THE GOVERNMENT MINUTE

IN RESPONSE TO

THE SIXTEENTH ANNUAL REPORT OF THE OMBUDSMAN

ISSUED IN JUNE 2004

Government Secretariat

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CONTENTS

	Page
Introduction	1
Part I – Investigated Cases	
Agriculture, Fisheries and Conservation Department	2
Architectural Services Department	12
Buildings Department	17
Correctional Services Department	23
Department of Health	28
Food and Environmental Hygiene Department	33
Government Property Agency	39
Government Secretariat – Education and Manpower Bureau	42
Home Affairs Department	48
Hospital Authority	52
Housing Department	65
Judiciary	74
Lands Department	76
Legal Aid Department	82
Leisure and Cultural Services Department	84
Marine Department	86
Social Welfare Department	89
Transport Department	92
Water Supplies Department	93
Part II – Direct Investigation Cases	
Enforcement of the Education Ordinance on universal basic education	98
Operation of the Integrated Call Centre	103
Assistance provided by the Home Affairs Department to owners and owners' corporations in managing and maintaining their buildings	108
Prevention of abuse of the Comprehensive Social Security Assistance Scheme	115
Handling of examination scripts under marking	128

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Introduction

The Chief Secretary for Administration presented the Sixteenth Annual Report of The Ombudsman to the Legislative Council at its sitting on 30 June 2004. The Administration undertook to prepare a Government Minute in response to The Ombudsman's Annual Report.

2. This Minute sets out the actions that the Administration has taken or intends to take in response to the cases in which The Ombudsman has made recommendations in her investigation reports. The cases referred to in Parts I and II of this Minute are those contained in Annexes 11 and 7 of the Annual Report respectively.

Part I
Investigated Cases

Agriculture, Fisheries and Conservation Department (AFCD)

Case No. 2002/1163：Misleading the complainant in her enquiry about her lost three-legged dog, which was euthanised at an Animal Management Centre in the course of her search.

3. The complainant lost a three-legged dog in February 2002. She called an Animal Management Centre (Centre A) under AFCD on 19 and 20 February 2002 but in response to her enquiry, the staff there said there was no record of such a dog. On 23 February 2002, the complainant learned from a voluntary organisation (the organisation) that it had handed over a three-legged dog to Centre A on 17 February 2002, but the dog had then been euthanised. The complainant thus went to Centre A to enquire again, but the staff insisted that there was no three-legged dog nor any record of one. However, when the complainant called Centre A on 25 February 2002, the staff there confirmed that a three-legged dog had been euthanised on 22 February 2002.

4. The complainant thus lodged a complaint with The Ombudsman in April 2002 against AFCD for misleading her in her enquiry about her lost three-legged dog.

5. After investigation, The Ombudsman noted that AFCD would normally fax details of animals reported lost to alert its four Animal Management Centres (AMCs). For the complainant's first call on 19 February 2002, it was made after office hours and hence was automatically transferred to the hotline of AFCD headquarters. Subsequently, staff A at AFCD headquarters called Centre A upon receipt of this call. However, the staff on duty at Centre A could not provide an answer. Staff A also sent a fax to all AMCs to enquire about the dog. Receipt of the fax document was recorded at two AMCs but not Centre A. In response to The Ombudsman's inquiry, staff B (the only staff on duty at Centre A at that time) claimed that he had not received any fax or telephone enquiry about a three-legged dog.

6. AFCD had also provided records from its mobile telephone service company, which showed that staff A did call Centre A. However, the Department could not ascertain whether his call had been answered by a staff member other than staff B. In any case, that staff member neither followed up nor recorded the enquiry.

7. In addition, AFCD had denied receipt of the complainant's second telephone enquiry on 20 February 2002. However, after carefully examining the investigation reports submitted by AFCD and on balance of probability, The Ombudsman was satisfied that the complainant did call Centre A the second time. The staff answered her enquiry based on the information at hand and did not record the call as a reported loss.

8. In any event, The Ombudsman had reservations over AFCD's careless attitude and practice. Moreover, the documents provided by AFCD and the organisation about the dog contained no description of it being three-legged. Their records were obviously too brief and rough.

9. On the other hand, had the dog been implanted with a microchip or carried some information on the owner, AFCD would have been able to trace its owner immediately and the outcome would have been different. The owner of the dog was, therefore, partly responsible for this incident. Overall, this complaint was substantiated.

10. AFCD has accepted and implemented The Ombudsman's recommendations as follows :

(a) AFCD has sent a written apology to the complainant;

(b) AFCD now requires all dogs be inspected on arrival at AMCs regardless of their origin. Their distinctive features will be recorded. AFCD will also record in its stray dog record book the location where the dog has been caught before it is sent to AFCD by the organisation;

(c) AFCD now requires all dogs sent in by the organisation to be accompanied with a new bi-lingual form in both Chinese and English to facilitate checking by AFCD staff (as some of the staff do not understand English). They have been instructed not to accept dogs

with incomplete information;

(d) 24 hours prior to the euthanasia of the animals, the officer-in-charge of the kennel management will compile a list of all the dogs to be euthanised to facilitate double-checking by the veterinary officer;

(e) prior to destroying animals, a check will be made to ensure that there is no dog on the missing dog list matching the description;

(f) AFCD has requested the organisation to provide reference numbers for cases so that these can also be added to AFCD's records;

(g) AFCD has cautioned its staff to write their full names and ranks when collecting dogs from the organisation to enable identification of the responsible officer who has collected the dogs; and

(h) whenever there is a missing dog enquiry, AFCD will ensure that visual checks are done on all dogs in all AMCs and a record is kept of this inspection. This is coordinated by a case officer responsible for handling the case and communicating with the owner.

Case No. 2002/3586：(a) Impropriety in the collection of dogs surrendered by the complainant; (b) Excessive use of force in the collection process; and (c) Providing the complainant with inaccurate information as to the time of euthanasia.

11. The complainant had requested AFCD to collect six dogs she wanted to surrender. She alleged that the Animal Management Team (the Team) of AFCD did not bring enough cages and so one of the puppies had to be put into the same cage with a strange big dog and was bitten to death. Furthermore, the Team had used dog-catching poles to loop and lead away three puppies, cruelly strangling them.

12. Later, the complainant called the AFCD hotline several times and indicated her intention to reclaim the dogs, but was told that all her dogs had already been euthanised. She said that she had not signed any documents to authorise the Department to euthanise her dogs. Moreover, different AFCD

staff gave her different answers as to the time of euthanasia. Their misleading information had cost her the chance of reclaiming her dogs.

13. The complainant lodged a complaint with The Ombudsman in October 2002 against AFCD for :

(a) impropriety in the collection of dogs surrendered by her;

(b) excessive use of the force in the collection process; and

(c) providing her with inaccurate information as to the time of euthanasia.

14. Regarding complaint point (a), AFCD pointed out that the Team had brought three large dog cages and a small one for the occasion. Two of the large cages had been occupied by two dogs collected from elsewhere that day. After putting two of the dogs surrendered by the complainant into two empty cages, the Team suggested that they would return with more cages the next day for her four remaining dogs. However, the complainant insisted that the six dogs should be collected together. Therefore, the Team put a puppy into the cage with a sick big dog and followed the complainant to her premises to collect the other three which had to be caged with other dogs.

