重大的船舶意外，因此，船隊科無需將報告交調查部作跟進處理（見上文**第 2.7 段**）。

3

海上事故調查報告中的建議的跟進機制

3.1 由調查部負責撰寫的事故報告，一經審批，調查部會把事故報告中的建議通知相關科別，以便其在負責範疇採取適當的跟進行動。若屬一般性安全建議，海事處會通過發出海事處佈告或香港商船資訊，讓業界從事故中汲取教訓，以防止同類事故再次發生。

3.2 海事處於二〇一三年六月以前，在跟進事故報告建議方面可說是採取自由放任模式，主要倚賴相關科別職員和船公司／船主自行糾正不足之處，沒有特定的跟進記錄和監控系統。二〇一二年十月二十六日，審計署發表第 59 號審計報告，當中批評海事處對事故報告中的建議跟進欠妥，並敦促該處改善。為此，海事處設立電腦系統，以便持續監察事故報告提出的建議的推行進度，確保其全面落實；有關電腦系統於二〇一三年六月正式運作。此外，該處於二〇一四年十二月修訂海上事故調查指引，新增有關跟進建議的內容，詳列跟進建議的步驟及負責執行的人員。為方便討論，本報告把該處設立上述電腦系統前後的運作機制分別稱為「舊機制」和「新機制」。

「舊機制」的運作

香港註冊遠洋船舶

3.3 香港註冊遠洋船舶，是指根據《商船（註冊）條例》（第 415 章）而註冊的船舶。若事故報告中的建議涉及香港註冊遠洋船舶，海事處會以《國際安全管理規則》[1]所訂的標準行事，細節如下：

[1] 《國際安全管理規則》是指由國際海事組織大會通過的，並可由該組織予以修正的《國際船舶安全營運和防上污染管理規則》；該規則旨在提供船舶安全管理、安全營運和防止污染的國際標準。

- 《國際安全管理規則》第 9 段訂明，由船公司設立的安全管理體系[2]須確保把事故或險情向船公司匯報，以進行調查和分析，並採取措施以防止同類事件再次發生。

- 在週期性「公司審核」[3]及「船舶審核」[4]中，獲海事處授權的船級社[5]會按照《國際安全管理規則》對有關船公司／船舶進行審查，其中有關**前段**所述安全管理體系的規定，船級社可以對船公司有否落實事故報告中的建議進行監察。若發現船公司／船舶未有採取適當措施或措施不足，船級社會發出相應的「不符合記錄」，指示船公司／船舶在指定限期前糾正問題。

- 根據《國際安全管理規則》第 13 段，「公司審核」應每年進行一次；「船舶審核」的週期為五年，除第一年及第五年之發證及換證審核外，在第二至第三年間亦須進行中期審核。

- 為監察船級社的表現，海事處會核查由船級社提交的審核報告。此外，該處亦會派驗船師參與船級社對船公司的審核；事前，該處驗船師會向調查部了解相關註冊船有否發生嚴重的海上意外，並於審核期間特別留意。

- 若發現船公司／船舶在落實建議方面不理想，海事處會考慮終止其「符合證明書」，令其失去繼續營運香港船的資格。

本地登記船舶

3.4 本地登記船舶，是指領有屬《商船（本地船隻）（證明書及牌照事宜）規例》（第 548D 章）所訂明的證明書和牌照的船隻。若事故報告中的建議涉及本地登記船舶，海事處的跟進如下：

- 若建議涉及必須根據相關法例而執行的項目，調查部會通知海事處內相關科別，並由該科別跟進及監察建議的推行。

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[2] 安全管理體系是指能使船公司人員有效實施船公司安全和環境保護方針的結構化和文件化的體系。

[3] 「公司審核」是海事處透過授權船級社對船舶管理公司，就其管理的船舶實施安全管理制度的審核。

[4] 「船舶審核」是海事處透過授權船級社對在船舶上實施安全管理制度的審核。

[5] 現時，獲海事處授權進行審核的船級社共八間，他們皆為國際船級社協會會員，船東或船公司可從該八間船級社自由選擇，並通知海事處。船級社代表海事處替香港註冊船驗船和簽發證書。

- 至於其他旨在建議有關船公司／船東／船長等改善船隻的安全操作，或提高船員的安全意識等項目，調查部會通知有關公司、船東、船長，並由他們自行落實。

「新機制」的運作

3.5 在二〇一三年六月以後完成的事故報告，調查部會透過電腦系統監察事故報告建議的落實（包括香港註冊遠洋船舶及本地登記船舶）。若建議屬可即時實施的項目（例如將事故中汲取到的教訓透過海事處佈告或香港商船資訊通知業界），驗船主任須即時跟進；若屬需持續跟進的項目（例如事涉船公司須進行附加安全審核，或事涉船隻須進行指定改裝等），驗船主任會轉交助理驗船督察跟進，包括聯絡相關船公司以了解有否推行相關的改善措施，並要適時更新電腦系統資料，以及定時向驗船主任或高級驗船主任匯報進展。

3.6 電腦系統會定時提示助理驗船督察仍未落實的建議，而高級驗船主任會監察助理驗船督察的跟進工作。此外，高級驗船主任亦會每月一次，於意外調查工作會議上檢視所有未完成跟進的個案，確保有關建議獲適當處理。

3.7 為更有效進行審核香港註冊遠洋船舶，海事處於二〇一三年八月修改內部指引（即國際標準化組織品質管理系統手冊），規定該處轄下貨船安全組在收到調查部就嚴重海上事故的調查分析後，須考慮要求有關船舶的船級社作相應的跟進。

「舊機制」、「新機制」的異同

3.8 在「舊機制」下，海事處只會將事故報告中所作的建議通知相關機構和人士，例如船旗國、船公司、船主、海事處轄下科別等，由他們自行處理和執行，並無既定機制監察有關機構和人士有否落實建議。

3.9 在「新機制」下，海事處除了按「舊機制」將事故報告中所作的建議通知相關機構和人士外，並會把有關建議輸入電腦系統，以便相關科別持續跟進，以及由管理層監察跟進進度，直至有關建議得以全面落實為止。

4

「舊機制」下的跟進情況及本署觀察所得

4.1 海事處於二〇一三年六月設立的電腦系統，並無將該日期前所完成的調查個案有關落實建議的資料輸入電腦資料庫。因應本署的要求，該處從不同科別彙集二〇〇五年至二〇一三年期間的記錄，並以人手翻查以重新整理及綜合與跟進事故報告建議有關的資料。所得資料顯示，在二〇〇五年一月至二〇一三年五月這八年多期間，海事處共完成 114 宗海上事故調查，合共提出 308 項建議。該處表示，已按「舊機制」完成該些建議的跟進工作（上文**第 3.3 至 3.4 段**）。

本署觀察所得

4.2 就海事處對上述 114 宗事故報告所提出建議的跟進，本署有以下觀察所得：

調查完成多年後仍沒有任何跟進行動

4.3 有五宗個案在海事處完成調查多年後，竟沒有作出任何跟進行動（包括並無將事故報告的建議通知有關機構，以讓他們自行處理和執行），大部分直至完成調查逾七年後才作跟進。該五宗個案的延誤情況，見下表，而有關的事故報告建議內容，見**附錄（一）**。

編號	事發日期	所涉船隻	調查完成日期	跟進建議日期	延誤時間
(1)	4/6/2005	本地貨船	3/1/2006	7/8/2014	8 年 7 個月
(2)	18/8/2005	本地風帆	26/10/2006	7/8/2014	7 年 9 個月

(3)	21/12/2005	中國貨船／本地汽艇	28/7/2006	24/7/2014	8 年
(4)	19/6/2006	香港高速客輪／中國船	2/3/2007	24/7/2014	7 年 4 個月
(5)	14/11/2009	香港貨船／韓國漁船	1/11/2010	24/7/2014 (3/11/2010[6])	3 年 8 個月

