申诉专员公署

主动调查报告
海事处对海上事故调查报告所作建议的跟进机制

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海事处对海上事故调查报告所作建议的跟进机制

主动调查报告摘要

背景

二〇一二年十月于南丫岛附近发生严重海上事故（「南丫事故」），经调查后发现，其中一艘肇事船只没有设置水密门，令该船只遭碰撞后入水并迅速沉没。其后，有报章报道，于二〇〇〇年曾有政府船只在船坞维修期间入水，由于船上水密舱壁不密封，该船只最终沉没。相关的事故调查报告，已建议海事处检查同类船只的水密舱壁；南丫事故的发生，令人质疑海事处一向以来有否落实海上事故调查报告的建议。

2. 为此，申诉专员决定就海上事故调查报告所作建议的跟进机制，向海事处展开主动调查。鉴于行政长官会同行政会议委任了独立调查委员会，就南丫事故进行调查（其中包括确定事故起因），而该调查委员会亦已完成调查并向行政长官提交调查报告。因此，本主动调查不会涵盖南丫事故的肇事原因及责任谁属问题。

为海上事故立案调查

3. 在任何水域的香港注册远洋船舶，或在香港水域内的本地登记船舶及其他所有非本地船舶，当发生意外时，其船东／船长／船只拥有人或其代理须向海事处处长报告有关事故。

4. 海事处辖下海事意外调查及船舶保安政策部（「调查部」）负责调查因应**前段**所述的规定而接报的海上事故。调查的主要目的，并不是要追究责任或采取检控行动／纪律处分，而是要确定事发经过和肇事原因，以期改善海上人命安全，并且藉着公布调查结果，让业界汲取事故的教训，避免日后再次发生同类意外事故。

5. 完成海上事故调查后，调查部会撰写海上事故调查报告(「事故报告」)；通过审批的事故报告，若事故确定不涉及正在进行或将会进行的法律诉讼程序，便会上载于海事处网页，让公众浏览。

海上事故调查报告中的建议的跟进机制

6. 海事处于二〇一三年六月以前，在跟进事故报告建议方面可说是采取自由放任模式，主要倚赖相关科别职员和船公司／船主自行纠正不足之处，没有特定的跟进记录和监控系统。因应审计署于二〇一二年十月发表的第 59 号审计报告，海事处设立计算机系统，把事故报告中所作建议输入计算机系统，以便持续监察建议的推行进度；有关计算机系统于二〇一三年六月正式运作。此外，该处于二〇一四年十二月修订海上事故调查指引，新增有关跟进建议的内容，详列跟进建议的步骤及负责执行的人员。为方便讨论，本报告把该处设立上述计算机系统前后的运作机制分别称为「旧机制」和「新机制」。

自由放任的「旧机制」

7. 海事处于二〇一三年六月设立的计算机系统，并无将该日期前所完成的调查个案有关落实建议的数据输入计算机数据库。因应本署的要求，该处从不同科别汇集二〇〇五年至二〇一三年期间的记录，并以人手翻查以重新整理及综合与跟进事故报告建议有关的资料。所得数据显示，在二〇〇五年一月至二〇一三年五月这八年多期间，海事处共完成 114 宗海上事故调查，合共提出 308 项建议。

8. 在「旧机制」下，海事处只会将事故报告中所作的建议通知相关机构和人士，由他们自行处理和执行，并无既定机制监察有关机构和人士有否落实建议。

9. 就海事处对上述 114 宗事故报告所提出建议的跟进，本署有以下观察所得：

于调查完成多年后海事处仍没有任何跟进行动

10. 有五宗个案在海事处完成调查多年后，竟没有作出任何跟进行动。其中延误最严重的一宗个案，海事处于完成调查八年七个月后才「补回」跟进事故报告中的建议。而另有三宗个案，则于完成调查逾七年后才「补回」跟进。

11. 至于余下的一宗个案，海事处在收到本调查报告的初稿后，再次翻查相关记录，发现事涉事故报告中的建议其实已获适时跟进，但该处在二〇一四年中应本署要求重新整理及综合资料时，却又未发现该「曾作跟进」的记录，于是再于同年七月「补回」跟进。其混乱情况，可见一斑。

12. 本署留意到，海事处「补回」跟进工作的日期均为二〇一四年七月之后，即本署要求该处翻查及整理旧记录之后。由此看来，若非本署进行主动调查，该处未必会发现有遗漏跟进的情况。

海事处遗漏跟进部分建议

13. 一般而言，每宗事故报告会提出多于一项建议，本署留意到，海事处在跟进其中 11 宗个案时，每宗至少遗漏跟进一项建议，并于多年后才「补回」跟进。延误最严重的一宗个案，海事处于二〇〇五年五月完成调查并提出七项建议，该处于同月及翌年一月，只跟进其中三项建议，而其余四项建议则延至二〇一四年八月，即逾九年后才作跟进。

14. 与上文**第 12 段**提及的情况相若，海事处「补回」跟进工作的日期均为二〇一四年七月后，相信是应本署要求翻查记录后才发现有遗漏而作出补救跟进行动。

个案数据甩漏、混乱不全

15. 根据海事处在调查期间向本署提供的记录，在二〇〇五年一月至二〇一三年五月期间完成的事故报告，合共 114 宗（上文**第 7 段**）。然而，本署从海事处网页发现，除了上述 114 宗外，尚有另外六宗发生于二〇〇九年八月至二〇一二年十一月的海上事故，这些个案只提供了事故报告摘要，其他详情未明。

16. 与上文**第 11 段**提及的情况相若，海事处在收到本调查报告的初稿后，随即搜索并翻查出该六宗个案的档案。该处解释，最初应本署要求于二〇一四年十月提供个案数据时，事涉六宗个案均涉法律诉讼，故未能公布有关调查报告全文。

17. 然而，本署须指出，在调查期间海事处向本署提供了 191 宗有关海上事故调查的资料，当中不乏未完成法律诉讼的个案，但却没有提及上述的六宗个案。此外，由于该处的数据混乱，本署曾于二〇一五年十一月，明确要求海事处确认在调查期间向本署提供的数据及数据是否准确无误；该处于同年十二月回复本署，确认有关数据及数据准确无误，明显意味该处根本没有严谨翻查记录，亦反映该处的记录混乱不全。

「新机制」不无缺失

18. 根据海事处提供的记录，由二〇一三年六月至二〇一五年十一月的两年多期间，该处已完成的事故报告共 77 宗，合共提出 215 项建议。在「新机制」下，海事处除了按「旧机制」将事故报告中所作的建议通知相关机构和人士外，并会把有关建议输入计算机系统，以便相关科别持续跟进，以及由管理层监察跟进进度，直至有关建议得以全面落实为止。

就非香港注册船舶及非本地登记船舶的建议跟进欠全面

19. 「新机制」实际上只适用于香港注册船舶及本地登记船舶，对于涉及非香港注册船舶的调查报告建议，海事处基本上仍是沿用「旧机制」，即将调查结果通知相关船旗国或船公司，再由他们自行处理和执行相关建议，该处一般不会再作跟进。