15. AFCD clarified that except for biter dogs which must be segregated, there was no specific rule to put each dog in a separate cage. The Team leader claimed that he had kept an eye on the cages. There was no fighting among the dogs in the same cages and no puppy bitten to death. Nevertheless, in view of the complainant's express request for collection of six dogs, The Ombudsman considered that the Team should have brought enough cages. Hence, they had not properly prepared themselves for the collection.

16. The Team leader stressed that he had explained to the complainant that her dogs would be euthanised and had asked her to sign the Authorisation of Animal Disposal form (Authorisation). However, claiming that she was not feeling well, she did not sign it. Hence they left with the dogs. AFCD considered this acceptable as the complainant, though agitated at the time, had given verbal consent to the Department to handle her dogs.

17. The Ombudsman considered that signed Authorisation is required as it

would avoid dispute and prove that the owner knew that the animals would be euthanised. It was improper and unwise of the Team to collect the complainant's dogs without her signing the Authorisation. Moreover, AFCD should formulate detailed guidelines on animal-collection procedures. Complaint point (a) was substantiated.

18. As for complaint point (b), the Team leader stated that they did not use excessive force while leading the three puppies away with dog-catching poles, let alone strangled them. Records in the AFCD Register for Surrendered Animals showed that the six dogs of the complainant were still healthy upon arrival at the Animal Management Centre. Before performing euthanasia, the veterinary officer did not find any of the dogs injured or dead. This complaint point was therefore unsubstantiated.

19. Concerning complaint point (c), the complainant called the AFCD hotline the day after the collection and left a message. AFCD staff returned the call, learned that she wanted her dogs back and told her the dogs had already been euthanised that morning before she called. The complainant telephoned the hotline again several times and went to AFCD to enquire about her dogs on the following days. Two other AFCD staff told her that her dogs were euthanised in the afternoon of that day. She considered herself to have been misled by inaccurate information and thus failed to reclaim her dogs.

20. The Ombudsman's investigation confirmed the time of euthanasia to be in the morning after collection and before the complainant's first call. So, the two AFCD staff had indeed provided wrong information but this did not affect her chances of reclaiming her dogs. As such, complaint point (c) was partially substantiated.

21. Overall, this complaint was partially substantiated.

22. AFCD has accepted The Ombudsman's recommendations and taken the following actions :

(a) AFCD has issued a verbal warning to the staff who had conveyed the wrong message and apologised to the complainant both for improper collection procedures and for the conflicting information in reply to her enquiry;

(b) AFCD has reminded staff of the Animal Management Centres (AMCs) to be aware of the proper procedures when receiving and handling surrendered dogs and to bring enough empty cages. AMCs have purchased additional folding cages in case extra storage is necessary;

(c) AMCs staff will inspect related documents when receiving surrendered dogs. Veterinary officers will make sure that the Authorisation is properly signed before destroying the animal; and

(d) AFCD has reviewed the procedures of collection of surrendered dogs and other pets and formulated detailed guidelines and notices for all staff undertaking these duties to ensure that they fully understand the correct procedures and to prevent the recurrence of similar cases.

Case No. 2003/0945：Delay in processing an application for Livestock Keeping Licence for quails.

23. In October 2001, AFCD wrote to all quail farmers outlining the draft regulations requiring the segregation of quails, advising farmers to shift production to avoid economic losses and that they could apply for assistance. The letter outlined the ex-gratia allowance (EGA) rates and stated that EGA would only be granted to those who ceased quail production and demolished the farm structures.

24. In February 2002, the complainant applied for EGA. In March 2002, AFCD advised her that the application for EGA was approved and if she wished to restart livestock keeping, she needed to apply for a new licence and must have the prior approval of the District Lands Office (DLO) of the Lands Department (Lands D) to build any structures in her farm. A copy of the letter was sent to DLO for reference. Subsequently, the complainant collected the EGA payable to her and surrendered her Livestock Keeping Licence (LKL).

25. In June 2002, AFCD received an application from the complainant to keep 30,000 quails at the same location. AFCD staff advised her that she needed to seek the approval of DLO to rebuild the sheds. In July 2002, DLO

received a letter from the complainant applying for a Letter of Approval to alter the existing unauthorised farm structures for raising quails.

26. In August 2002, AFCD requested the complainant to provide a selling plan for the quails and a copy of the approval from DLO for rebuilding the sheds. AFCD also advised her that AFCD was amending the licence conditions for keeping quails. The complainant then wrote to AFCD describing her marketing strategy for the quails as well as the potential purchasers. At the same time, AFCD wrote to DLO and asked if the rebuilding of sheds had been approved.

27. In September 2002, AFCD requested the complainant to provide confirmation of demand by her potential purchasers and also advised the complainant that DLO had been requested to advise on the farm structures. In November 2002, AFCD informed the complainant of the licence conditions for keeping quails. Conditions included requirement for metal cages; buyers of quails to be approved by AFCD; records of sales to be kept; notification to AFCD if there were abnormally high death rates in any batch; and equipment must be disinfected and spelled between batches.

28. In December 2002, DLO advised AFCD that they would not entertain the application to regularise the structures unless AFCD agreed and the structures were covered by a LKL. After AFCD learned that DLO had not issued any approval letter to the complainant, AFCD repeatedly warned the complainant not to carry out any works prior to obtaining approval from DLO.

29. An outbreak of avian influenza occurred in wild birds for the first time in Hong Kong in late 2002. To minimise the risk posed to both the local poultry industry and public health, the licence conditions for keeping quails and other poultry were reassessed. One of the additional requirements was that new applications for keeping any poultry species must locate the premises to be licensed at least 500 metres from the existing licensed poultry premises with effect from early 2003.

30. On 20 January 2003, having misunderstood DLO's requirements relating to the processing of the application, the complainant sent a sketch of the farm structures, the owner's consent and rent receipt to DLO. On 29 January 2003, AFCD staff inspected the structures which the complainant had

requested to be licensed and advised her that only part of the structures met the biosecurity requirements. Subsequently, AFCD was advised by the potential quail purchasers proposed by the complainant in March 2003 that due to the outbreak of avian influenza, they were no longer seeking a supply of quails.

31. As AFCD had not issued her a LKL ten months after her application, the complainant lodged her initial complaint with The Ombudsman in April 2003 against AFCD for its unreasonable delay in issuing her a LKL.

32. On 7 May 2003 AFCD wrote to the complainant advising that her application for a LKL would not be granted. The reasons given were as follows :

(a) no approval was received from DLO for building the sheds;

(b) potential purchasers proposed by the complainant no longer wanted the supply of quails; and

(c) close proximity of the farm concerned to other poultry farms.

33. The Ombudsman then received another complaint letter from the complainant on 28 May 2003 rebutting the three reasons given by AFCD for rejecting her application and complained against AFCD and Lands D for delaying and rejecting her application for a LKL.