4.4 上表編號(1)個案的延誤最嚴重，海事處於二〇〇六年一月完成調查，但在八年七個月後才開始跟進事故報告中的建議。至於編號(2)至(4)個案，則於完成調查逾七年後才作跟進。

4.5 本署留意到，海事處「補回」跟進工作的日期均為二〇一四年七月之後，即本署要求該處翻查及整理舊記錄之後。由此看來，若非本署進行主動調查，該處未必會發現有遺漏跟進的情況。

4.6 至於上表編號(5)個案，海事處在收到本調查報告的初稿後（上文**第 1.5 段**），再次翻查相關記錄，發現該個案其實已於二〇一〇年十一月三日跟進了事故報告中的建議，並解釋因為在二〇一四年中重新整理及綜合資料時未有發現曾作跟進的記錄，於是再於同年七月「補回」跟進；故此，該處要求本署從上表中剔除編號(5)的個案。

遺漏跟進部分建議

4.7 一般而言，每宗事故報告會提出多於一項建議，本署留意到，海事處在跟進下表列出的 11 宗個案時，每宗均有遺漏跟進最少一項建議，並於多年後才「補回」跟進。該 11 宗個案的延誤情況，見下表，而有關的事故報告建議內容，見**附錄（二）**。

編號	**事發日期**	**所涉船隻**	**調查完成日期（建議數目）**	**跟進建議情況**	**延誤時間**
(1)	11/01/2005	中國船	3/6/2005 (2 項建議)	一項建議於 6/6/2005 跟進；另一項於 24/7/2014 才跟進	9 年 1 個月
(2)	17/02/2005	中國高速客輪／內地集裝箱貨船	25/5/2005 （7 項建議）	一項建議於 31/5/2005 跟進；另有兩項於 23/1/2006 跟進；其餘四項於	9 年 3 個月

[6] 請參閱上文**第 4.6 段**。

				7/8/2014 才跟進	
(3)	28/03/2005	中國高速客輪／本地非自航鋼躉	21/9/2005（4 項建議)）	三項建議於 2005 年內跟進，其餘一項於 24/7/2014 才跟進	8 年 10 個月
(4)	12/06/2005	兩艘本地遊樂船	9/5/2006（3 項建議）	一項建議於 28/8/2006 開始跟進；其餘兩項分別於 28/7/2014 和 09/10/2014 才跟進	8 年 2 個月
(5)	01/02/2007	香港散貨船	12/2/2008（3 項建議）	兩項建議分別於 23/10/2008 和 17/9/2009 跟進；其餘一項於 8/8/2014 才跟進	6 年 6 個月
(6)	20/05/2007	兩艘香港高速客輪	5/3/2008（2 項建議）	一項建議於 7/3/2008 跟進，另一項於 24/7/2014 才跟進	6 年 4 個月
(7)	03/06/2007	本地非自航鋼躉	6/2/2008（2 項建議）	一項建議於 20/02/2008 跟進；另一項於 08/10/2014 才跟進	6 年 8 個月
(8)	13/09/2007	本地非自航鋼躉	24/9/2008（3 項建議）	一項建議於 21/10/2008 跟進；另一項於 10/9/2009；其餘一項 9/10/2014 才跟進	6 年
(9)	31/07/2010	中國貨船	23/12/2010（4 項建議）	三項建議分別於 6/1/2011 和 18/7/2011 跟進；其餘一項於 24/7/2014 才跟進	最少 3 年 6 個月
(10)	18/05/2011	本地遊樂船	27/7/2012（3 項建議）	兩項建議分別於 7/8/2012 和 22/8/2012 跟進；其餘一項於 13/8/2014 才跟進	2 年
(11)	01/07/2011	中國船	27/11/2012（6 項建議）	五項建議於 2012 年跟進，其餘一項於 24/7/2014 才跟進	1 年 8 個月

4.8 上表編號(2)個案的延誤最嚴重，海事處於二〇〇五年五月完成調查並提出七項建議。同月及翌年一月，該處跟進其中三項建議，但其餘四項建議則於二〇一四年八月，即逾九年後才作跟進。

4.9 與上文**第 4.6 段**提及的情況相若，海事處「補回」跟進工作的日期均為二〇一四年七月後，相信是應本署要求翻查記錄後才發現有遺漏而作出補救跟進。

個案資料甩漏、混亂不全

4.10 根據海事處在調查期間向本署提供的記錄，在二〇〇五年一月至二〇一三年五月期間完成的事故報告，合共 114 宗（上文**第 4.1 段**）。然而，本署從海事處網頁發現，除了上述 114 宗外，尚有另外六宗發生於二〇〇九年八月至二〇一二年十一月的海上事故，這些個案只提供了事故報告摘要，其他詳情未明。該六宗海上事故的基本資料如下：

編號	事發日期	所涉船隻	調查完成日期
(1)	3/8/2009	本地非自航鋼躉／本地拖船	沒有提供
(2)	29/9/2011	圖瓦盧半潛躉船	沒有提供
(3)	21/10/2011	本地渡輪	沒有提供
(4)	6/6/2012	中國集裝箱船	沒有提供
(5)	13/8/2012	香港漁船／中國沿海油船	沒有提供
(6)	24/11/2012	香港雜貨船	沒有提供

4.11 在「舊機制」下，海事處並無制定跟進建議的工作指引，也沒有監控跟進進度的資訊管理系統。該處應本署要求下以人手翻查所得記錄是否齊全和準確，存在疑問。

4.12 與上文**第 4.6 段**提及的情況相若，海事處在收到本調查報告的初稿後（上文**第 1.5 段**），隨即搜索並翻查出該六宗個案的檔案。該處辯稱，最初應本署要求於二〇一四年十月提供個案資料時，事涉六宗個案均涉法律訴訟，因此，有關調查報告未能公布；該署並「補回」有關事故的調查完成日期（見下表）：

編號	事發日期	所涉船隻	調查完成日期
(1)	3/8/2009	本地非自航鋼躉／本地拖船	16/3/2011
(2)	29/9/2011	圖瓦盧半潛躉船	31/8/2012
(3)	21/10/2011	本地渡輪	17/7/2012
(4)	6/6/2012	中國集裝箱船	29/5/2012
(5)	13/8/2012	香港漁船／中國沿海油船	9/10/2014
(6)	24/11/2012	香港雜貨船	24/11/2014

4.13 然而，本署須指出，在調查期間海事處向本署提供了 191 宗有關海上事故調查的資料，當中不乏未完法律訴訟的個案，但

卻沒有提及上述的六宗個案。此外，本署曾於二〇一五年十一月，明確要求海事處確認在調查期間向本署提供的資料及數據是否準確無誤；該處於同年十二月回覆本署，確認有關資料及數據準確無誤，明顯意味該處根本沒有嚴謹翻查記錄，甚或反映該處的記錄混亂不全。

《南丫事故報告》

4.14 二〇一二年十月二十二日，行政長官會同行政會議委任獨立調查委員會，就南丫事故進行調查。該調查委員會於二〇一三年四月十九日完成調查並向行政長官提交了《二〇一二年十月一日南丫島附近撞船事故調查委員會報告》(「《南丫事故報告》」)。

4.15 二〇一三年五月三日，運輸及房屋局成立「海事處制度改革督導委員會」，以督導海事處處長對海事處進行全面檢查及徹底改革，及制定落實改革方案的時間表。該委員會的職權並包括參照《南丫事故報告》的建議，就規管乘客安全及規管與檢驗本地船隻事宜的法例遵行情況及行政措施，進行全面檢討、擬訂詳細改善方案，並監督方案的落實。

4.16 同期，海事處內部成立改革執行小組，由新設的副處長（特別職務）領導，配合「海事處制度改革督導委員會」推展全面檢討及改革，當中包括監察《南丫事故報告》的建議的落實情況。故此，上文**第 3 章**提及的跟進建議機制，並不適用於南丫事故。