20. 本署明白，海事处对于监察非香港注册船舶及非本地登记船舶落实建议，有一定困难，但本署认为，该处最低限度应知悉有关船舶有否作出改善，以评估这些船舶再度进入香港水域时可能出现的海事安全风险。

未有严谨处理每宗个案

21. 在「新机制」下，海事处对落实建议的跟进，较「旧机制」有系统，但本署观察到，大部分在「新机制」下的个案，海事处在收到相关机构回复，指已经或将会落实有关建议后，跟进工作便告一段落，未有进一步核实落实情况。

22. 在处理较为严谨的小部分个案中，海事处会在收到相关机构提交的证明文件，又或派员进行审查以确定建议已落实后，才会结束跟进工作。在上文**第 18 段**提及的 77 宗个案中，这类处理较为严谨的个案只有 13 宗。

23. 本署认为，海事处应如上述 13 宗个案般，严谨地处理每一项涉及海上航行安全的建议，确保该些建议全面落实。

本署的评论

「旧机制」记录混乱不全、海事处跟进不足、监察不力

24. 在二〇一三年六月设立计算机系统以前，海事处并无设立建议数据库和监察建议落实的信息管理系统。为响应本署查核资料

的要求，该处整理分散于辖下不同科别的旧个案，再以人手翻查与跟进建议有关部分的资料，耗时半年才完成。更甚的是，从上文**第 11、15 至 17 段**所述的情况可见，该处的记录明显混乱不全，更遑论监察进度。

25. 在没有妥善记录的情况下，海事处的管理层实难以监察改善建议有否得以落实，又或跟进是否有遗漏情况。这差劣的情况一直延至审计署于二〇一二年十月发表审计报告，该处才作检讨跟进，显示该处一直以来不重视监察跟进工作的进展。

26. 即使有跟进建议，在「旧机制」下，海事处亦只是将事故报告中所作的建议通知相关机构和人士，任由他们自行处理和执行（上文**第 8 段**），海事处并无尽责去监督建议的推行，确保本港的海上安全。

「新机制」欠全面和严谨

27. 海事处在二〇一三年六月设立计算机系统，以适时向负责职员作出提示，而该处管理层又会定期监察仍未结束跟进的个案。本署认为，设立这系统是迈向有效监管的第一步。

28. 不过，本署留意到，除小部分个案外（见上文**第 22 段**），海事处主要仍是依赖船公司和相关机构汇报，以监察推行建议的情况。当收到回复指已落实建议，跟进工作便告一段落，亦不会进一步核实。本署重申，要确保海上安全，该处必须严谨跟进每项建议，于取得确切数据显示建议已获全面落实后才终结跟进工作。再者，该处对于涉及非香港注册船舶的建议，仍只作通知，并无监察落实情形，如问题船舶再进入香港水域，会造成一定风险，有欠理想（见上文**第 20 段**）。

海事处不将「新机制」用于旧个案

29. 海事处表示，已完成跟进「旧机制」下的308项建议（上文**第7段**）。在本署查询下，该处澄清，若套用「新机制」的运作模式于上述308项建议，则有20宗个案涉及22项建议需持续跟进。

30. 本署曾建议海事处，应一并把「新机制」用于二〇一三年六月计算机化以前完成调查的个案。然而，该处表示基于人手及资源所限，加上经逐一翻查事涉20宗个案后，确认没有发现同类事故重复发生于相关船只，因此，该处认为无需以「新机制」跟进该22项建议。

31. 本署认为，海事意外调查的目的，除了确定事发经过和肇事原因，亦是为避免同类意外再发生而危害生命财产安全，所谓「前事不忘，后事之师」；本署难以接纳该处以人手及资源所限，以及没有发现同类事故重复发生于相关船只为由，便决定不以「新机制」跟进该22项建议，这对本港海事安全可能构成风险。

有否「漏网之鱼」未获海事处跟进建议的个案存疑

32. 为响应本署要求查核以往跟进事故报告建议的情况，海事处耗时半年去整理旧记录，并再应本署其后的询问，确认有关记录准确无误。尽管如此，本署仍发现有六宗遗漏个案（见上文**第15段**），显示该处的记录明显混乱。直至本署将调查报告的初稿送交该处评论后，该处方再次翻查记录并向本署提供该六宗个案的数据（上文**第16段**）。在「旧机制」下，海事处并无制定跟进建议的工作指引，也没有监控跟进进度的信息管理系统，故此，是否仍有「漏网之鱼」的个案未获适切的跟进，以及以人手翻查所得记录是否齐全和准确等，顿成疑问。

本署的建议

33. 鉴于以上所述，申诉专员敦促海事处：

（一） 主动核查事故报告建议是否已获全面落实，而非只依赖相关机构或人士的汇报，并将此程序加入为跟进建议的常规步骤（见上文**第 23 段**）。

（二） 适当跟进非香港注册船舶及非本地登记船只落实建议的情况（见上文**第 20 段**）。

（三） 在保障海上人命安全的前提下，重新考虑以「新机制」跟进上文**第 29 段**所述的 22 项事故报告建议（见上文**第 31 段**）。

（四） 考虑再次复核「旧机制」下的个案数据，避免**第 11、15 至 17 段**所显示的记录混乱情况重演，并确保有关事故报告的建议获适当跟进。

（五） 定时检讨「新机制」下跟进事故报告所作建议的情况，确保达到预期的效果。

34. 海事处接纳本署的建议，并已着手跟进。本署感谢该处在调查过程中予以合作，亦欣悉该处接纳本署的所有建议。本署会继续监察，直至该处全面落实建议。

申诉专员公署
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 二〇一二年十月于南丫岛附近发生严重海上事故（「南丫事故」），经调查后发现，其中一艘肇事船只没有设置水密门，令该船只遭碰撞后入水并迅速沉没。其后，有报章报道，于二〇〇〇年曾有政府船只在船坞维修期间入水，由于船上水密舱壁不密封，该船只最终沉没。相关的事故调查报告，已建议海事处检查同类船只的水密舱壁；南丫事故的发生，令人质疑海事处一向以来有否落实海上事故调查报告的建议。

1.2 为此，申诉专员于二〇一三年五月二十八日向海事处展开初步查讯，并于二〇一五年十一月二日决定根据《申诉专员条例》（第 397 章）第 7(1)(a)(ii)条就海上事故调查报告所作建议的跟进机制，向海事处展开主动调查。由于行政长官会同行政会议委任了独立调查委员会，就南丫事故进行调查（其中包括确定事故起因），而该调查委员会已于二〇一三年四月十九日完成调查并向行政长官提交调查报告。因此，本主动调查不会涵盖南丫事故的肇事原因及责任谁属问题。