34. After investigation, The Ombudsman observed that AFCD and Lands D held different views on whether an approval from the latter was needed for the issue of a LKL. AFCD opined that it was necessary while Lands D opined that it was not. AFCD admitted that the two Departments had agreed at a meeting in 1998 that, when dealing with LKL related matters and illegal agricultural structures, AFCD would assume that Lands D did not object to an application under process if it received no notification of objection from Lands D within three months from the date of application. Nevertheless, AFCD added that requiring those licence applicants (including the complainant) who had received EGA to seek Lands D's approval was a special condition. The Ombudsman commented that AFCD, although having informed the complainant that she was required to obtain prior approval from Lands D to facilitate its consideration of her application, had failed to discuss with, or even

informed Lands D of this special condition and how to resolve the problems arising from the implementation of this special condition.

35. The Ombudsman commented that whilst an application was under consideration, AFCD no doubt had to take into account public health issues and examine the applications to see whether the conditions were completely fulfilled, including those strict biosecurity requirements. Hence, there was nothing wrong with the decision made by AFCD not to issue a LKL to the complainant. However, imperfection was noted in the process of handling the application. Therefore, the complaint against AFCD was substantiated.

36. The Ombudsman also commented that there was nothing wrong with Lands D for adhering to the 1998 agreement but Lands D did not act appropriately in giving its reply only in December 2002, i.e. four months after receiving AFCD's enquiry in August 2002. Besides, the complainant submitted some information in support of his application in January 2003. Lands D should have noticed that there might be some misunderstanding. Nevertheless, it did not take the initiative to offer explanations to the complainant or give any remarks with regard to the information given. The complaint against Lands D was thus partially substantiated.

37. In response to The Ombudsman's recommendations, AFCD and Lands D have taken the following actions :

(a) AFCD and Lands D have agreed on a one-stop-service operational mode in handling the issue of Letter of Approval so as to eliminate the grey area existing in this span of duty between the two Departments. The new procedures have taken effect from 1 May 2004. From then onwards, applicants will not be required to separately approach two Government Departments. All applications for Letter of Approval will be processed and vetted by AFCD. When AFCD is satisfied that an applicant is a genuine farmer and the structures under application are essential for agricultural purpose, the case will be referred to Lands D who will issue the Letter of Approval and pass it back to AFCD for delivery to the applicant;

(b) AFCD has reviewed the policy of granting LKL to quail keeper receiving EGA for business cessation and the findings were as

follows –

(i) it has been the Government policy that a quail keeper receiving EGA for business cessation would not be granted a LKL for quail farming at the same location;

(ii) since EGA was offered to quail farmers as if the land on which the farm stood was resumed, and as EGA had already been paid to the complainant after she had chosen to wind up her quail farm operation, it would not be in line with the Government policy to consider her quail farm licence application again. The decision to process the application was therefore an oversight and a misinterpretation of the policy in the implementation process; and

(iii) the application procedure was further compounded by development and changes to the licensing conditions and requirements in the light of the avian influenza outbreak in 2002. AFCD therefore took more time to process the application; and

(c) in view of the current heavy workload situation and the reduced number of staff, Lands D is reviewing the practicality of setting specific time limits for handling different approval letters and licences. Lands D has reminded and will continue to remind its staff of the customer-oriented principle in handling applications.

38. It is also worth noting that AFCD has now temporarily suspended the processing of LKL applications for quail farming. All such applicants will be advised accordingly when they submit applications. In addition, AFCD has reviewed the implementation of the policy for granting EGA to quail farmers to ensure that similar incidents will not arise in the future.

Architectural Services Department (Arch SD)

Case No. 2002/2484：Impropriety in handling an application to include a water-proof product in the approved list of Arch SD.

39. The complainant was the general manager of a waterproof material decorate company. He made an enquiry to Arch SD in August 2001 regarding the procedures necessary for the inclusion of a waterproof material in "Arch SD list of Acceptable Materials", which is a list intended for Arch SD's internal use only.

40. The complainant first submitted the information for application to Arch SD in November 2001. However, Arch SD did not proceed with the processing of the application as expected. He thus lodged a complaint with The Ombudsman in August 2002 against Arch SD for impropriety in handling his application to include a water-proof product in the approved list. He pointed out that Arch SD's investigation officer had, on several occasions, verbally promised to give him a reply within a short period of time, but no written response had been received from Arch SD.

41. After investigation, The Ombudsman has noted that there are many new materials submitted for application for inclusion in "Arch SD List of Acceptable Materials" every day, and these applications are dealt with by officers who handle these investigation duties on a part-time basis only. Nevertheless, the Arch SD officer concerned had failed to provide a timely written response to the complainant's application. On the other hand, the processing was delayed mainly due to the fact that the information submitted by the complainant was incomplete for assessment. In particular, the proof of official authorisation from the original product manufacturer was missing. In view of the above, the complaint was considered as partially substantiated.

42. Arch SD has accepted and implemented The Ombudsman's recommendations as follows :

(a) a letter of apology has been sent to the complainant on 6 November 2003; and

(b) Arch SD has reviewed the application procedures on the inclusion of materials in "Arch SD List of Acceptable Materials". Its Technical Instruction on "Procedure for the Application for Inclusion on to the Arch SD List of Acceptable Materials" has been revised and issued for internal circulation on 17 May 2004. The application procedures are now available on the Arch SD website.

Case No. 2003/0649：Failing to provide prompt and appropriate services to an aided school in the back-flow of sewage into its lift pit on three occasions.

43. The complainant, an aided school, was situated within a Home Ownership Scheme (HOS) estate, the Owners' Corporation of which had yet to be formed. The Housing Department (HD), as the agent of the Hong Kong Housing Authority (HA) to execute the Deed of Mutual Covenant, was responsible for supervising the estate management company's day-to-day performance. According to the contract, the management company was required to inspect the public drainage in the estate once a month and to carry out dredging or maintenance as necessary. However, the responsibility of maintaining the school premises had been entrusted by the Education and Manpower Bureau (EMB) to Arch SD. In accordance with EMB's guidelines, the school should fax an application to Arch SD direct with a copy to EMB for emergency repairs. Upon receipt of such application, Arch SD staff would visit the school for investigation. Should the repair cost be less than $3,000, the school would have to arrange and pay for the works. Nevertheless, Arch SD was responsible for providing professional assessment and technical advice.

44. On 19 March 2002, back-flow of sewage into the school's lift pit occurred for the first time and caused damage to the lift. This was due to blockage of a public drain in the estate. The school notified Arch SD. Later, on learning that the drain was under HD management, the school sought compensation from HD for repair of the lift. HD immediately directed the management company to check the drain and to refer the school's claim to HA's insurance company. In October 2002, the notary public appointed by the insurance company explained to the school that since the blockage had been caused by reckless disposal of construction waste by tenants or workers, the insurance company would not pay for the repair. Nevertheless, to prevent

recurrence, HD instructed the management company to step up inspection of the public drainage to twice a month and to post notices in the building lobbies and distribute leaflets to residents on the proper use of drains.

45. On 27 and 29 January 2003, similar incidents occurred in the school and it notified Arch SD and HD immediately. The management company promptly arranged dredging and cleaning up. It further issued notices to remind residents to use the drains properly.

46. On the other hand, Arch SD officer visited the site the next day after the first incident and found the blockage in the public drain had been cleared by the Drainage Services Department. As the trapped effluent had subsided, he closed the case.