5

「新機制」下的跟進情況及本署觀察所得

5.1 根據海事處提供的記錄，由二〇一三年六月至二〇一五年十一月的兩年多期間，該處已完成的事故報告共 77 宗，合共提出 215 項建議。在「新機制」下，調查部的高級驗船主任須即時跟進可即時實施的項目，以及更新電腦系統資料；對於需持續跟進的項目，該處除了將事故報告中所作的建議通知相關機構和人士外，亦要持續跟進直至有關建議得以全面落實為止（上文**第 3.5 至 3.6 段**）。

本署觀察所得

就非香港註冊船舶及非本地登記船舶的建議跟進欠全面

5.2 「新機制」實際上只適用於香港註冊船舶及本地登記船舶，對於涉及非香港註冊船舶的調查報告建議，海事處基本上仍是沿用「舊機制」，即將調查結果通知相關船旗國或船公司，再由他們自行處理和執行相關建議，該處一般不會再作跟進。

5.3 本署明白，海事處對於監察非香港註冊船舶及非本地登記船舶落實建議，有一定困難，但本署認為，該處最低限度應知悉有關船舶有否作出改善，以評估這些船舶再度進入香港水域時可能出現的海事安全風險。

未有嚴謹處理每宗個案

5.4 在「新機制」下，海事處對落實建議的跟進，較「舊機制」有系統，但本署觀察到，大部分在「新機制」下的個案，海事處在收到相關機構回覆，指已經或將會落實有關建議後，跟進

工作便告一段落，未有進一步核實落實情況。

5.5 在處理較為嚴謹的小部分個案中，海事處會在收到相關機構提交的證明文件，又或派員進行審查以確定建議已落實後，才會結束跟進工作。在上文**第 5.1 段**提及的 77 宗個案中，這類處理較為嚴謹的個案有 13 宗，列述如下：

編號	**事發日期**	**事故名稱**	**海事處的建議（只羅列須持續跟進的項目）**	**跟進建議情況**
(1)	13/3/2012	香港籍散貨船水手死亡	事涉船的管理公司發公告，提醒船長和駕駛員有關事故調查的結果及需遵守安全規則。此外，海事處轄下船舶事務科應監察事涉香港船的管理公司有否落實海事處的建議	海事處轄下船舶安全監督部（隸屬船舶事務科）參加事涉船的年度審核，並與管理公司討論及指示如何落實有關建議
(2)	3/4/2012	香港雜貨及木材船沉沒	事涉船的管理公司應檢討其安全管理系統	海事處轄下船舶安全監督部參加事涉船的年度審核，並與管理公司討論及指示如何落實有關建議
(3)	9/4/2012	香港集裝箱船與中國漁船碰撞	事涉香港船的船主/管理公司發公告，提醒船長和駕駛員需遵守安全規則，並檢討其安全管理系統的相關程序	事涉香港船的管理公司回覆海事處，並提供文件證明已落實有關建議
(4)	8/5/2012	香港高速客船與中國漁船碰撞	海事處轄下船舶事務科應定期視察事涉香港船的管理公司	海事處轄下船舶安全監督部（隸屬船舶事務科）監察事涉船公司的安全管理審核，並跟進改善措施的落實進度
(5)	13/5/2012	香港散貨船與中國漁船碰撞	事涉香港船的管理公司發公告，提醒船長和駕駛員有關意外調查的結果及需遵守安全規則。此外，海事處轄下船舶事務科應到事涉香港船上進行安全管理審核	事涉香港船的管理公司回覆海事處，並提供文件證明已落實有關建議。此外，海事處轄下船舶安全監督部（隸屬船舶事務科）到事涉香港船上進行安全管理審核

(6)	7/6/2012	本地漁船上發生致命火警意外	事涉船長應遵守安全規定。此外，海事處轄下港口管理航行監察部海港巡邏組應就事故作適當跟進	海事處轄下港口管理航行監察部海港巡邏組到事涉船隻檢查
(7)	15/9/2012	香港載木船船長失蹤	事涉船主／管理公司發公告，提醒船長和駕駛員有關事故調查的結果及進行改善措施。另外，海事處轄下船舶事務科應為管理公司及船隻進行安全管理審查	事涉船公司回覆海事處已跟進有關建議，其後，海事處轄下船舶安全監督部（隸屬船舶事務科）進行安全管理審查，發現船公司其實並未推行有關建議，故要求船公司再作跟進及於稍後進行額外審查。船公司之後提供文件證明已作改善。此外，船舶安全監督部亦有到事涉船隻進行安全管理審核
(8)	29/12/2012	香港高速客船碰撞浮筒	事涉船主/管理公司發公告，提醒船長和駕駛員有關事故調查的結果及需遵守安全規則	事涉管理公司回覆海事處，並提供文件證明公司已落實有關建議
(9)	5/11/2013	香港集裝箱船與中國大陸沿海船碰撞	事涉香港船的船主／管理公司發公告，提醒船長和駕駛員有關事故調查的結果及需遵守規則	事涉管理公司回覆海事處，並提供文件證明已落實有關建議
(10)	20/2/2014	香港散貨船上致命事故	事涉船主／管理公司發公告及制定船上安全指引	事涉管理公司回覆海事處，並提供文件證明已落實有關建議
(11)	21/5/2014	本地非自航躉船水手墮海遇溺死亡	事涉船主／管理公司張貼海事處公告，提示員工遵守安全規定，以防止類似事故重演	事涉管理公司回覆海事處，並提供相片證明已落實有關建議
(12)	21/5/2014	香港高速客輪與中國內河船碰撞	事涉香港船的船主／管理公司張貼海事處公告，提示員工遵守安全規定，以防止類似事故重演	事涉香港船的管理公司回覆海事處，並提供文件證明已落實有關建議
(13)	2/7/2014	香港散貨船上致命事故	事涉船主/管理公司應確保，海事處所作的相關安全規定建議得以落實	事涉管理公司回覆海事處，並提供文件證明已落實有關建議

5.6 本署認為，海事處應如上述 13 宗個案般，嚴謹地處理每一項涉及海上航行安全的建議，確保該些建議全面落實。

6

本署的評論及建議

整體評論

6.1 毫無疑問，政府應竭盡所能以防南丫事故再次發生。南丫事故的調查和責任誰屬的問題，已有專責調查委員會處理（見上文**第 4.14 至 4.16 段**），故本署是次主動調查不會涵蓋該事故。本主動調查，著眼點是海事處跟進事故報告中的建議的整體機制。

6.2 海事處是負責保障本港水域航行安全的部門，若有海上事故發生，迅速作出調查並提出改善建議，以避免同類事故再發生，固然是責之所在，但妥善落實每項改善建議，避免慘劇重演，更為重要。然而，本署的調查發現，海事處在二〇一三年六月前的「舊機制」，在跟進建議方面十分疏漏，亦無監控可言：事故報告中的建議與跟進建議的記錄，分散於該處不同科別；該處亦沒有設立記錄建議的資料庫和監察建議落實的資訊管理系統，管理層根本無從確保建議獲妥善跟進。

6.3 海事處於二〇一三年六月設立電腦系統，並以「新機制」跟進事故報告建議，其後的跟進力度明顯加強，惟仍有可改善之處。

6.4 整體而言，本署認為海事處跟進事故報告建議的情況有以下不足之處：

(一)「舊機制」記錄混亂不全、跟進不足、監察不力

6.5 在二〇一三年六月設立電腦系統以前，海事處並無設立建議資料庫和監察建議落實的資訊管理系統。簡言之，該處沒有系統地記錄和跟進相關建議的落實進度。為回應本署查核資料的要求，該處整理分散於轄下不同科別的舊個案，再以人手翻查與跟進建議有關部分的資料，耗時半年才完成。更甚的是，從上文**第 4.6、4.10 至 4.13 段**所述的情況可見，該處的記錄明顯混亂不全，更遑論監察進度。