调查范围

1.3 这项主动调查的审研范围包括：

- 长久以来海事处对海上事故调查报告所作建议的跟进机制是否全面及适切。
- 可予改善及加强之处。

调查过程

1.4 这项主动调查的工作主要包括以下几方面：

- 向海事处索取海上事故的相关数据和数据；

- 实地视察海事处计算机系统的运作；

- 审研有关海事处工作成效的报告，包括审计报告，以及「海事处制度改革督导委员会」的调查报告相关部分。

1.5 二〇一六年四月十一日，本署将调查报告的初稿送交海事处评论。应海事处要求，本署职员于五月三日与该处职员会面，聆听该处对调查报告的初稿的意见。会后，本署于五月十六日收到该处的书面回应。经考虑及适当纳入他们的意见后，本署于二〇一六年六月八日完成这份报告。

2

有关海上事故调查的背景资料

报告海上事故的法例规定

2.1 根据《商船（安全）条例》（第 369 章）第 80 条、《商船（本地船只）条例》（第 548 章）第 57 条，以及《船舶及港口管制条例》（第 313 章）第 67 条，在任何水域的香港注册远洋船舶，或在香港水域内的本地登记船舶及其他所有非本地船舶，当发生意外时，其船东 / 船长 / 船只拥有人或其代理须向海事处处长报告有关事故。

海上事故的分类

2.2 海上事故大致分为以下三类：

(1) 船舶意外—即坊间常说的海事意外，与船舶有关，例如碰撞、倾斜、搁浅 / 沉没、火警 / 爆炸等。

(2) 海上职业意外—主要涉及船员或船上其他人员因工受伤，例如滑倒、从高处堕下、烧伤等。

(3) 海上工业意外—主要涉及因船只的修理 / 拆卸、货物处理或海上建造工程等导致的意外。

为海上事故立案调查的目的和指引

2.3 海事处辖下海事意外调查及船舶保安政策部（「调查部」）负责调查因应上文**第 2.1 段**所述的规定而接报的海上事故。调查的主要目的，并不是要追究责任或采取检控行动 / 纪律处分，而是要确定事发经过和肇事原因，以期改善海上人命安全，并且藉着公布调查结果，让业界汲取事故的教训，避免日后再次发生同类意外事故。

2.4 并非所有海上事故都会立案调查，调查部需视乎有关事故的严重程度而决定。根据海事处的海上事故调查指引（二〇一四年十二月修订版本），调查部的高级验船主任负责为接报的海上事故的严重性作评估及分类。所有被归类为非常严重的事故，调查部均须立案调查；其他不太严重的事故，则视乎个案性质，再决定是否立案调查，但若决定不立案调查，必须先得到调查部主管（即总海事意外调查及船舶保安政策主任）的批准。至于无需立案调查的轻微事故，调查部须作一般评估以确定肇事原因，并将结果存档作统计之用。

海上事故调查报告的公布

2.5 完成海上事故调查后，调查部会撰写海上事故调查报告（「事故报告」）；若事故的严重程度属非常严重，事故报告会交海事处处长审批，其余事故报告，则会交总海事意外调查及船舶保安政策主任审批。通过审批的事故报告，若事故确定不涉及正在进行或将会进行的法律诉讼程序，有关事故报告便会上载于海事处网页，让公众浏览。

涉及政府船只的海上事故

2.6 根据海事处的内部指引，当海上事故只涉及政府船只（即没有涉及非政府船只），其所属政府部门须负责撰写意外报告，并提交海事处辖下政府船队科（「船队科」），以便其对有关事故提供意见或进行初步调查及提供建议。

2.7 若事故属重大程度，船队科须将初步调查结果送交调查部；调查部再评估从有关事故中所汲取的教训，并在有需要时提出建议或发出海事处布告。若事故同时涉及政府船只及非政府船只，船队科于整合初步调查结果后，会交予调查部作评估或进一步调查；调查部的处理程序与上文**第 2.4 至 2.5 段**相同。

2.8 船队科所撰写的初步调查报告，只会用作内部讨论及参考，并不会上载于海事处网页供公众浏览。调查报告中所提出的建议，会由船队科自行跟进，并于船队科的定期维修会议（每两星期举行）和定期管理会议（每星期举行）中检视落实建议的进度。

2.9 根据海事处提供的资料，上文**第 1.1 段**提及的二〇〇〇年政府船只意外，并非在航行期间发生。而是在停泊于政府船坞

进行修理时，因承办商工人疏忽导致机房入水，其后海水再渗进毗连两柜舱，最终导致沉船。该意外于二〇〇〇年三月发生后，海事处处长随即指示当时的政府船坞工业安全主任展开调查，报告于同年四月完成，并针对船队科辖下维修组及政府船坞的承办商提出了改善建议，当中包括详细检查事涉船只及同类政府船只的水密舱壁；相关建议已于二〇〇〇年内落实。

2.10 海事处续指，**前段**提及的意外，并无涉及非政府船只，亦不属于重大的船舶意外，因此，船队科无需将报告交调查部作跟进处理（见上文**第 2.7 段**）。

3

海上事故调查报告中的建议的跟进机制

3.1 由调查部负责撰写的事故报告，一经审批，调查部会把事故报告中的建议通知相关科别，以便其在负责范畴采取适当的跟进行动。若属一般性安全建议，海事处会通过发出海事处布告或香港商船信息，让业界从事故中汲取教训，以防止同类事故再次发生。

3.2 海事处于二〇一三年六月以前，在跟进事故报告建议方面可说是采取自由放任模式，主要倚赖相关科别职员和船公司／船主自行纠正不足之处，没有特定的跟进记录和监控系统。二〇一二年十月二十六日，审计署发表第 59 号审计报告，当中批评海事处对事故报告中的建议跟进欠妥，并敦促该处改善。为此，海事处设立计算机系统，以便持续监察事故报告提出的建议的推行进度，确保其全面落实；有关计算机系统于二〇一三年六月正式运作。此外，该处于二〇一四年十二月修订海上事故调查指引，新增有关跟进建议的内容，详列跟进建议的步骤及负责执行的人员。为方便讨论，本报告把该处设立上述计算机系统前后的运作机制分别称为「旧机制」和「新机制」。

「旧机制」的运作

香港注册远洋船舶

3.3 香港注册远洋船舶，是指根据《商船（注册）条例》（第 415 章）而注册的船舶。若事故报告中的建议涉及香港注册远洋船舶，海事处会以《国际安全管理规则》[1]所订的标准行事，细节如下：

- 《国际安全管理规则》第 9 段订明，由船公司设立的安全管理体系[2]须确保把事故或险情向船公司汇报，以

[1] 《国际安全管理规则》是指由国际海事组织大会通过的，并可由该组织予以修正的《国际船舶安全营运和防上污染管理规则》；该规则旨在提供船舶安全管理、安全营运和防止污染的国际标准。

[2] 安全管理体系是指能使船公司人员有效实施船公司安全和环境保护方针的结构化和文件化的体系。

进行调查和分析，并采取措施以防止同类事件再次发生。

- 在周期性「公司审核」[3]及「船舶审核」[4]中，获海事处授权的船级社[5]会按照《国际安全管理规则》对有关船公司/船舶进行审查，其中有关**前段**所述安全管理体系的规定，船级社可以对船公司有否落实事故报告中的建议进行监察。若发现船公司/船舶未有采取适当措施或措施不足，船级社会发出相应的「不符合记录」，指示船公司/船舶在指定限期前纠正问题。