47. The school asked Arch SD several times for advice on a permanent solution to the problem. The Arch SD officer suggested that the school should block the drainage outlet at the bottom of the lift pit. However, he added that he was not sure whether such blockage would violate any regulations and that it could only be an interim measure. He also refused to carry out the works for the school because it cost less than $3,000. After three months and on HD's recommendation, Arch SD finally agreed to block the outlet in question.

48. In view of the incidents, the complainant lodged a complaint with The Ombudsman against :

(a) HD for shirking responsibility in the back-flow of sewage into the lift pit of the school on three occasions, and failing to follow up the blockage of public drainage to prevent recurrence of back-flow of sewage; and

(b) Arch SD for failing to provide prompt and appropriate services to the school in the back-flow of sewage into the lift pit of the school on three occasions.

49. After investigation, The Ombudsman found that HD had actively followed up all three incidents of back-flow and had not shirked its responsibility. The complainant against HD was therefore unsubstantiated.

50. On the other hand, The Ombudsman found no specific instructions in Arch SD's guidelines or performance pledge to advise its staff on how to handle applications from aided schools for repairs. Notwithstanding, The Ombudsman considered the Arch SD officer's service attitude passive and lacking in enthusiasm. The "professional advice" given to the school by the Arch SD officer was also vague and perfunctory. Therefore, the complaint against Arch SD was substantiated.

51. HD and Arch SD have fully accepted and implemented all The Ombudsman's recommendations as follows :

(a) HD has instructed the Property Management Agent of the relevant HOS estate to inspect the concerned drain at least once a week upon receipt of the renovation application from the occupants in the estate in order to identify possible blockage at an early stage. HD would also arrange to carry out "television survey" of the concerned drain if necessary;

(b) HD has instructed the Property Management Agent of the HOS estate concerned on 17 October 2003 to forward the school's claim to HOS estate owners' public liability insurance company for follow-up action. HD has also instructed the Property Management Agent that if there are similar insurance claims in the future, they should be directed to HOS estate owners' public liability insurance company and Property Management Agent's insurer for handling. In parallel, such claims should also be given to HA's insurer for necessary action;

(c) Arch SD has reviewed and revised the guidelines and performance pledge on the procedures and handling of the emergency repair service. The guidelines have been agreed by EMB and issued on 9 March 2004. The improvement measures in the revised guidelines and procedures include –

  (i) Arch SD staff should, on receipt of verbal or written emergency repair request from subvented schools, accord priority according to the degree of urgency of the request and arrange site investigation to assess the extent of repair works required as soon as possible;

(ii) if inspection cannot be carried out immediately, staff should inform the school and make appointment for subsequent site inspection;

(iii) site supervisory staff should seek advice from professional staff in case they have doubt on technical or statutory issue;

(iv) all advice given should be clear, accurate and professional in nature; and

(v) staff should take a proactive attitude in dealing with all emergency repair request; and

(d) Arch SD has issued a letter of apology to the complainant on 21 October 2003.

Buildings Department (BD)

Case No. 2002/3267：Failing to update the complainant's correspondence address as requested.

52. In 2000, BD sent two letters to the complainant for the urgent removal of a canopy on the external wall of his premises. As the letters had been sent to his old address, he wrote to BD to request an update of his correspondence address. BD thus updated its records and sent the letters to the new address.

53. However, in 2002, when BD issued another order for the removal of unauthorised building works (UBWs) in the complainant's premises, the letter was again sent to his old address. On his enquiry, BD staff told him that information on the owner was provided by the Land Registry (LR). The complainant then called LR to request a change of his correspondence address but LR refused, stating that it was BD's responsibility to update the records. The complainant was dissatisfied and lodged a complaint with The Ombudsman against BD in September 2002 for failing to update his correspondence address as requested.

54. After investigation, The Ombudsman noticed that the Land Registrar was not empowered by the Land Registration Ordinance to change or update any information on the registration documents in LR. In this case, BD had recorded the new address of the complainant in the relevant files upon receipt of the complainant's request for updating his correspondence address. However, as the case regarding the urgent removal of the canopy in 2000 and the one regarding the order for the removal of UBWs in 2002 were in two separate files and were handled by different units in BD, the officer responsible for issuing the latter order was not aware of the change of address. BD regretted the inconvenience caused to the complainant. At the same time, BD staff had been reminded to check whether individual owner had changed the address when handling old file records.

55. To avoid similar complaints in the future, LR held a meeting with other departments to remind them that owners' addresses in the registration documents might not be the most up-to-date. A remark to that effect would be added to the Reports-on-Title provided to various departments concerned and

the registration date of the documents with the address would also be indicated.

56. Based on the above, The Ombudsman considered that the complaint against BD was partially substantiated.

57. BD has accepted and implemented all the recommendations of The Ombudsman as follows :

(a) in response to The Ombudsman's recommendations, BD has already reminded their staff in the Existing Buildings Divisions by e-mail on 6 December 2002 and 2 August 2003 to update ownership information in the Building Condition Information System (BCIS) upon receiving any new ownership information from owners, and to explain to owners the ambit of LR. These recommendations have already been developed into departmental working procedures. Guidelines are now available in the department's Manual for reference of BD staff;

(b) as BD staff have already been reminded to update BCIS upon receiving any new ownership information, a check in BCIS will enable them to obtain the most updated information available in the Department's records for issuing orders. In addition, BD staff will also check the relevant files which are readily available to ensure that the most updated ownership information are used;

(c) regarding The Ombudsman's proposal to obtain the latest correspondence addresses of building owners from other channels, BD is now actively studying and discussing with the Efficiency Unit whether BD may participate in the on-line "Easy Change of Address" system being implemented by EU; and

(d) BD has already issued circular to its staff to improve the communication among sections to ensure that enforcement work by the respective sections is taken in a coordinated manner.

Case No. 2002/4085：Delay in the issue of dangerous slope repair order to property owners.

58. The Geotechnical Engineering Office (GEO) recommended to BD on 11 February 2000 that a Dangerous Hillside Order (DH Order) be issued to the owner of a slope. Having followed the stipulated guidelines and verified the ownership and the maintenance responsibility of the slope, BD issued a DH Order on 24 October 2000. On the other hand, the complainant and another person entered into a provisional sale and purchase agreement in May 2000 for the purchase of the concerned property. The transaction was completed on 18 September 2000. The complainant and another owner thus acquired the ownership of the slope related to the concerned property. Subsequently, BD received a notice from the former owner advising that the ownership had changed. BD thus issued a new DH Order to the new owner on 5 December 2000.

59. Having received the DH Order, the complainant claimed that he had made written enquiries to BD in mid-2001 and May 2002 respectively, but did not receive any prompt reply. The complainant was of the view that if BD had promptly implemented the recommendations of GEO to issue the repair order, he and the other person might have been aware of the risks and maintenance responsibility of the slope earlier, which would affect their decision to purchase the property. The complainant thus lodged a complaint with The Ombudsman in November 2002 against BD for :

(a) delay in and wrong issue of a DH Order; and

(b) delay in replying to his enquiries about the DH Order.

60. After the investigation, The Ombudsman considered that after receiving the recommendation from GEO, BD had promptly responded by verifying the property ownership and land boundary issue. As slope repair works usually involved complicated issues regarding legal responsibilities and substantial costs for the repair works, BD had to carefully liaise and consult other departments to avoid disputes over the responsibilities to carry out repair. This process would take some time and there was therefore no evidence of delay. Complaint point (a) was not substantiated.