6.6 在沒有妥善記錄的情況下，海事處的管理層實難以監察改善建議有否得以落實，又或跟進是否有遺漏情況。這差劣的情況一直延至審計署於二〇一二年十月發表審計報告，該處才作檢討跟進，顯示該處一直以來不重視監察工作的進展。

6.7 即使有跟進建議，在「舊機制」下，海事處亦只是將事故報告中所作的建議通知相關機構和人士，例如船旗國、船公司、船東、海事處轄下科別等，任由他們自行處理和執行（上文**第 3.3 至 3.4 段**）。在此情況下，有關建議會否得到確切和全面的落實，全依賴相關機構的自律，海事處並無盡責去監督建議的推行，確保本港的海上安全。

(二)「新機制」欠全面和嚴謹

6.8 海事處在二〇一三年六月設立電腦系統，規定負責職員將事故報告中的建議輸入電腦系統；電腦系統會適時向負責職員作出提示，而該處管理層又會定期監察仍未結束跟進的個案。本署認為，設立這系統是邁向有效監管的第一步。

6.9 不過，本署留意到，雖然海事處跟進建議的機制已改善，並會持續跟進建議實施進度至落實，但除小部分個案外（見上文**第 5.5 段**），主要仍是依賴船公司和相關機構匯報，以監察推行建議的情況。當收到回覆指已落實建議，跟進工作便告一段落，亦不會進一步核實。本署重申，要確保海上安全，該處必須嚴謹跟進每項建議，於取得確切資料顯示建議已獲全面落實後才終結跟進工作。再者，該處對於涉及非香港註冊船舶及非本地登記船舶的建議，仍只作通知，並無監察落實情形，如問題船舶再進入香港水域，會造成一定風險，有欠理想（見上文**第 5.3 段**）。

(三)不將「新機制」用於舊個案

6.10 海事處表示，已完成跟進「舊機制」下的 308 項建議（上文**第 4.1 段**）。在本署查詢下，該處澄清，若套用「新機制」的運作模式於上述 308 項建議，則有 20 宗個案涉及 22 項建議需持續跟進。該 22 項建議的內容，載於**附錄（三）**。

6.11 本署曾建議海事處，應一併把「新機制」用於二〇一三年六月電腦化以前完成調查的個案。然而，該處表示基於人手及資源所限，暫無意把「新機制」用於舊個案，但若日後資源情況

有改善，該處會再考慮本署的建議。

6.12 其後，應本署要求，海事處逐一評估上文**第 6.10 段**所述的 22 項建議，以確定不依「新機制」跟進會否對本港海事安全構成風險及影響。該處回應，經逐一翻查事涉 20 宗個案後，確認沒有發現同類事故重複發生於相關船隻，因此，該處認為無需以「新機制」跟進該 22 項建議。

6.13 本署認為，海事意外調查的目的，除了確定事發經過和肇事原因，亦是為避免同類意外再發生而危害生命財產安全，所謂「前事不忘，後事之師」；本署難以接納該處以人手及資源所限，以及沒有發現同類事故重複發生於相關船隻為由，便決定不以「新機制」跟進該 22 項建議，這對本港海事安全可能構成風險。

(四) 有否「漏網之魚」未獲跟進建議的個案存疑

6.14 為回應本署要求查核以往跟進事故報告建議的情況，海事處耗時半年去整理舊記錄，並再應本署其後的詢問，確認有關記錄準確無誤。儘管如此，本署仍發現有六宗遺漏個案（見上文**第 4.10 段**），顯示該處的記錄明顯混亂。直至本署將調查報告的初稿送交該處評論後，該處再次翻查記錄並向本署提供該六宗個案的資料（上文**第 4.12 段**）。在「舊機制」下，該處沒有系統地記錄和跟進相關建議的落實進度，故此，是否仍有「漏網之魚」的個案未獲適切的跟進，亦成疑問。

本署的建議

6.15 鑑於以上所述，申訴專員敦促海事處：

（一）主動核查事故報告建議是否已獲全面落實，而非只依賴相關機構或人士的匯報，並將此程序加入為跟進建議的常規步驟（見上文**第 5.6 段**）。

（二）適當跟進非香港註冊船舶及非本地登記船隻落實建議的情況（見上文**第 6.9 段**末句）。

（三）在保障海上人命安全的前提下，重新考慮以「新機制」跟進上文**第 6.10 段**所述的 22 項事故報告

建議（見上文**第 6.13 段**）。

（四）考慮再次覆核「舊機制」下的個案資料，避免**第 4.6、4.10 至 4.13 段**所顯示的記錄混亂情況重演，並確保有關事故報告的建議獲適當跟進。

（五）定時檢討「新機制」下跟進事故報告建議的情況，確保達到預期的效果。

6.16 海事處接納本署的建議，並已着手跟進。本署感謝該處在調查過程中予以合作，亦欣悉該處接納本署的所有建議。本署會繼續監察，直至該處全面落實建議。

申訴專員公署

檔案：OMB/DI/334

二〇一六年六月

附錄

「舊機制」下多年後才作跟進的五宗個案

編號	意外類別	事發日期／所涉船隻／調查完成日期	建議詳情 (原文節錄自有關事故報告)	跟進建議日期
(1)	船舶意外	4/6/2005 本地貨船 3/1/2006	1. A copy of this report should be sent to the owner of the Vessel and Cargo-boats Transportation Workers' Union to draw their attention on the findings of this incident and lessons learnt. They should be reminded that the cargo should be properly loaded and secured before sailing.	7/8/2014
(2)	船舶意外	18/8/2005 本地風帆 26/10/2006	1. It is recommended that a letter should be issued to the RHKYC requesting them to review their safety guidelines, safety measures and procedures for sailing to ensure safety especially procedures for capsize drill, rigging of trapeze wires and communication.	7/8/2014
			2. It is also recommended that the RHKYC should exchange information with Royal Yacht Association of Great Britain, other Yacht Association and Leisure and Cultural Services Department from time to time to promote the safety of yacht sailing.	
			3. It is further recommended that RHKYC should ensure their instructors and assistant instructors fully familiarize with procedures for handling situations in time of emergency.	
(3)	船舶意外	21/12/2005 中國貨船／本地汽艇 28/7/2006	1. A copy of this report should be sent to Guangdong MSA advising them the findings of this report.	24/7/2014
			2. A copy of this report should be sent to the Master and the management company of "*中食 238*" advising them the findings of the incident.	7/8/2014
			3. A copy of this report should be sent to the Fishermen Development Union and draw the attention of the operators to the importance of adhering to the Collision Regulations.	