- 根据《国际安全管理规则》第13段，「公司审核」应每年进行一次；「船舶审核」的周期为五年，除第一年及第五年之发证及换证审核外，在第二至第三年间亦须进行中期审核。

- 为监察船级社的表现，海事处会核查由船级社提交的审核报告。此外，该处亦会派验船师参与船级社对船公司的审核；事前，该处验船师会向调查部了解相关注册船有否发生严重的海上意外，并于审核期间特别留意。

- 若发现船公司/船舶在落实建议方面不理想，海事处会考虑终止其「符合证明书」，令其失去继续营运香港船的资格。

本地登记船舶

3.4 本地登记船舶，是指领有属《商船（本地船只）（证明书及牌照事宜）规例》（第548D章）所订明的证明书和牌照的船只。若事故报告中的建议涉及本地登记船舶，海事处的跟进如下：

- 若建议涉及必须根据相关法例而执行的项目，调查部会通知海事处内相关科别，并由该科别跟进及监察建议的推行。
- 至于其他旨在建议有关船公司/船东/船长等改善船只的安全操作，或提高船员的安全意识等项目，调查部会通知有关公司、船东、船长，并由他们自行落实。

[3] 「公司审核」是海事处透过授权船级社对船舶管理公司，就其管理的船舶实施安全管理制度的审核。
[4] 「船舶审核」是海事处透过授权船级社对在船舶上实施安全管理制度的审核。
[5] 现时，获海事处授权进行审核的船级社共八间，他们皆为国际船级社协会会员，船东或船公司可从该八间船级社自由选择，并通知海事处。船级社代表海事处替香港注册船验船和签发证书。

「新机制」的运作

3.5 在二〇一三年六月以后完成的事故报告，调查部会透过计算机系统监察事故报告建议的落实（包括香港注册远洋船舶及本地登记船舶）。若建议属可实时实施的项目（例如将事故中汲取到的教训透过海事处布告或香港商船信息通知业界），验船主任须实时跟进；若属需持续跟进的项目（例如事涉船公司须进行附加安全审核，或事涉船只须进行指定改装等），验船主任会转交助理验船督察跟进，包括联络相关船公司以了解有否推行相关的改善措施，并要适时更新计算机系统数据，以及定时向验船主任或高级验船主任汇报进展。

3.6 计算机系统会定时提示助理验船督察仍未落实的建议，而高级验船主任会监察助理验船督察的跟进工作。此外，高级验船主任亦会每月一次，于意外调查工作会议上检视所有未完成跟进的个案，确保有关建议获适当处理。

3.7 为更有效进行审核香港注册远洋船舶，海事处于二〇一三年八月修改内部指引（即国际标准化组织质量管理系统手册），规定该处辖下货船安全组在收到调查部就严重海上事故的调查分析后，须考虑要求有关船舶的船级社作相应的跟进。

「旧机制」、「新机制」的异同

3.8 在「旧机制」下，海事处只会将事故报告中所作的建议通知相关机构和人士，例如船旗国、船公司、船主、海事处辖下科别等，由他们自行处理和执行，并无既定机制监察有关机构和人士有否落实建议。

3.9 在「新机制」下，海事处除了按「旧机制」将事故报告中所作的建议通知相关机构和人士外，并会把有关建议输入计算机系统，以便相关科别持续跟进，以及由管理层监察跟进进度，直至有关建议得以全面落实为止。

4

「旧机制」下的跟进情况及本署观察所得

4.1 海事处于二〇一三年六月设立的计算机系统，并无将该日期前所完成的调查个案有关落实建议的数据输入计算机数据库。因应本署的要求，该处从不同科别汇集二〇〇五年至二〇一三年期间的记录，并以人手翻查以重新整理及综合与跟进事故报告建议有关的资料。所得数据显示，在二〇〇五年一月至二〇一三年五月这八年多期间，海事处共完成 114 宗海上事故调查，合共提出 308 项建议。该处表示，已按「旧机制」完成该些建议的跟进工作（上文**第 3.3 至 3.4 段**）。

本署观察所得

4.2 就海事处对上述 114 宗事故报告所提出建议的跟进，本署有以下观察所得：

调查完成多年后仍没有任何跟进行动

4.3 有五宗个案在海事处完成调查多年后，竟没有作出任何跟进行动（包括并无将事故报告的建议通知有关机构，以让他们自行处理和执行），大部分直至完成调查逾七年后才作跟进。该五宗个案的延误情况，见下表，而有关的事故报告建议内容，见**附录（一）**。

编号	事发日期	所涉船只	调查完成日期	跟进建议日期	延误时间
(1)	4/6/2005	本地货船	3/1/2006	7/8/2014	8 年 7 个月
(2)	18/8/2005	本地风帆	26/10/2006	7/8/2014	7 年 9 个月
(3)	21/12/2005	中国货船 / 本地汽艇	28/7/2006	24/7/2014	8 年
(4)	19/6/2006	香港高速客轮 / 中国船	2/3/2007	24/7/2014	7 年 4 个月
(5)	14/11/2009	香港货船 / 韩国渔船	1/11/2010	24/7/2014	3 年 8 个月

				(3/11/2010[6])	

4.4 上表编号(1)个案的延误最严重，海事处于二〇〇六年一月完成调查，但在八年七个月后才开始跟进事故报告中的建议。至于编号(2)至(4)个案，则于完成调查逾七年后才作跟进。

4.5 本署留意到，海事处「补回」跟进工作的日期均为二〇一四年七月之后，即本署要求该处翻查及整理旧记录之后。由此看来，若非本署进行主动调查，该处未必会发现有遗漏跟进的情况。

4.6 至于上表编号(5)个案，海事处在收到本调查报告的初稿后（上文**第 1.5 段**），再次翻查相关记录，发现该个案其实已于二〇一〇年十一月三日跟进了事故报告中的建议，并解释因为在二〇一四年中重新整理及综合资料时未有发现曾作跟进的记录，于是再于同年七月「补回」跟进；故此，该处要求本署从上表中剔除编号(5)的个案。

遗漏跟进部分建议

4.7 一般而言，每宗事故报告会提出多于一项建议，本署留意到，海事处在跟进下表列出的 11 宗个案时，每宗均有遗漏跟进最少一项建议，并于多年后才「补回」跟进。该 11 宗个案的延误情况，见下表，而有关的事故报告建议内容，见**附录（二）**。