61. However, The Ombudsman considered that BD could further simplify the procedures for ownership checking and slope boundary clarification with a view to expediting the issue of orders. BD should not have relied on outdated ownership information, which resulted in the wrong issue of the repair order to the former owner. This clearly pointed to the need for improvement in the relevant procedures.

62. Regarding the failure to respond promptly to the written enquiries of mid-2001 and May 2002, The Ombudsman had checked BD's record and it revealed that BD had not received any written enquiry from the complainant in mid-2001. Regarding the enquiry received in May 2002, owing to the change in staffing, the new case officer only started to contact the owner in mid-July 2002, which was not in line with the performance pledge and resulted in obvious delay in the process. BD finally provided the reply only when the complainant made a further telephone enquiry in August 2002. Therefore, complaint point (b) was substantiated. On the whole, the complaint was partially substantiated.

63. BD has taken the following actions in response to The Ombudsman's recommendations :

(a) BD has been conscious of the need to simplify the ownership search procedures in order to expedite the issue of statutory orders. In this connection, BD is a member of the Land Registry Customer Liaison Group set up by the Land Registry (LR). The Group discusses matters relating to the services provided by LR to Government departments including ownership search procedures. If BD identifies any improvement measures, they are put forward to the Group for consideration.

    In February 2003, BD established with LR a simplified way of ownership search (Counter Search Services). This service has simplified the process for checking if there is any change in ownership. Separately, in order to ensure the effective co-ordination between BD and other Government departments in dealing with slope repair works, BD also attends a number of standing co-ordination conferences with GEO and other departments concerned on a regular basis;

(b) BD has written to the complainant on 11 September and 15 September 2002 to apologize for not promptly serving a repair order on the complainant, and for BD's late reply to the enquiries made by the complainant;

(c) guidelines have been included in the Slope Safety Section Manual, reminding staff of the need to re-confirm ownership records in order to verify whether there is any change of ownership owing to a lapse of time;

(d) guidelines on making interim reply have already been provided in the BD Handbook. Staff are reminded to follow the guidelines when making replies; and

(e) the requirements for preparing handover notes in the event of a change of posting are specified in the BD Handbook and incorporated in the Slope Safety Section Manual. Staff have been reminded to adhere to the requirements.

Case No. 2003/0981：Failing to issue advisory letters and removal orders concurrently on three items of unauthorised building works in the same property.

64. The complainant lodged a complaint with The Ombudsman in April 2003 that between June 2002 and March 2003, BD had issued separate advisory letters and removal orders on three different items of unauthorised building works (UBWs) in the same property. As a result, he could not arrange for concurrent demolition, resulting in a waste of his time and money. The three items of UBWs were flower rack and canopies attached to the external wall, a rooftop structure and an outward swinging metal gate obstructing the means of escape.

65. BD explained that the three UBWs came under the purview of three different sections of the Department: Existing Buildings Division (EB Division), Illegal Rooftop Structures Unit (IRS Unit) and Fire Safety Section (FS Section).

66. In May 2002, FS Section issued advisory letters to all flat owners of the complainant's building, advising them to "remove any UBW". In June 2002, IRS Unit and EB Division coordinated the issue of an advisory letter to demolish the rooftop structure and an order to remove the UBWs attached to the external wall. In November 2002, FS Section issued an advisory letter to the complainant's outward swinging metal gate. Finally, IRS Unit served a removal order in respect of his rooftop structure in March 2003.

67. The Ombudsman considered that IRS Unit and EB Division had worked together in issuing their order and advisory letter concurrently and such coordinated efforts should be encouraged. However, FS Section did not issue its advisory letter at the same time and the contents of the letter were vague. As an enforcement agent, BD should try to assist owners to understand and comply with the statutory requirements while carrying out the work to ensure public safety and protect property. BD should also minimise the nuisance to owners and avoid wasting their resources. Therefore, the complaint was partially substantiated.

68. BD has taken the below follow-up actions in response to The Ombudsman's recommendations :

(a) clear instructions and guidelines have been issued for all sections to co-ordinate their enforcement actions as far as possible, so as to minimise any disturbance and inconvenience to the owners and occupants affected; and

(b) in case BD needs to advise building owners to remove UBWs in common areas affecting fire safety, a standard letter listing the types and locations of the UBWs required to be removed will be issued.

Correctional Services Department (CSD)

Case No. 2002/3445：(a) Failing to fulfill a promise to set up a religious choir after the complainant had provided musical instruments and associated items; and (b) Forcing him to donate musical instruments and associated items.

69. The complainant was a prisoner and used to be a member of a voluntary music group in a prison. He alleged that from 1999 to 2002, a CSD officer had requested members of the music group, including him, to purchase musical instruments. The complainant had entrusted a friend to purchase musical instruments and books, then donated or lent to the prison, in the name of an association, for use by prisoners inside the prison. The complainant claimed that the CSD officer had promised to set up a religious choir by October 2002 if musical instruments were donated to the music group. In the end, the choir was not set up and the complainant said that he had been removed from the music group.

70. The complainant lodged a complaint with The Ombudsman in October 2002 against CSD for :

(a) failing to fulfill a promise to set up a religious choir after he had provided musical instruments and associated items; and

(b) forcing him to donate musical instruments and associated items.

71. The Ombudsman had obtained information from two priests of the association and the prisoner's friend. No evidence could be found to support the allegation that the CSD officer had promised to set up a religious choir in exchange for donation made by the complainant. Complaint point (a) was thus unsubstantiated. There was also no evidence to show that the staff concerned had forced the complainant to donate musical instruments and associated items. Therefore, complaint point (b) was unsubstantiated as well. Overall, this complaint was unsubstantiated.

72. Nevertheless, The Ombudsman believed that the staff did know that the donated items were actually financed by the complainant, yet he did not

report the incident to the institutional management and failed to record the items received in detail. According to CSD's record, the Department only took over a batch of musical instruments which the association had applied to lend to the Department in June 2001. However, the record in respect of all the musical instruments and associated items received from the association by the staff under complaint was incomplete.

73. The Ombudsman considered that the officer-in-charge of the music group, in the course of organising prisoner-participating activities, should handle articles deposited by prisoners cautiously. If such articles were not exclusively used by the prisoner himself but for the joint use of the music group, the prisoner would be, in essence, sponsoring CSD activities. In any event, the officer concerned should comply with section 18 of the Prisons Ordinance and rule 74 of the Prison Rules by seeking prior approval from the Commissioner of Correctional Services. If the management deemed it appropriate to accept such articles, they should be properly kept and recorded. It should also be specified that the prisoner owning such items could withdraw them at any time. The Ombudsman reckoned that this could prevent any inconsistency in the management's records and avoid any perceived conflict of interests.

74. Following The Ombudsman's recommendations, the musical instruments lent to CSD by the association have been properly recorded after obtaining approval. As for components/spare parts brought in by the association from time to time to cater for wear-and-tear of the musical instruments in use, since such replacement takes place in the presence of CSD officers' supervision, no record for such accessories as to quantity or otherwise is considered necessary. Separately, guidelines governing the procedures for handling articles deposited or donated by any person, including articles handed in by prisoners, are already in place and are considered sufficient.