編號	意外類別	事發日期/所涉船隻/調查完成日期	建議詳情 (原文節錄自有關事故報告)	跟進建議日期
(4)	船舶意外	19/6/2006 香港高速客輪／中國船 2/3/2007	1. A copy of the report should be sent to the China MSA for their information.	24/7/2014
			2. A copy of this report should be sent to the owners/ Masters of *New Ferry LXXXV* and *Dong Qu Yi Hao* drawing their attention of the findings	11/8/2014
(5)	船舶意外	14/11/2009 香港貨船／韓國漁船 1/11/2010	1. A copy of the report should be sent to the Korea (Mokpo) Maritime Safety Tribunal and the Korea (Seogwipo) Coast Guard.	3/11/2010
			2. A copy of the report should be sent to the owner/ Master of *No.3 Dae Kyung*.	3/11/2010
			3. The owner of *No.3 Dae Kyung* should ensure that the Master and the crew comply with COLREGS at all times, in particular, Rule 5 in collision avoidance.	
			4. A copy of the report should be sent to the owner/management company, the Master and the Third Officer of *Joshu Maru*.	3/11/2010
			5. The owner and the management company of *Joshu Maru* are recommended to: ● issue notice/circular to draw the attention of their Masters and Officers to the findings of this report and ensure that: - they strictly comply with COLREGS at all times, in particular, Rule 7, Rule 8, and Rule 15; and - they make proper use of the radar and ARPA facility and its information in collision avoidance. ● clarify the instruction and guidance to their Masters and Officers on the circumstances when the Officer of the Watch should call the Master. ● enhance induction and training programme for bridge watch-keeping officers to ensure that they are aware of and familiar with: - the proper use of the bridge mounted main engine and propeller control system,	

編號	意外類別	事發日期 / 所涉船隻 / 調查完成日期	建議詳情 (原文節錄自有關事故報告)	跟進建議日期
			if deem necessary, in adjusting the ship's speed and/or propulsion in collision avoidance; and - the need to call the Master at an early stage in development of any hazardous situation taken into account of the ship's design that the Master's cabin is on the upper deck and it takes about 20 to 30 seconds for the Master to reach the navigating bridge should he called for assistance. ● establish the procedure for the proper preservation/back-up of the VDR data after significant incidents occurred to the ship and ensure that bridge watch-keeping officers are aware of the procedure.	
			6. The Master of *Joshu Maru* should ensure that the recommendations in 7.4 are effectively implemented onboard, with particular focus given to junior and newly joined officers.	

「舊機制」下「補回」跟進部分建議的 11 宗個案

編號	意外類別	事發日期／所涉船隻／調查完成日期	建議詳情 (原文節錄自有關事故報告)	跟進建議日期
(1)	職業意外	11/1/2005 中國船 3/6/2005	1. A copy of this report should be sent to the owners and master of *Fo Shan 8 Hao* drawing their attention on the findings of this incident and urging them to instruct their crew members to take extra precaution against the risk of falling overboard while working on deck. The crew members should also observe the safe working practices, i.e. wear safety shoes while working on deck.	6/6/2005
			2. A copy of this report should be sent to the Administration of the vessel informing them the findings of the investigation and drawing their attention that the height of the bulwark is about 235mm which is insufficient to prevent people from falling overboard.	24/7/2014
(2)	船舶意外	17/2/2005 中國高速客輪／內地集裝箱貨船 25/5/2005	1. The Investigating Officer is of the opinion that the causes of collision have been established. In view that this investigation has revealed certain shortcomings of the PRC Masters of both vessels, a copy of the report should be sent to the PRC Administration for their information and appropriate follow up action.	31/5/2005
			2. The Marine Department is recommended to seek advice from the High Speed Craft Consultative Committee (HSCCC) to install AIS in advance to all existing passenger HSC in enabling identification and monitoring under the VTC.	23/1/2006
			3. A copy of the report should be sent to the HSCCC requesting the HSC ferry companies to look into the findings of this accident with a view to ensuring that safety of navigation and passengers of their HSC are maintained.	23/1/2006
			4. The VTC is recommended to consider giving advice on the validity of SREP during the broadcast of fog warning.	7/8/2014

編號	意外類別	事發日期 / 所涉船隻 / 調查完成日期	建議詳情 (原文節錄自有關事故報告)	跟進建議日期
			5. The ferry company is recommended to review its procedures and sailing arrangement in ensuring safe navigation during restricted visibility situation. The procedures should also give discretion to the HSC Masters in case of delay.	
			6. The ferry company should assess the risks and hazards with respect to safety of passengers associated with the operating of HSC as mentioned in paragraph 6.7 and establish policies and procedures with a view to eliminating such risks.	
			7. The ferry company should develop measures of continuous improvement to its crew with a view to enhance the safety awareness. The performance standard of the crew should also be monitored during their course of duty.	
(3)	船舶意外	28/3/2005 中國高速客輪／本地非自航鋼躉 21/9/2005	1. The attention of the Marine Department is drawn to the fact that there are vessels anchoring at the inshore zone between the Ma Wan Fairway and Tsing Yi Island and between the Northern Fairway and the Public Cargo Working area at Stonecutters Island obstructing the free passage of other vessels proceeding along the course of Northern Fairway and Ma Wan Fairway. As a result, these vessels are unable to follow the direction of flow in the fairway which may cause a head on situation with other vessels. The situation could be dangerous especially in time of restricted visibility.	2/9/2005
			2. A copy of the report should be sent to Chu Kong Passenger Transport Co., Ltd, Master of *Nan Hua*, Owners and Masters/Person in Charge of the tug *Hoi Sing*, tug *Wo Shing 5* and DSL *Shing Wai No. 2* drawing their attention of the findings.	5/10/2005
			3. The HSC operators/companies should ensure adequate training to the bridge team members of HSC so that the Chief Officer can effectively convey the radar information to the Master for collision avoidance in time of restricted visibility.	6/10/2005

編號	意外類別	事發日期 / 所涉船隻 / 調查完成日期	建議詳情 (原文節錄自有關事故報告)	跟進建議日期
			4. A copy of the report should be sent to the PRC Administration for their information.	24/7/2014
(4)	船舶意外	12/6/2005 兩艘本地遊樂船 9/5/2006	1. A copy of the report should be sent to the Owners and Masters of PV122288 and PV106538 drawing their attention on the findings of the investigation, and the importance to maintain a proper lookout and safe speed appropriate to the prevailing circumstances and conditions whilst their vessels are underway in the waters of Hong Kong.	28/8/2006
			2. The attention of the Marine Department should be drawn that the Life Saving Appliances of PV122288 and PV106538 do not comply with the requirements stipulated in the license, the Master of PV122288 does not possess an appropriate Local Certificate of Competency as the Engineer to take charge PV122288 and the navigational lights of PV106538 do not comply with Colregs.	28/7/2014
			3. A Marine Department Notice should be issued to promulgate that pleasures vessels should position the navigational lights in accordance with the regulations stipulated in Colregs.	9/10/2014
(5)	職業意外	1/2/2007 香港散貨船 12/2/2008	1. A copy of this report should be sent to the master and the management company of *the Vessel* advising them the findings of this accident and urging them to observe the following safety practices in order to prevent recurrence of similar accident: • Precautionary measures against fire should be taken before any hot work is carried out; • Source of fuel oil leakage should rectified immediately; and • Safety requirements stipulated in the ship repair agreement should be strictly followed.	23/10/2008

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			2. A Merchant Shipping Information Note should be issued to draw the attention of all concerned parties to the lessons learnt in this accident in particular fire prevention on ship repair.	17/9/2009
			3. A copy of this report should be sent to *the Dockyard* advising them the findings of this incident.	8/8/2014
(6)	船舶意外	20/5/2007 兩艘 香港高速客輪 5/3/2008	1. A copy of the report should be sent to the owners and Masters of *Universal Mk 2008* and *Universal Mk 2010* drawing their attention of the findings. The Masters should be urged to closely monitor the vessel's position in restricted visibility and vessels should be slowed down to allow more time to assess the situation. The Masters will be reminded to tune the radars properly before departing from berths.	7/3/2008
			2. A copy of this report should be sent to the Macau Administration for their information.	24/7/2014
(7)	職業意外	3/6/2007 本地非自航鋼躉 6/2/2008	1. The owner and person in charge of the *Lighter* should be informed of the findings of the investigation.	20/2/2008
			2. A Marine Department Notice should be issued to draw the attention of all concerned parties to the lessons learnt in this accident and advise them the need to observe the following safety practices in order to prevent the reoccurrence of similar accidents: ● roller fairleads should be properly designed and of good mechanical construction; ● roller fairleads should be properly maintained and periodically inspected; ● during towing, the force on towline should rest on bitts rather than on roller fairleads unless the design of fairleads is intended for such loading; and ● the design of fairleads should be substantially strengthened if the fairleads are intended to take up the force of towlines under tow.	8/10/2014