编号	事发日期	所涉船只	调查完成日期（建议数目）	跟进建议情况	延误时间
(1)	11/01/2005	中国船	3/6/2005 (2 项建议)	一项建议于 6/6/2005 跟进；另一项于 24/7/2014 才跟进	9 年 1 个月
(2)	17/02/2005	中国高速客轮 / 内地集装箱货船	25/5/2005 （7 项建议）	一项建议于 31/5/2005 跟进；另有两项于 23/1/2006 跟进；其余四项于 7/8/2014 才跟进	9 年 3 个月
(3)	28/03/2005	中国高速客轮 / 本地非自航钢趸	21/9/2005 （4 项建议)）	三项建议于 2005 年内跟进，其余一项于 24/7/2014 才跟进	8 年 10 个月
(4)	12/06/2005	两艘本地游乐船	9/5/2006 （3 项建议）	一项建议于 28/8/2006 开始跟进；其余两项分别于 28/7/2014 和	8 年 2 个月

[6] 请参阅上文**第 4.6 段**。

				09/10/2014 才跟进	
(5)	01/02/2007	香港散货船	12/2/2008 （3 项建议）	两项建议分别于 23/10/2008 和 17/9/2009 跟进；其余一项于 8/8/2014 才跟进	6 年 6 个月
(6)	20/05/2007	两艘香港高速客轮	5/3/2008 （2 项建议）	一项建议于 7/3/2008 跟进，另一项于 24/7/2014 才跟进	6 年 4 个月
(7)	03/06/2007	本地非自航钢趸	6/2/2008 （2 项建议）	一项建议于 20/02/2008 跟进；另一项于 08/10/2014 才跟进	6 年 8 个月
(8)	13/09/2007	本地非自航钢趸	24/9/2008 （3 项建议）	一项建议于 21/10/2008 跟进；另一项于 10/9/2009；其余一项 9/10/2014 才跟进	6 年
(9)	31/07/2010	中国货船	23/12/2010 （4 项建议）	三项建议分别于 6/1/2011 和 18/7/2011 跟进；其余一项于 24/7/2014 才跟进	最少 3 年 6 个月
(10)	18/05/2011	本地游乐船	27/7/2012 （3 项建议）	两项建议分别于 7/8/2012 和 22/8/2012 跟进；其余一项于 13/8/2014 才跟进	2 年
(11)	01/07/2011	中国船	27/11/2012 （6 项建议）	五项建议于 2012 年跟进，其余一项于 24/7/2014 才跟进	1 年 8 个月

4.8 上表编号(2)个案的延误最严重，海事处于二〇〇五年五月完成调查并提出七项建议。同月及翌年一月，该处跟进其中三项建议，但其余四项建议则于二〇一四年八月，即逾九年后才作跟进。

4.9 与上文**第 4.6 段**提及的情况相若，海事处「补回」跟进工作的日期均为二〇一四年七月后，相信是应本署要求翻查记录后才发现有遗漏而作出补救跟进。

个案数据甩漏、混乱不全

4.10 根据海事处在调查期间向本署提供的记录，在二〇〇五年一月至二〇一三年五月期间完成的事故报告，合共 114 宗（上

文**第 4.1 段**）。然而，本署从海事处网页发现，除了上述 114 宗外，尚有另外六宗发生于二〇〇九年八月至二〇一二年十一月的海上事故，这些个案只提供了事故报告摘要，其他详情未明。该六宗海上事故的基本数据如下：

编号	事发日期	所涉船只	调查完成日期
(1)	3/8/2009	本地非自航钢趸／本地拖船	没有提供
(2)	29/9/2011	图瓦卢半潜趸船	没有提供
(3)	21/10/2011	本地渡轮	没有提供
(4)	6/6/2012	中国集装箱船	没有提供
(5)	13/8/2012	香港渔船／中国沿海油船	没有提供
(6)	24/11/2012	香港杂货船	没有提供

4.11 在「旧机制」下，海事处并无制定跟进建议的工作指引，也没有监控跟进进度的信息管理系统。该处应本署要求下以人手翻查所得记录是否齐全和准确，存在疑问。

4.12 与上文**第 4.6 段**提及的情况相若，海事处在收到本调查报告的初稿后（上文**第 1.5 段**），随即搜索并翻查出该六宗个案的档案。该处辩称，最初应本署要求于二〇一四年十月提供个案数据时，事涉六宗个案均涉法律诉讼，因此，有关调查报告未能公布；该署并「补回」有关事故的调查完成日期（见下表）：

编号	事发日期	所涉船只	调查完成日期
(1)	3/8/2009	本地非自航钢趸／本地拖船	16/3/2011
(2)	29/9/2011	图瓦卢半潜趸船	31/8/2012
(3)	21/10/2011	本地渡轮	17/7/2012
(4)	6/6/2012	中国集装箱船	29/5/2012
(5)	13/8/2012	香港渔船／中国沿海油船	9/10/2014
(6)	24/11/2012	香港杂货船	24/11/2014

4.13 然而，本署须指出，在调查期间海事处向本署提供了 191 宗有关海上事故调查的资料，当中不乏未完法律诉讼的个案，但却没有提及上述的六宗个案。此外，本署曾于二〇一五年十一月，明确要求海事处确认在调查期间向本署提供的数据及数据是否准确无误；该处于同年十二月回复本署，确认有关数据及数据准确无误，明显意味该处根本没有严谨翻查记录，甚或反映该处的记录混乱不全。

《南丫事故报告》

4.14 二〇一二年十月二十二日，行政长官会同行政会议委任独立调查委员会，就南丫事故进行调查。该调查委员会于二〇一三年四月十九日完成调查并向行政长官提交了《二〇一二年十月一日南丫岛附近撞船事故调查委员会报告》(「《南丫事故报告》」)。

4.15 二〇一三年五月三日，运输及房屋局成立「海事处制度改革督导委员会」，以督导海事处处长对海事处进行全面检查及彻底改革，及制定落实改革方案的时间表。该委员会的职权并包括参照《南丫事故报告》的建议，就规管乘客安全及规管与检验本地船只事宜的法例遵行情况及行政措施，进行全面检讨、拟订详细改善方案，并监督方案的落实。

4.16 同期，海事处内部成立改革执行小组，由新设的副处长（特别职务）领导，配合「海事处制度改革督导委员会」推展全面检讨及改革，当中包括监察《南丫事故报告》的建议的落实情况。故此，上文**第 3 章**提及的跟进建议机制，并不适用于南丫事故。

5

「新机制」下的跟进情况及本署观察所得

5.1 根据海事处提供的记录，由二〇一三年六月至二〇一五年十一月的两年多期间，该处已完成的事故报告共 77 宗，合共提出 215 项建议。在「新机制」下，调查部的高级验船主任须实时跟进可实时实施的项目，以及更新计算机系统数据；对于需持续跟进的项目，该处除了将事故报告中所作的建议通知相关机构和人士外，亦要持续跟进直至有关建议得以全面落实为止（上文**第 3.5** 至 **3.6 段**）。

本署观察所得

就非香港注册船舶及非本地登记船舶的建议跟进欠全面

5.2 「新机制」实际上只适用于香港注册船舶及本地登记船舶，对于涉及非香港注册船舶的调查报告建议，海事处基本上仍是沿用「旧机制」，即将调查结果通知相关船旗国或船公司，再由他们自行处理和执行相关建议，该处一般不会再作跟进。