Case No. 2002/4566：(a) Falsely representing to the Security Bureau that all records relating to the complainant had been destroyed; (b) Failing to comply with Prison Rule 11 in handling his property; (c) Failing to record his request for getting back part of his property; and (d) Misleading the court.

75. The complainant was suspected of committing an offence and arrested by the Police. Since 21 August 1996, he was remanded in CSD's custody. On 5 September 1996, the complainant was granted bail by the court. He subsequently requested CSD to retrieve $500 which was received and kept earlier to pay for the sum due by the recognizance. However, CSD told him that the Department had not received and kept any of his property. In fact, his property had been received and kept by a court but not CSD. CSD had also contacted the court concerned to enquire on this matter. The complainant was dissatisfied and claimed that when he was remanded in CSD's custody in August 1996, CSD had not followed rule 11 of the Prison Rules regarding the keeping of a prisoner's property, compiled a list of his property for the Judiciary Administrator to enforce the payment of the sum due by the recognizance. Also, CSD had not recorded his request for using the $500 kept for paying the sum due by the recognizance.

76. On 10 September 1996, the complainant attended court due to another case. He claimed that CSD had submitted a report to the court saying that he had never been granted bail in the past suspected cases. Therefore, the magistrate at that time did not grant bail to him.

77. In June 2000, for the purpose of investigating a complaint by the complainant against the Police, the Police requested CSD to provide information to prove that the complainant had requested to get back his property during a certain period in 1996, and to provide details of the arrangement made by CSD in order to get back his property from the court. In August 2000, CSD gave a reply to the Police claiming that the relevant record in respect of the complainant's request to get back his property could not be found. After knowing this, the complainant was dissatisfied and lodged a complaint with the Chief Executive and Security Bureau (SB) against the Police and CSD in May 2001 on matters related to their handling of his personal property while he was remanded in custody. Based on the information provided by CSD, SB gave a reply to the complainant in June 2001

stating that "the relevant record had been destroyed".

78. Subsequently, the legal representative of the complainant requested information from CSD regarding a case of the Small Claims Tribunal, and the requested information included the record in respect of the complainant's request to get back his property from CSD during a certain period in 1996. CSD gave a reply to the legal representative of the complainant that the Department possessed those information. Therefore, the complainant came to know that those records had not been wholly destroyed. He thus lodged a complaint with The Ombudsman in December 2002 against CSD for :

(a) falsely representing to SB that all records relating to him had been destroyed;

(b) failing to comply with rule 11 of the Prison Rules in handling his property;

(c) failing to record his request for getting back part of his property; and

(d) misleading the court.

79. Having studied the correspondence between SB and CSD, The Ombudsman inferred that CSD had indeed informed SB that the records in respect of the complainant had been destroyed. The Ombudsman opined that if CSD could thoroughly and carefully checked the records maintained by the Department from the outset, the Department should have found those information. Therefore, complaint point (a) was substantiated.

80. Regarding complaint points (b) and (c), The Ombudsman had accepted CSD's explanation that since the Department had not received any property belonging to the complainant, rule 11 of the Prison Rules should not be applicable. Furthermore, request made by the complainant about retrieving part of his property could be found in CSD's record. Therefore, complaint points (b) and (c) were unsubstantiated.

81. As for complaint point (d), The Ombudsman was of the view that the complainant had not provided substantive evidence to prove that CSD had misled the court. Moreover, misleading the court was a question of law and

did not fall under The Ombudsman's jurisdiction. Hence, complaint point (d) was unfounded. Overall, this complaint was partially substantiated.

82. Following The Ombudsman's recommendation, CSD has promulgated relevant instruction to remind its staff that they should exercise caution and care in handling all enquires and should discuss with the Heads of Institutions concerned before making replies.

Department of Health (DH)

Case No. 2002/1879：Impropriety in verifying personal identity documents.

83. The rates of charge of general outpatient services were published in the gazette. Eligible Persons would be charged at a lower rate than Non-eligible Persons. DH had issued a Standing Circular setting out the valid documents for checking in order to identify Eligible Persons for service units to follow in determining the rate of charge.

84. The complainant's wife was a visitor from the Mainland. In 2002, she visited the complainant who is a Hong Kong resident. In May 2002, the complainant accompanied his wife to seek consultation at a general outpatient clinic. At the registration office, the relevant documents including the complainant's Hong Kong Identity Card were checked and the complainant's wife was confirmed to be eligible for the rate of charge applicable to Eligible Persons. To remind patients to bring along the required documents for subsequent consultations, staff of the registration office specified on the follow-up card of the complainant's wife that the documents required included, among others, the complainant's Hong Kong Identity Card.

85. In June 2002, the complainant's wife sought consultation from the same clinic again. Staff of the registration office, acting in accordance with the departmental circular, requested her to present the required documents including the complainant's Hong Kong Identity Card. She produced the required documents except for the complainant's Hong Kong Identity Card. The staff then exercised flexibility and informed her that a photocopy of the Hong Kong Identity Card would also be accepted. Unfortunately, she did not have a photocopy. Subsequently, the complainant faxed a copy of his Hong Kong Identity Card to his wife and consultation was provided to her at a rate applicable to Eligible Persons. The complainant then lodged a complaint with The Ombudsman against DH in July 2002 for impropriety in verifying personal identity documents.

86. After investigation, The Ombudsman considered that the staff of the registration office had acted according to the relevant Government policy and departmental procedure. As such, this complaint was not substantiated.

87. Due to a change in Government policy, spouses of holders of Hong Kong Identity Card, if they are not themselves holders of Hong Kong Identity Card, are no longer qualified for the rate of charge applicable to Eligible Persons with effect from 1 April 2003. In response to the policy change, DH has issued a Standing Circular on 31 March 2003 to inform staff of the new policy, the changed definition of Eligible Persons and the requirement to display a note for patients seeking public health services informing them of the valid documents they need to bring along for assessment of their eligibility status.

Case No. 2003/0422：(a) Unfair queuing system in the out-patient service of a public clinic; (b) Lack of appropriate guidelines to determine if extra outpatient service should be provided when the day's quota was exhausted; and (c) Improper handling of the complaint by a nursing staff.

88. In principle, consultation chips of the general outpatient clinics were allotted on a "first come, first serve" and "one person, one chip" basis. However, if a person could produce the identification documents of a sick person and had reasonable grounds for the latter's failure to come and queue personally for the chip, like in the case of an elderly person with walking difficulties or a very young child, that person would be given at most one more chip.

89. The number of chips to be allotted each day would be displayed on the notice board in every clinic. Before the allotment started, the clinic staff would count the number of people and proxies queuing for chips. Those waiting near the end of queue would be alerted as soon as possible that they might not be able to get a chip so that they might decide whether to continue waiting. Although numbered seats were available at the clinic queuing zones, they were meant only to facilitate orderly queuing and not to coincide with the number of the chip.

90. Besides, additional chips might be issued on a case-by-case basis depending on the condition of the patient who made the request.