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(8)	職業意外	13/9/2007 本地非自航鋼躉／本地拖船 24/9/2008	1. A copy of this report should be sent to the employer of crane operators of the *Lighter*, owner of the *Tug* and Shenzhen Maritime Safety Administration advising them the findings of this accident.	21/10/2008
			2. The General Guide to Safety during Towing and Lightering Operation issued by Marine Department should be enhanced with the lessons learnt from this accident.	10/9/2009
			3. A Marine Department Notice should be issued to promulgate the lessons learnt from this fatal accident, drawing the industry's attention on the findings of this accident and urging them to observe the following safety practices in order to prevent reoccurrence of similar accidents: ● when working aloft where there is a risk of falling more than two metres, workers should wear a safety harness attached to a lifeline as far as reasonably practicable. Such recommendations are stipulated in the Code of Practice on Using Protective Clothing and Equipment for Works on Local Vessels and the Shipbuilding and Ship-Repairing Safety Guide; ● workers should be aware of the danger of carrying out high risk work such as working aloft when feeling tired or under the influence of medications. Any worker on board who has taken medications should inform his employer or person in charge of vessel; ● no repair work should be carried out on board unless it is supervised by a works supervisor who has completed the works supervisor safety training; ● suitable means of communication device such as walkie-talkie or mobile telephone should be provided between the towing vessel and the vessel being towed to facilitate communications in an emergency; ● when a vessel is in an emergency in Shenzhen waters, the local maritime	9/10/2014

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			authority, i.e., the Shenzhen Maritime Safety Administration, should be called immediately for help; and • workers should have reasonable rest period in order to prevent onset of fatigue, particularly at high risk work. A tired worker may endanger himself as well as other workers working with him.	
(9)	工業意外	31/7/2010 中國貨船 23/12/2010	1. A copy of report should be sent to owner and the Master of "*Ming Fen*" advising them the findings of the accident.	6/1/2011
			2. The Company and the Master of the *Ming Fen* are required to review the cargo operation procedure on board and provide the necessary trainings to crewmembers in order to ensure their safety during cargo operation, in particular the handling of pontoon hatch covers.	
			3. Marine Department Notice should be issued to promulgate the lessons learnt from this accident.	18/7/2011
			4. China Maritime Safety Administration should also be provided with a copy of the report for their information.	24/7/2014
(10)	船舶意外	18/5/2011 本地遊樂船 27/7/2012	1. 本報告副本須送交遊樂船 26749 號的船長，讓他知悉這宗火警意外的調查結果。在船上進行玻璃纖維修補工作時，須時刻注意保持室內空氣流通，以防易燃氣體積聚。	7/8/2012
			2. 海事處須發出海事處佈告，載述從這宗火警意外中汲取的教訓，避免同類事故再次發生。	22/8/2012
			3. 這份報告的副本應送交船舶事務科，本地船舶安全部，以供參考。	13/8/2014
(11)	工業意外	1/7/2011 中國船／本地非自航鋼躉 27/11/2012	1. 本調查報告副本須送交海事處船舶事務科海事工業安全組，以供考慮是否發出海事處佈告，載述從這宗意外汲取的教訓。	6/11/2012
			2. 本調查報告副本須送交海事處船舶事務科本地船舶安全組作參考。	

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			3. 本報告副本須送交非自航鋼躉"浩溢 1"的船東和工程負責人,以及中國籍貨船"凱宏 8"的船東和船長，讓他們知悉這宗意外的調查結果。	20/12/2012
			4. "凱宏 8"的船東須確保所有在船上參與集裝箱處理工作的船長、高級船員和船員均知悉有關工作的風險。裝卸貨物的程序應予檢討，並 於檢討時考慮下列在本意外調查所發現的安全因素： ● 有關人員應在每日工作開始之前向參與貨物裝卸作業的船員講解安全事宜; ● 應確保船上參與貨物裝卸作業的船員之間能夠有效溝通; ● 掛鈎員攀上或攀下堆疊集裝箱另一層時，應使用適當的梯子; ● 掛鈎員應在集裝箱被起吊前盡快從集裝箱頂部撤離至安全地方; 以及 ● 避免利用吊機同時起吊兩個集裝箱。	
			5. "浩溢 1"的船東和工程負責人須檢討貨物裝卸程序，確保所有參與 貨物裝卸作業的人員安全，考慮事項包括： ● 有關人員應在每日工作開始之前向參與貨物裝卸作業的船員講解 安全事宜; ● 應確保船上參與貨物裝卸作業的船員之間能夠有效溝通; ● 所有船員均應有充分休息; 以及 ● 避免利用吊機同時起吊兩個集裝箱。	
			6. 本調查報告副本須送交廣東海事局作參考。	24/7/2014

不以「新機制」跟進的 22 項建議

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(1)	船舶意外	28/3/2005 中國高速客輪／本地非自航鋼躉／兩艘本地拖船 21/9/2005	1. The attention of the Marine Department is drawn to the fact that there are vessels anchoring at the inshore zone between the Ma Wan Fairway and Tsing Yi Island and between the Northern Fairway and the Public Cargo Working area at Stonecutters Island obstructing the free passage of other vessels proceeding along the course of Northern Fairway and Ma Wan Fairway. As a result, these vessels are unable to follow the direction of flow in the fairway which may cause a head on situation with other vessels. The situation could be dangerous especially in time of restricted visibility.	2/9/2005
			2. A copy of the report should be sent to Chu Kong Passenger Transport Co., Ltd, Master of *Nan Hua*, Owners and Masters/Person in Charge of tug *Hoi Sing*, tug *Wo Shing 5* and DSL *Shing Wai No. 2* drawing their attention of the findings.	5/10/2005 6/10/2005
			*3.The HSC operators/companies should ensure adequate training to the bridge team members of HSC so that the Chief Officer can effectively convey the radar information to the Master for collision avoidance in time of restricted visibility.	6/10/2005
			4. A copy of the report should be sent to the PRC Administration for their information.	24/7/2014
(2)	職業意外	8/5/2005 本地非自航鋼躉 28/12/2005	*1. A copy of this report should be sent to the owner and the operator of the Vessel advising them the findings of this incident to ensure that: ● Electrical cables should be properly maintained; ● Non-weatherproof electrical socket and wirings should not be used in wet environment; ● Earthing wires in the electrical plugs and sockets should be properly connected using 3-core electric cable; and	23/3/2006 22/6/2006

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			● Wearing of slippers at work should not be allowed, safety shoes should be worn.	
(3)	船舶意外	22/8/2005 本地貨船 27/2/2006	1. The Marine Department may consider appropriate measures to monitor more closely the movements of DG carrying vessels.	3/3/2006
			2. A copy of this report should be sent to the owner and the operator of *the Vessel* advising them the findings of this incident and instructing them to follow proper safety precautions, e.g. ● no electrical machinery should be used in cargo hold when carrying DG; ● the vessel must be under command of a competent Coxswain; ● all DG and other goods should be properly segregated and secured; and ● conditions as stipulated in the Conveyance Permit should be strictly followed, such as the designated routing for *the Vessel* and under supervision of a Special Effects Operator.	2/5/2006
			*3. Instructions and procedures for the disposal of unused and misfired PSEM should be established and made known to all crewmembers.	
			4. The Marine Department may consider that all locally licensed vessels carrying DG should be equipped with VHF radio installations to enable reliable communication between the vessels and shore stations.	
(4)	船舶意外	22/2/2006 本地油躉船／本地木艇 7/9/2006	*1. A copy of this report should be sent to the Master and the management company of *the Barge* advising them the findings of the incident, in particular the adverse effect on lookout that affected by the installation of securing bars at the front windows. As the securing bar might affect the safe lookout, the Company of *the Barge* should arrange to remove them as soon as possible.	3/10/2006