5.3 本署明白，海事处对于监察非香港注册船舶及非本地登记船舶落实建议，有一定困难，但本署认为，该处最低限度应知悉有关船舶有否作出改善，以评估这些船舶再度进入香港水域时可能出现的海事安全风险。

未有严谨处理每宗个案

5.4 在「新机制」下，海事处对落实建议的跟进，较「旧机制」有系统，但本署观察到，大部分在「新机制」下的个案，海事处在收到相关机构回复，指已经或将会落实有关建议后，跟进工作便告一段落，未有进一步核实落实情况。

5.5 在处理较为严谨的小部分个案中，海事处会在收到相关机构提交的证明文件，又或派员进行审查以确定建议已落实后，

才会结束跟进工作。在上文**第 5.1 段**提及的 77 宗个案中，这类处理较为严谨的个案有 13 宗，列述如下：

编号	事发日期	事故名称	海事处的建议（只罗列须持续跟进的项目）	跟进建议情况
(1)	13/3/2012	香港籍散货船水手死亡	事涉船的管理公司发公告，提醒船长和驾驶员有关事故调查的结果及需遵守安全规则。此外，海事处辖下船舶事务科应监察事涉香港船的管理公司有否落实海事处的建议	海事处辖下船舶安全监督部（隶属船舶事务科）参加事涉船的年度审核，并与管理公司讨论及指示如何落实有关建议
(2)	3/4/2012	香港杂货及木材船沉没	事涉船的管理公司应检讨其安全管理系统	海事处辖下船舶安全监督部参加事涉船的年度审核，并与管理公司讨论及指示如何落实有关建议
(3)	9/4/2012	香港集装箱船与中国渔船碰撞	事涉香港船的船主/管理公司发公告，提醒船长和驾驶员需遵守安全规则，并检讨其安全管理系统的相关程序	事涉香港船的管理公司回复海事处，并提供文件证明已落实有关建议
(4)	8/5/2012	香港高速客船与中国渔船碰撞	海事处辖下船舶事务科应定期视察事涉香港船的管理公司	海事处辖下船舶安全监督部（隶属船舶事务科）监察事涉船公司的安全管理审核，并跟进改善措施的落实进度
(5)	13/5/2012	香港散货船与中国渔船碰撞	事涉香港船的管理公司发公告，提醒船长和驾驶员有关意外调查的结果及需遵守安全规则。此外，海事处辖下船舶事务科应到事涉香港船上进行安全管理审核	事涉香港船的管理公司回复海事处，并提供文件证明已落实有关建议。此外，海事处辖下船舶安全监督部（隶属船舶事务科）到事涉香港船上进行安全管理审核
(6)	7/6/2012	本地渔船上发生致命火警意外	事涉船长应遵守安全规定。此外，海事处辖下港口管理航行监察部海港巡逻组应就事故作适当跟进	海事处辖下港口管理航行监察部海港巡逻组到事涉船只检查
(7)	15/9/2012	香港载木船船长失踪	事涉船主／管理公司发公告，提醒船长和驾驶员有关事故调查的结果及进行改善措施。另外，海事处辖下	事涉船公司回复海事处已跟进有关建议，其后，海事处辖下船舶安全监督部（隶属船舶事务科）

			船舶事务科应为管理公司及船只进行安全管理审查	进行安全管理审查，发现船公司其实并未推行有关建议，故要求船公司再作跟进及于稍后进行额外审查。船公司之后提供文件证明已作改善。此外，船舶安全监督部亦有到事涉船只进行安全管理审核
(8)	29/12/2012	香港高速客船碰撞浮筒	事涉船主/管理公司发公告，提醒船长和驾驶员有关事故调查的结果及需遵守安全规则	事涉管理公司回复海事处，并提供文件证明公司已落实有关建议
(9)	5/11/2013	香港集装箱船与中国大陆沿海船碰撞	事涉香港船的船主／管理公司发公告，提醒船长和驾驶员有关事故调查的结果及需遵守规则	事涉管理公司回复海事处，并提供文件证明已落实有关建议
(10)	20/2/2014	香港散货船上致命事故	事涉船主／管理公司发公告及制定船上安全指引	事涉管理公司回复海事处，并提供文件证明已落实有关建议
(11)	21/5/2014	本地非自航趸船水手堕海遇溺死亡	事涉船主／管理公司张贴海事处公告，提示员工遵守安全规定，以防止类似事故重演	事涉管理公司回复海事处，并提供相片证明已落实有关建议
(12)	21/5/2014	香港高速客轮与中国内河船碰撞	事涉香港船的船主／管理公司张贴海事处公告，提示员工遵守安全规定，以防止类似事故重演	事涉香港船的管理公司回复海事处，并提供文件证明已落实有关建议
(13)	2/7/2014	香港散货船上致命事故	事涉船主/管理公司应确保，海事处所作的相关安全规定建议得以落实	事涉管理公司回复海事处，并提供文件证明已落实有关建议

5.6 本署认为，海事处应如上述 13 宗个案般，严谨地处理每一项涉及海上航行安全的建议，确保该些建议全面落实。

6

本署的评论及建议

整体评论

6.1 毫无疑问，政府应竭尽所能以防南丫事故再次发生。南丫事故的调查和责任谁属的问题，已有专责调查委员会处理（见上文**第 4.14 至 4.16 段**），故本署是次主动调查不会涵盖该事故。本主动调查，着眼点是海事处跟进事故报告中的建议的整体机制。

6.2 海事处是负责保障本港水域航行安全的部门，若有海上事故发生，迅速作出调查并提出改善建议，以避免同类事故再发生，固然是责之所在，但妥善落实每项改善建议，避免惨剧重演，更为重要。然而，本署的调查发现，海事处在二〇一三年六月前的「旧机制」，在跟进建议方面十分疏漏，亦无监控可言：事故报告中的建议与跟进建议的记录，分散于该处不同科别；该处亦没有设立记录建议的数据库和监察建议落实的信息管理系统，管理层根本无从确保建议获妥善跟进。

6.3 海事处于二〇一三年六月设立计算机系统，并以「新机制」跟进事故报告建议，其后的跟进力度明显加强，惟仍有可改善之处。

6.4 整体而言，本署认为海事处跟进事故报告建议的情况有以下不足之处：

(一)「旧机制」记录混乱不全、跟进不足、监察不力

6.5 在二〇一三年六月设立计算机系统以前，海事处并无设立建议数据库和监察建议落实的信息管理系统。简言之，该处没有系统地记录和跟进相关建议的落实进度。为响应本署查核资料的要求，该处整理分散于辖下不同科别的旧个案，再以人手翻查与跟进建议有关部分的资料，耗时半年才完成。更甚的是，从上文**第 4.6、4.10 至 4.13 段**所述的情况可见，该处的记录明显混乱不全，更遑论监察进度。