91. On 29 January 2003, the complainant was waiting in seat no. 35 for

consultation at a general outpatient clinic. 38 consultation chips were to be allotted. As part of the established practice, staff of the clinic alerted those waiting near the end of the queue that they might not be able to get a chip if people queuing in front got more than one chip. When the patient waited in seat no. 33 was registered, the clinic staff informed those waiting behind that all the chips had been allotted.

92. The complainant tried to reason with the staff. In response, a nurse of the clinic explained that some patients queuing in front had taken more than one chip, which resulted in those waiting at the end of the queue not getting chips otherwise available to them. The complainant requested for issuance of an additional chip. The doctor-in-charge of the clinic assessed her conditions and decided that it was not justified to issue an additional chip to her.

93. The complainant was still dissatisfied after the staff of the clinic had explained to her the principle of chip allotment arrangement. She was then given the contacts of the Client Relation Unit of DH in order to lodge a complaint. Subsequently, the complainant lodged a complaint with The Ombudsman against DH in February 2003 for :

(a) unfair queuing system in the outpatient service of a public clinic;

(b) lack of appropriate guidelines to determine if extra outpatient service should be provided when the day's quota was exhausted; and

(c) improper handling of the complaint by a nursing staff.

94. For complaint point (a), The Ombudsman considered that since a numbered queuing zone was designated in the clinic, the intention was surely to inform those waiting whether they could get a chip. However, the actual situation was that a person was permitted to get more than one chip. Consequently, a person apparently within the zone would still have to wait until the actual distribution of chips before he would know if he could get one. As such, this complaint point was substantiated. Complaint points (b) and (c) were not substantiated because staff of the clinic had assessed the complainant's conditions following the established practice to handle her request for an additional chip and had handled her complaint properly. Overall, this complaint was partially substantiated.

95. Since 1 July 2003, the Hospital Authority (HA) has taken over the general outpatient clinics under DH and continued the chip allotment system.

96. HA has implemented the following measures in response to the recommendations of The Ombudsman :

(a) the purpose of allotting a chip or one more chip to people who could produce the identification documents of a sick person and offer reasonable grounds for the failure to come and queue personally for the chip, is to facilitate the socially disadvantaged such as in the case of an elderly with walking difficulties or very young children to use the service. This chip distribution has been widely accepted by the service users. While HA adheres to the "one person, one chip" and "first come, first served" principle, it would exercise flexibility to allot at most two chips to people who could produce the identification documents of a sick person and offer reasonable grounds for the sick person's failure to come and queue personally for the chip. This is to avoid inaccessibility to the necessary service by the socially disadvantaged due to inability to queue for a chip personally. To promote communication with the service users and avoid misunderstanding, HA would put up a standardised notice in the queuing zone of all clinics notifying users of the basic principle of "one person, one chip" and the special conditions where one more chip would be allotted. Besides, as an additional measure, staff would be arranged to explain the arrangement to users verbally to further strengthen communication. HA would continue to monitor the situation;

(b) under the existing arrangement, chips would be allotted only to those people who can produce the identification documents of a sick person. The identity of the sick person would be recorded during registration. Therefore, the chip could not be transferred or resold. Besides, clinic staff would maintain order at the queuing zone. If the staff suspects any illegal activities, he would consult his senior and report the incidents for follow-up by the Police as and when required; and

(c) the existing arrangement to issue additional chip on individual request

will be reviewed given that the mode of operation of general out-patient clinics has been gradually changing after the transfer to HA, taking into account the importance of maintaining a fair queuing system while attaching due weight to the need of the socially disadvantaged.

Food and Environmental Hygiene Department (FEHD)

Case No. 2003/0567：Poor staff attitude and impropriety in handling a complaint.

97. The complainant complained that in the morning of 18 February 2003, he witnessed a dispute between some FEHD officers and three vegetable hawkers. The vegetable hawkers were not satisfied with FEHD officers for selectively prosecuting them for street obstructions and refused to board the Department's vehicle. The complainant claimed that he told an FEHD officer that his manner was rude when that FEHD male officer behaved rudely to a vegetable hawker. The officer then replied impolitely that if the complainant was not satisfied with his manner, the complainant could take down his staff number and lodge a complaint. Subsequently, the complainant rang up FEHD's Complaint Section to complain against the officer's rudeness. However, the female officer answering the call asked him to provide details of the incident and elaborate on how impolite and unfriendly the officer was. The female officer said that the definition of being impolite was too wide, and if he could not provide specific details, she could only take down the complaint but could not take follow-up action.

98. The complainant considered that the behaviour of the FEHD male officer was rude, and that the way the female officer of the Complaint Section had handled his complaint was improper. The female officer did not even ask him the staff number of the male officer, and the complainant had to point this out to her by himself. The complainant thus lodged a complaint with The Ombudsman in February 2003 against FEHD for poor staff attitude and impropriety in handling his complaint.

99. Upon inquiry, FEHD indicated that on the day of the incident, the male officer concerned had explained to the complainant that he had been discharging his duties. He had followed the relevant departmental instructions and had completed his job with proper manner and restraint. The officer also pointed out that if the complainant would like to lodge a complaint, he could not stop it. Afterwards, the officer recorded the matter in his notebook, but had not informed the complainant of the proper channel for lodging a complaint. Also, he had not reported the matter to his supervisor.

FEHD indicated that it had reasons to believe that the complainant had tried to obstruct its staff in performing their enforcement duties. It was therefore not unreasonable for the officer in question to consider the complainant more as instigating than complaining, and hence had not reported the incident to the Department for follow-up action.

100. As regards the complainant's claim that he had rung up the Complaint Section of FEHD to lodge a complaint, based on the Department's record, no such complaint had been received. Although according to the mobile phone service records produced by the complainant, the latter had telephoned the Command Centre of the Department's Hawker Control Team, the three female staff on duty that day could not recall having answered the complainant's call.

101. After investigation, The Ombudsman considered that the FEHD officer in question should not be left to decide subjectively whether the complainant was instigating, as there might be bias in his handling of the matter. The Ombudsman observed that FEHD had not provided its staff with guidelines on how to properly handle complaints lodged by members of the public while they were on duty. For this reason, the complaint in this respect was considered substantiated. As regards the allegation against rudeness of the officer, the complaint on this aspect was considered not substantiated in the absence of concrete evidence to show that the officer had actually behaved rudely. Overall, this complaint was partially substantiated.

102. In implementing The Ombudsman's recommendations, FEHD has taken the following actions :

(a) FEHD has suitably revised and issued Administrative Circulars No. 20/03 "Handling of Staff-related Complaints" and No. 21/03 "Handling of Operations-related Complaints" on 27 November 2003, providing clear and adequate instructions to its staff that –

    (i) if an officer receives a complaint from a member of the public in the course of discharging his duties, the officer should explain to the member of the public the proper procedures for lodging the complaint, and should report the matter in detail to his supervisor as soon as possible; and

(ii) staff should properly record in writing all telephone complaints lodged by members of the public. In addition, the management should take effective measures to ensure that the telephone conversations with members of the public would be properly recorded and followed up;

(b) in order to ensure that all supervisory staff, all staff receiving and handling complaints as well as all outdoor frontline staff would duly observe the instructions set out in the two Administrative Circulars mentioned above, FEHD has also issued Operational Circular No. 3/03 "Handling of Operations-related Complaints Received by Outdoor Frontline Staff" on 1 December 2003 for compliance by all staff concerned; and

(c) the above circulars would be re-circulated every six months.