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			2. A copy of this report should be sent to of the Fishermen Development Union and draw the attention of the fishermen to the danger when they operate their vessel in fishing near a traffic lane.	
			3. A Marine Department Notice should be promulgated to alert the industry that securing bars should not be installed at the front windows of the wheelhouse, as they may affect the proper lookout. For oil barges of local design, the adverse effect on lookout as a result of excessive stern trim on should be highlighted. The Master of these barges should consider using the radar as a navigation aid and to post an additional lookout when their barge is in lightweight condition. A person cannot keep a lookout and engage in steering at the same time.	5/10/2006
			4. The Marine Department may consider the need to supplement extra lookout on the local oil barges due to the large blind sector when they are in lightweight condition.	18/10/2006
(5)	職業意外	16/11/2006 香港貨船 14/6/2007	*1. A copy of this report should be sent to the management company and the Master, advising them the findings of this incident. It is recommended that the SMM should include the following safety procedures for the carriage of wood pellets: ● The enclosed stair trunks should be properly ventilated preferably by mechanical means and tested for the safety levels of oxygen and carbon monoxide prior to the entry of personnel; ● Wood pellets are classified as Group B cargoes, the master and the crewmembers should be well aware the safety requirements stipulated in the BC Code. ● Appropriate warning signs should be displayed at the entrances of the stair trunks.	29/8/2007

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			2. A copy of this report should be sent to the Swedish Maritime Administration advising them the findings of this incident.	
			3. A Merchant Shipping Information Note should be issued to promulgate the lessons learnt from this fatal accident, drawing the industry's attention on the safe entry of confined spaces.	29/11/2007
(6)	職業意外	11/3/2007 香港貨船 17/10/2007	1. A Merchant Shipping Information Note should be issued to promulgate the lessons learnt from this fatal accident, drawing the industry's attention on the embarkation and disembarkation between vessels.	5/12/2007
			*2. A copy of this report should be sent to the management company and the Master, advising them the findings of the accident. They should ensure the crewmembers to observe the following safety guidelines: ● Safe means of access should be provided personnel to get back ashore; and ● Personnel should be aware of the dangers of any unexpected ship movements while transferring people between vessels.	24/12/2007
(7)	職業意外	4/3/2008 香港貨船 21/9/2009	1. A copy of the investigation report is to be sent to the Ship Management Company and the Master of *APOLLO LYNUX* advising them the findings of the accident investigation.	8/10/2009
			*2. The Ship Management Company and Master of ship are required to: ● review the relevant work procedures in the Safety Management System and provide sufficient training onboard so as to ensure: - the crewmembers should not enter into cargo hold alone without the knowledge of the responsible person; - effective communication should be established between person in charge of work and the crewmembers working	10/10/2009

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			inside cargo hold before entry into cargo hold; - precautionary measures and protection to prevent crew falling from the top of the pontoon are taken when securing the sling wires for hatch opening/closing operation; ● conduct regular internal safety shipboard audits to ensure that all shipboard staff follows the safe working procedures stipulated in the Company Safety Management System Manual.	
			3. A Merchant Shipping Information Note (MSIN) should be issued to promulgate the lessons learnt from this fatal accident.	4/11/2009
(8)	船舶意外	5/3/2008 香港貨櫃船／中國散貨船 18/5/2009	1. A copy of the report is to be sent to the owners and Masters of *CSCL HAMBURG* and *LIAN HUA FENG*, and the Maritime Safety Administration of China advising them the findings of the accident investigation.	29/6/2009
			*2.The Companies and the Masters involved are required to review and enhance training of the watch keeping procedures to ensure: ● watch keeping officers, especially junior watch keeping officers, to call the Master in ample time when necessary or when they are in doubt; ● junior watch keeping officers to gain enough practical watch keeping experience under close supervision or monitoring by qualified training officer or Master; and/or by systematic simulator training before posting the person to take charge of the navigational watch; ● watch keeping procedures and the onboard bridge team management to be implemented effectively and verified by voyage records (e.g. VDR), particularly with regard to: taking early avoiding action with proper	

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			manoeuvring sound and light signal, in accordance with the COLREGS; ● VHF radio communication for collision avoidance aid should be used with extreme caution.	
			3. A Merchant Shipping Information Note should be issued to draw the dangers in the use of VHF radio in collision avoidance.	30/7/2009
(9)	職業意外	19/5/2008 香港貨櫃船 11/6/2010	1. A copy of the report should be sent to the Master and the ship management company of *BLUE OCEAN* advising the findings of the investigation into this accident.	15/6/2010
			*2. The Company is required to issue circular and/or safety instructions to its fleet reminding the Masters and officers of their vessels to: ● strictly follow the relevant safety procedural guidelines and instructions whenever lifeboat drills is to be conducted; ● provide proper monitoring and guidance to newly-joined and/or inexperienced junior officers whenever they are assigned to work independently on lifeboat.	
			3. A Merchant Shipping Information Note (MSIN) should be issued to promulgate the lessons learnt from this accident.	25/6/2010
(10)	職業意外	27/7/2008 本地遊樂船 17/3/2009	*1. A copy of this report is to be sent to the Master and company of *Crescent Island* drawing their attention on the findings of the investigation. The Company should issue guidelines to the masters warning them not to operate the engine unless they are absolutely sure after checking by himself or by a lookout that there are no divers in close proximity to their vessels. A good communication must be established between the Master and the lookout if posted.	20/3/20092 3/3/2009

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			2. A Marine Department Notice should be issued to advise the public of taking all necessary safety precautions when engaged in diving activities.	30/3/2009
(11)	職業意外	5/8/2008 香港散貨船 27/8/2009	*1. A copy of the report should be sent to the ship management company of *FEDERAL RIDEAU* who should issue notice to draw the attention of their masters and officers to the findings of this report. The masters should be reminded to take measures to ensure that in rough weather, no crewmembers will be allowed to go on to open deck without their permission.	28/8/2009
			2. A Merchant Shipping Information Note (MSIN) should be issued to draw the attention of the Shipowners, Ship Managers, Ship Operators, Ship Masters and Officers of Hong Kong registered ships the lessons to be learnt from this incident and urging them to pay more attention to newly-joined and / or inexperienced junior officers and ratings on their safety awareness in shipboard environment.	7/9/2009
(12)	船舶意外	21/10/2008 香港貨櫃船／中國貨船 20/07/2011	1. Copy of the investigation report should be sent to the following parties informing them of the findings in this accident investigation: ● the management company and the Master of *OOCL Europe*; ● the management company and the Master of *Xing Hai 668* via Maritime Safety Authority of China; and ● the Maritime Safety Authority of China (Guangdong) as coastal State.	26/9/2011
			2. The management company of the *Xing Hai 668* should disseminate the findings of this accident investigation to the Masters and officers of the vessel. The company may wish to conduct a review of the procedures and instructions relating to the implementation of the SMS in the safe operation of ship in compliance with the national requirement to ensure:	

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			● the vessel is to be manned with qualified and certified crew as required by Minimum Safe Manning Certificate; ● COLREGS is compiled by all navigational officers on board at all times, including the proper use of all available means for lookout and to determine risk of collision and appropriate action to avoid collision in ample time; and ● Master and officers on board should follow the emergency and procedures, in particular to the proper activation of distress signals as stated in Annex IV of COLREGS.	
			*3. The management company of *OOCL Europe* should disseminate the lesson learned to the Masters and officers of all the Hong Kong registered vessels managed by the company. The company may wish to consider to review the effectiveness of the implementation of the SMS on board to ensure following are understood and satisfied: ● effective exchange of navigational information and on the bridge is maintained at all times; ● COLREGS is complied with by all navigational officers on board at all time, including the proper use of all available means (e.g. Radar, ARPA and AIS, etc.) for lookout and to determine risk of collision and appropriate action to avoid collision in ample time; ● Aware of the danger of using VHF radio for bridge to bridge communication with the details in the Marine Safety Information Notice - MSIN 14/2009, for collision avoidance action at sea; and ● Any suspected accident and near miss incident should be careful verified to ensure the safety of own and other ship.	