6.6 在没有妥善记录的情况下，海事处的管理层实难以监察改善建议有否得以落实，又或跟进是否有遗漏情况。这差劣的情

况一直延至审计署于二〇一二年十月发表审计报告，该处才作检讨跟进，显示该处一直以来不重视监察工作的进展。

6.7 即使有跟进建议，在「旧机制」下，海事处亦只是将事故报告中所作的建议通知相关机构和人士，例如船旗国、船公司、船东、海事处辖下科别等，任由他们自行处理和执行（上文**第 3.3 至 3.4 段**）。在此情况下，有关建议会否得到确切和全面的落实，全依赖相关机构的自律，海事处并无尽责去监督建议的推行，确保本港的海上安全。

(二)「新机制」欠全面和严谨

6.8 海事处在二〇一三年六月设立计算机系统，规定负责职员将事故报告中的建议输入计算机系统；计算机系统会适时向负责职员作出提示，而该处管理层又会定期监察仍未结束跟进的个案。本署认为，设立这系统是迈向有效监管的第一步。

6.9 不过，本署留意到，虽然海事处跟进建议的机制已改善，并会持续跟进建议实施进度至落实，但除小部分个案外（见上文**第 5.5 段**），主要仍是依赖船公司和相关机构汇报，以监察推行建议的情况。当收到回复指已落实建议，跟进工作便告一段落，亦不会进一步核实。本署重申，要确保海上安全，该处必须严谨跟进每项建议，于取得确切数据显示建议已获全面落实后才终结跟进工作。再者，该处对于涉及非香港注册船舶及非本地登记船舶的建议，仍只作通知，并无监察落实情形，如问题船舶再进入香港水域，会造成一定风险，有欠理想（见上文**第 5.3 段**）。

(三)不将「新机制」用于旧个案

6.10 海事处表示，已完成跟进「旧机制」下的 308 项建议（上文**第 4.1 段**）。在本署查询下，该处澄清，若套用「新机制」的运作模式于上述 308 项建议，则有 20 宗个案涉及 22 项建议需持续跟进。该 22 项建议的内容，载于**附录（三）**。

6.11 本署曾建议海事处，应一并把「新机制」用于二〇一三年六月计算机化以前完成调查的个案。然而，该处表示基于人手及资源所限，暂无意把「新机制」用于旧个案，但若日后资源情况有改善，该处会再考虑本署的建议。

6.12 其后，应本署要求，海事处逐一评估上文**第 6.10 段**所述的 22 项建议，以确定不依「新机制」跟进会否对本港海事安全构成风险及影响。该处回应，经逐一翻查事涉 20 宗个案后，确认没

有发现同类事故重复发生于相关船只，因此，该处认为无需以「新机制」跟进该 22 项建议。

6.13 本署认为，海事意外调查的目的，除了确定事发经过和肇事原因，亦是为避免同类意外再发生而危害生命财产安全，所谓「前事不忘，后事之师」；本署难以接纳该处以人手及资源所限，以及没有发现同类事故重复发生于相关船只为由，便决定不以「新机制」跟进该 22 项建议，这对本港海事安全可能构成风险。

(四) 有否「漏网之鱼」未获跟进建议的个案存疑

6.14 为响应本署要求查核以往跟进事故报告建议的情况，海事处耗时半年去整理旧记录，并再应本署其后的询问，确认有关记录准确无误。尽管如此，本署仍发现有六宗遗漏个案（见上文**第 4.10 段**），显示该处的记录明显混乱。直至本署将调查报告的初稿送交该处评论后，该处再次翻查记录并向本署提供该六宗个案的数据（上文**第 4.12 段**）。在「旧机制」下，该处没有系统地记录和跟进相关建议的落实进度，故此，是否仍有「漏网之鱼」的个案未获适切的跟进，亦成疑问。

本署的建议

6.15 鉴于以上所述，申诉专员敦促海事处：

（一）主动核查事故报告建议是否已获全面落实，而非只依赖相关机构或人士的汇报，并将此程序加入为跟进建议的常规步骤（见上文**第 5.6 段**）。

（二）适当跟进非香港注册船舶及非本地登记船只落实建议的情况（见上文**第 6.9 段**末句）。

（三）在保障海上人命安全的前提下，重新考虑以「新机制」跟进上文**第 6.10 段**所述的 22 项事故报告建议（见上文**第 6.13 段**）。

（四）考虑再次复核「旧机制」下的个案数据，避免**第 4.6、4.10 至 4.13 段**所显示的记录混乱情况重演，并确保有关事故报告的建议获适当跟进。

（五）定时检讨「新机制」下跟进事故报告建议的情况，确保达到预期的效果。

6.16 海事处接纳本署的建议，并已着手跟进。本署感谢该处在调查过程中予以合作，亦欣悉该处接纳本署的所有建议。本署会继续监察，直至该处全面落实建议。

申诉专员公署
档案：OMB/DI/334
二〇一六年六月

附錄

「旧机制」下多年后才作跟进的五宗个案

编号	意外类别	事发日期 / 所涉船只 / 调查完成日期	建议详情 (原文节录自有关事故报告)	跟进建议日期
(1)	船舶意外	4/6/2005 本地货船 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 本地风帆 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 中国货船 / 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.	
(4)	船舶意外	19/6/2006	1. A copy of the report should be sent to the China MSA for their information.	24/7/2014

编号	意外类别	事发日期 / 所涉船只 / 调查完成日期	建议详情 (原文节录自有关事故报告)	跟进建议日期
		香港高速客轮 / 中国船 2/3/2007	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 香港货船 / 韩国渔船 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, 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	

编号	意外类别	事发日期 / 所涉船只 / 调查完成日期	建议详情 (原文节录自有关事故报告)	跟进建议日期
			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.	

「旧机制」下「补回」跟进部分建议的 **11** 宗个案

编号	意外类别	事发日期 / 所涉船只 / 调查完成日期	建议详情 (原文节录自有关事故报告)	跟进建议日期
(1)	职业意外	11/1/2005 中国船 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 中国高速客轮 / 内地集装箱货船 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

编号	意外类别	事发日期 / 所涉船只 / 调查完成日期	建议详情 (原文节录自有关事故报告)	跟进建议日期
			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 中国高速客轮 / 本地非自航钢趸 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

编号	意外类别	事发日期 / 所涉船只 / 调查完成日期	建议详情 (原文节录自有关事故报告)	跟进建议日期
			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 两艘本地游乐船 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)	职业意外	1/2/2007 香港散货船 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

编号	意外类别	事发日期 / 所涉船只 / 调查完成日期	建议详情 (原文节录自有关事故报告)	跟进建议日期
			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 两艘 香港高速客轮 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)	职业意外	3/6/2007 本地非自航钢趸 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
(8)		13/9/2007	1. A copy of this report should be sent to the	21/10/2008

编号	意外类别	事发日期 / 所涉船只 / 调查完成日期	建议详情 (原文节录自有关事故报告)	跟进建议日期
	职业意外	本地非自航钢趸 / 本地拖船 24/9/2008	employer of crane operators of the *Lighter*, owner of the *Tug* and Shenzhen Maritime Safety Administration advising them the findings of this accident.	
			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 authority, i.e., the Shenzhen Maritime Safety Administration, should be called	9/10/2014

编号	意外类别	事发日期 / 所涉船只 / 调查完成日期	建议详情 (原文节录自有关事故报告)	跟进建议日期
			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)	工业意外	31/7/2010 中国货船 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 本地游乐船 27/7/2012	1. 本报告副本须送交游乐船 26749 号的船长，让他知悉这宗火警意外的调查结果。在船上进行玻璃纤维修补工作时，须时刻注意保持室内空气流通，以防易燃气体积聚。	7/8/2012
			2. 海事处须发出海事处布告，载述从这宗火警意外中汲取的教训，避免同类事故再次发生。	22/8/2012
			3. 这份报告的副本应送交船舶事务科，本地船舶安全部，以供参考。	13/8/2014
(11)	工业意外	1/7/2011 中国船 / 本地非自航钢趸 27/11/2012	1. 本调查报告副本须送交海事处船舶事务科海事工业安全组，以供考虑是否发出海事处布告，载述从这宗意外汲取的教训。	6/11/2012
			2. 本调查报告副本须送交海事处船舶事务科本地船舶安全组作参考。	
			3. 本报告副本须送交非自航钢趸"浩溢 1"的船东和工程负责人，以及中国籍货船"凯宏 8"的船东和船长，让他们知悉这宗意外的调查结	20/12/2012

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			果。	
			4. “凯宏 8”的船东须确保所有在船上参与集装箱处理工作的船长、高级船员和船员均知悉有关工作的风险。装卸货物的程序应予检讨，并 于检讨时考虑下列在本意外调查所发现的安全因素： • 有关人员应在每日工作开始之前向参与货物装卸作业的船员讲解安全事宜; • 应确保船上参与货物装卸作业的船员之间能够有效沟通; • 挂钩员攀上或攀下堆栈集装箱另一层时，应使用适当的梯子; • 挂钩员应在集装箱被起吊前尽快从集装箱顶部撤离至安全地方; 以及 • 避免利用吊机同时起吊两个集装箱。	
			5. “浩溢 1”的船东和工程负责人须检讨货物装卸程序，确保所有参与 货物装卸作业的人员安全，考虑事项包括： • 有关人员应在每日工作开始之前向参与货物装卸作业的船员讲解 安全事宜; • 应确保船上参与货物装卸作业的船员之间能够有效沟通; • 所有船员均应有充分休息; 以及 • 避免利用吊机同时起吊两个集装箱。	
			6. 本调查报告副本须送交广东海事局作参考。	24/7/2014

不以「新机制」跟进的 22 项建议

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(1)	船舶意外	28/3/2005 中国高速客轮 / 本地非自航钢趸 / 两艘本地拖船 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)	职业意外	8/5/2005 本地非自航钢趸 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 ● Wearing of slippers at work should not be	23/3/2006 22/6/2006

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			allowed, safety shoes should be worn.	
(3)	船舶意外	22/8/2005 本地货船 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 本地油趸船 / 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)	职业意外	16/11/2006 香港货船 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)	职业意外	11/3/2007 香港货船 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)	职业意外	4/3/2008 香港货船 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 inside cargo hold before entry into cargo	10/10/2009

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			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 香港货柜船 / 中国散货船 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 manoeuvring sound and light signal, in accordance with the COLREGS;	

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			● 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)	职业意外	19/5/2008 香港货柜船 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)	职业意外	27/7/2008 本地游乐船 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
			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

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(11)	职业意外	5/8/2008 香港散货船 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 香港货柜船 / 中国货船 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: ● 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	

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			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)	工业意外	13/1/2009 本地非自航钢趸 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 本地客轮 / 中国货船 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.	
(15)		23/8/2009	1. A copy of this report should be sent to the owners	28/10/2010

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	职业意外	两艘 本地非自航钢趸 / 本地拖船 18/10/2010	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.	
			*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)	工业意外	9/3/2010 中国货柜船 / 本地非自航钢趸 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; and ● ensure that all wire ropes used for the derrick	

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			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)	职业意外	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 本地木制工作船 / 本地拖船 / 本地非自航钢趸 21/6/2012	1. 本报告副本须送交下列人士/单位，让他们知悉这宗意外的调查结果： ● "Ng Mui"船长的家人； ● "Sun Lee 1"的船东及船长； ● "Hoi Lung No.88"的负责人； ● 海事处船舶事务科；以及 ● 海事处港口管理科。	27/8/2012, 28/8/2012

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			*2. 建议拖船“Sun Lee 1”的船东采取适当措施，确保其船长: ● 安排拖船和被拖船遵照《避碰规则》第 24 条的规定，在拖曳作业期间时刻展示适当的航行灯号 ； ● 遵照《避碰规则》第 5 条的规定提高警觉，执行瞭望工作，尤以在避风塘内拖曳船只时为甚 ；以及 ● 视力符合标准，必要时在航行期间使用助视镜。	28/8/2012
(19)	工业意外	9/4/2011 本地非自航钢趸 13/7/2012	1. 海事处须发出海事处布告，载述从这宗意外汲取的教训。	9/11/2011
			2. 本报告副本须送交“Kam Ying”的船东和工程负责人，让他们知悉这宗意外的调查结果。	10/1/2013
			*3. “Kam Ying”的船东和工程负责人须： ● 妥善评估装卸堆栈货物的风险，并采取预防措施把潜在风险减至最低；以及 ● 确保堆栈的货物时刻保持稳固，使货物处于稳定的状态。	
(20)	工业意外	27/3/2012 中国货船 / 本地非自航钢趸 27/11/2012	1. 本报告副本须送交以下相关人士和部门，让他们知悉这宗意外的调查结果： ● 航信 368 的船东和船长； ● 金洋 8 号的船东/工程负责人和起重机操作员； ● 海事工业安全组；以及 ● 航信 368 的注册机关-中国广东海事局。	2/1/2013
			2. 航信 368 的船东和船长，进行货物装卸工程时： ● 须确保船员不得停留在悬吊货物可能经过之处，以免因货物不正常摆动而受伤； ● 装卸双方应在进行货物装卸前先议定集装箱的装卸次序，不应 由重机操作员自行决	

编号	意外类别	事发日期 / 所涉船只 / 调查完成日期	建议详情 (原文节录自有关事故报告) (「*」表示在「新机制」下仍需跟进的建议)	跟进建议日期
			定； ● 在装卸过程时，应委派一名指定信号员，以确保处理吊货索的装卸工人和起重机操作员之间的有效协调和沟通； ● 装卸过程必须由讯号员指挥，并工作前与所有工作人员建立有效沟通渠道；以及 ● 确保船员前往或离开货舱时，使用适当的梯子。	
			*3. 金洋 8 号的船东和工程负责人，在货物装卸工程时： ● 装卸双方应在进行货物装卸前先议定集装箱的装卸次序，在未有双方协议前，不应由起重机操作员临时自由决定; ● 避免使用一四脚吊索同时吊运两个集装箱；以及 ● 起重机操作员在吊运集装箱时，必须时刻注意讯号员指示，切勿操之过急。	