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(13)	工業意外	13/1/2009 本地非自航鋼躉 11/7/2010	*1. A copy of this report should be sent to the owner and the person in charge of the *DSL* advising them the findings of the accident. The owner and the person in charge of the *DSL* are required to: ● ensure their crewmembers use proper working gears; and ● maintain a safe shipboard working environment.	8/3/2009
			2. A Marine Department Notice should be issued to promulgate the lessons learnt from this accident.	27/4/2009
(14)	船舶意外	20/3/2009 本地客輪／中國貨船 8/6/2011	1. One copy of the report of investigation into the accident should be sent to following parties advising them the findings of the investigation: ● The owner/operator, the Master and Assistant Master of *First Ferry XI*; ● The owner/operator, the Master and Chief Officer of *Xin Hui Ji 9* ; ● Guangdong Maritime Safety Administration of P.R.C.	15/9/2011
			*2. The companies of *First Ferry XI* and *Xin Hui Ji 9* should ensure the masters of their vessels follow COLREGS at all times, and in particular to observe the following precautions as set forth in Rule 19 when navigating in or near the area of restricted water: ● to proceed at a safe speed; ● to sound appropriate signals; ● to maintain proper lookout by all available means, including radar observation and plotting/ATA by competent radar operator; and ● to assess the risk of collision of targets detected by radar.	
			3. The owner/operator of *Xin Hui Ji 9* are required to ensure that the manning of the vessel complies with the requirement of the minimum safe manning certificate.	

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(15)	職業意外	23/8/2009 兩艘 本地非自航鋼躉 ／本地拖船 18/10/2010	1. A copy of this report should be sent to the owners and Masters of *Yun Wai*, and the Person-In-Charge of *Sui Sun 105* and *Sui Sun 108* advising them of the findings of the accident investigation.	28/10/2010
			*2. The respective owners of *Yun Wai* and *Sui Sun 105* are required to ensure their masters/PIC of their vessels would take all necessary precautionary measures to ensure safe mooring operations.	
			*3. The owners of *Sui Sun 108* should ensure the PIC of the vessel: ● to be aware that the condition of the mooring ropes would be deteriorated rapidly due to chafing against the seawall during berthing when the vessel is in loaded condition; and ● to check the condition of the mooring ropes regularly and replace them when found deteriorated.	
			*4. The owners of *Sui Sun 105* are required to provide proper training to crewmembers onboard who would be engaged in the mooring operation, emphasizing on the personal danger when staying inside the snapback zones of any mooring ropes under all circumstances.	28/10/2010 28/8/2013
			5. A Marine Department Notice should be issued to promulgate the lessons learnt from this fatal accident.	7/12/2010
(16)	工業意外	9/3/2010 中國貨櫃船／ 本地非自航鋼躉 8/6/2011	1. A copy of the report should be sent to owners and person in charge of *Shun Fat 6*, and the Master of *Rong Jing 588* advising them the findings of the accident.	19/8/2011
			*2. The owners and person in charge of *Shun Fat 6* are required to : ● ensure that all crew member working onboard the vessel are properly trained and certificated for the such duties as crane operator, works supervisor and ligtherman;	

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			and ● ensure that all wire ropes used for the derrick crane onboard are to be regularly maintained and lubricated; and to be inspected by a competent person either monthly or three-monthly, as required, before being put into use.	
			3. A Marine Department Notice should be issued to promulgate the lessons learnt from this accident.	1/9/2011
(17)	職業意外	11/4/2010 香港油船 5/9/2011	1. A copy of report should be sent to the Ship Management Company and the Master of *Zhong Hua 11* advising them the findings of the accident investigation.	6/9/2011
			*2. The Ship Management Company and the Master are required to: ● reinforce the crew's safety awareness for entry into enclosed space; ● ensure the crew follow the enclosed space entry procedures of the ship's safety management system; ● ensure the name plates of all on board valves are installed and the pipelines are easily identified; ● review the suitability of the breathing apparatus and other rescue equipment and replace them if required; and ● ensure the crew follow the proper rescue procedures.	
			3. A Marine Shipping Information Note should be issued to promulgate the lessons learnt from this accident.	9/9/2011
(18)	船舶意外	09/03/2011 本地木製工作船／本地拖船／本地非自航鋼躉	1. 本報告副本須送交下列人士/單位，讓他們知悉這宗意外的調查結果： ● "Ng Mui"船長的家人； ● "Sun Lee 1"的船東及船長； ● "Hoi Lung No.88"的負責人；	27/8/2012, 28/8/2012

編號	意外類別	事發日期/所涉船隻/調查完成日期	建議詳情 (原文節錄自有關事故報告) (「*」表示在「新機制」下仍需跟進的建議)	跟進建議日期
		21/6/2012	● 海事處船舶事務科；以及 ● 海事處港口管理科。	
			*2. 建議拖船"Sun Lee 1"的船東採取適當措施，確保其船長: ● 安排拖船和被拖船遵照《避碰規則》第 24 條的規定，在拖曳作業期間時刻展示適當的航行燈號； ● 遵照《避碰規則》第 5 條的規定提高警覺，執行瞭望工作，尤以在避風塘內拖曳船隻時為甚；以及 ● 視力符合標準，必要時在航行期間使用助視鏡。	28/8/2012
(19)	工業意外	9/4/2011 本地非自航鋼躉 13/7/2012	1. 海事處須發出海事處佈告，載述從這宗意外汲取的教訓。	9/11/2011
			2. 本報告副本須送交"Kam Ying"的船東和工程負責人，讓他們知悉這宗意外的調查結果。	10/1/2013
			*3. "Kam Ying"的船東和工程負責人須： ● 妥善評估裝卸堆疊貨物的風險，並採取預防措施把潛在風險減至最低；以及 ● 確保堆疊的貨物時刻保持穩固，使貨物處於穩定的狀態。	
(20)	工業意外	27/3/2012 中國貨船／ 本地非自航鋼躉 27/11/2012	1. 本報告副本須送交以下相關人士和部門，讓他們知悉這宗意外的調查結果： ● 航信 368 的船東和船長； ● 金洋 8 號的船東/工程負責人和起重機操作員； ● 海事工業安全組；以及 ● 航信 368 的註冊機關-中國廣東海事局。	2/1/2013
			2. 航信 368 的船東和船長，進行貨物裝卸工程時：	

編號	意外類別	事發日期 / 所涉船隻 / 調查完成日期	建議詳情 (原文節錄自有關事故報告) (「*」表示在「新機制」下仍需跟進的建議)	跟進建議日期
			● 須確保船員不得停留在懸吊貨物可能經過之處，以免因貨物不正常擺動而受傷； ● 裝卸雙方應在進行貨物裝卸前先議定集裝箱的裝卸次序,不應 由重機操作員自行決定； ● 在裝卸過程時，應委派一名指定信號員，以確保處理吊貨索的裝卸工人和起重機操作員之間的有效協調和溝通； ● 裝卸過程必須由訊號員指揮，並工作前與所有工作人員建立有效溝通渠道；以及 ● 確保船員前往或離開貨艙時，使用適當的梯子。	
			*3. 金洋 8 號的船東和工程負責人，在貨物裝卸工程時： ● 裝卸雙方應在進行貨物裝卸前先議定集裝箱的裝卸次序，在未有雙方協議前，不應由起重機操作員臨時自由決定; ● 避免使用一四腳吊索同時吊運兩個集裝箱；以及 ● 起重機操作員在吊運集裝箱時，必須時刻注意訊號員指示，切勿操之過急。	