Case No. 2003/0664：Mishandling a withdrawal of food business licence transfer application.

103. The complainant claimed that on 30 January 2003, she and the licensee of a Light Refreshment Restaurant (LRR) approached FEHD in person to apply for transfer of the LRR licence to her. A Health Inspector (HI) explained the relevant procedures to them. After they had handed in their application form and copy of their identity cards, they left the office. On 10 March 2003, when the complainant's brother made a call to FEHD to enquire about the position, he was told that the licensee had withdrawn the application. In addition, the complainant's copy of identity card was already destroyed and could not be returned to her. The complainant therefore lodged a complaint with The Ombudsman against FEHD in March 2003 for mishandling a food business licence transfer application.

104. Upon inquiry, FEHD found that the licensee had returned to FEHD's office later on 30 January 2003 and told the HI concerned that after consulting the complainant, he would like to withdraw the application. Since the application form and related documents were not yet put on file, the HI tore up the application form and related documents with the agreement of the licensee and discarded them into the waste paper bin. In the morning of 10 March

2003, the Department received a telephone call from the complainant's brother enquiring about the position of the application. That afternoon, the HI made a reply call to explain the matter to the complainant.

105. Having examined the matter, FEHD considered that the HI concerned had not properly handled the application for transfer of licence and the complainant's copy of identity card. The HI had failed to take suitable follow-up actions since he had mistakenly believed that the licensee had already obtained the agreement of the complainant before withdrawing the application. As he had already disposed of the application form and copy of the complainant's identity card, he could not inform the complainant in writing about the cancellation of the application. Overall, FEHD considered that this was only an isolated incident, for which suitable disciplinary action had been taken against the HI concerned.

106. FEHD indicated that it was stated in the application form for transfer of food licence/permit that in the event the transferor or transferee wanted to make any changes to the application, he was required to notify FEHD and the other party in writing. Notwithstanding this, in order to remind staff of the need to inform both parties about the progress or result of the application, an e-mail on "Proper Procedures for Handling Applications for Transfer of Licence" was issued on 12 May 2003 to relevant staff. In addition, staff were required to properly file all applications for transfer of licence and the related supporting documents. In the absence of proper authorisation, such documents should not be destroyed.

107. After investigation, The Ombudsman concluded that the HI concerned had failed to follow the requirements set out in the application form that withdrawal of application should be made in writing. He had not considered whether the complainant had agreed to the withdrawal of the application, nor had he informed her about the licensee's action in this regard. In addition, the casual disposal of the torn up application form and copy of identity cards in the waste paper bin had raised concern over possible leak of personal information.

108. The Ombudsman also considered that it was not proper for FEHD to require only the transferor or transferee of licence to inform the Department and the other party in writing about any changes of the application. In the Department's guidelines for processing applications for transfer of food licence,

no instruction had been provided on the action to be taken to ensure that the other party was aware of the changes made. Also, the Administrative Circular issued by FEHD did not contain any guidelines on the proper handling of documents containing personal data, or on the need to comply with the "Code of Practice on the Identity Card Number and Other Personal Identifiers – A Compliance Guide for Data Users" issued by the Office of the Privacy Commissioner for Personal Data (OPCPD). Overall, The Ombudsman considered that the complaint was substantiated.

109. FEHD has accepted and implemented The Ombudsman's recommendations as follows :

(a) a letter of apology was issued to the complainant on 28 October 2003;

(b) the Department's guidelines concerning "Proper Handling of Applications for Transfer of Licences" was incorporated into the Operational Manual for Hygiene Services;

(c) a revised Administrative Circular No. 19/03 "Personal Data (Privacy) Ordinance" was issued on 28 October 2003. The revised circular has incorporated detailed guidelines on the proper handling of documents containing personal data, and has clearly advised staff about the need to observe the Code of Practice issued by OPCPD; and

(d) FEHD has uploaded the performance pledge on handling applications for transfer of licence onto the departmental website, and has included these into the Performance Pledge leaflets issued by the Department in March 2004.

Case No. 2003/1652：Failing to follow up complaints about unauthorised building works, hygiene and pollution problems at two adjacent streets.

110. The complainant claimed that she had lodged complaints with FEHD on 12 May 2003 and 9 June 2003 respectively against the undesirable environmental hygiene conditions at Street A and Street B, and the illegal extension of a shop selling marine products onto the pavement at Street A. However, the Department failed to take action on her complaint and did not

give her any written reply. She thus lodged a complaint with The Ombudsman against FEHD in June 2003 for failing to follow up her complaints about unauthorised building works, hygiene and pollution problems at Street A and Street B.

111. Upon inquiry, it was found that the fax number through which the complainant had faxed the complaint letters in fact belonged to the Duty Room (Hong Kong and Islands) of FEHD instead of the Eastern Environmental Hygiene District Office of FEHD. The Department had checked the original documents faxed to and out from the Duty Room in May and June 2003 but could not trace the complaint letters. In this connection, staff of the Duty Room had not kept the fax transaction journals automatically generated by the fax machine for record.

112. It was not until 18 July 2003 when FEHD received the complainant's letter of 12 May 2003 through referral from the Buildings Department (BD) that it learned about the complaint about the undesirable environmental hygiene conditions at Street A and Street B. FEHD staff therefore called the complainant to better understand the situation but she refused to disclose further information or her correspondence address. Nevertheless, after taking follow-up actions on the hygiene problems and defective pipes referred from BD, FEHD had verbally informed the complainant on 11 August 2003 of the investigation results.

113. It was only when The Ombudsman commenced its investigation into this complaint case on 26 September 2003 that FEHD came to know about the complainant's complaint against the illegal shop extension at Street A which she faxed to the Department on 9 June 2003. Subsequently, FEHD started to take follow-up action on 3 October 2003 and prosecuted the licensee of the fresh provision shop concerned on 8 October 2003.

114. In view of the above, The Ombudsman considered that this complaint was unsubstantiated.

115. FEHD has accepted The Ombudsman's recommendation and issued FEHD General Circular No. 3/04 “Handling of Fax Transaction Journals” to require Division/Section Heads to keep all transaction journals of fax machines maintained by them for six months.

Government Property Agency (GPA)

Case No. 2002/3014：Disclosing the complainant's personal data to the complainee without his prior consent.

116. The complainant resided in a GPA-managed Disciplined Services Quarters, where there were four residents' associations set up respectively by four disciplined services. He alleged that a resident, assisted by the wife of the Chairman of one of the residents' associations (the Chairman), distributed in the Quarters photocopies of newspaper cuttings that might be defamatory to him.

117. Consequently, he lodged a written complaint with GPA and requested that his letter be referred to the Quarters Team of the disciplined service concerned. GPA complied with his request to refer his letter to the concerned Quarters Team and copied the letter with his personal data to the Chairman. The complainant was dissatisfied that GPA, without his consent, had copied his complaint letter to the Chairman who was the husband of one of the persons involved. He thus lodged a complaint with The Ombudsman against GPA in September 2002 for disclosing his personal data to the complainee without his prior consent.

118. GPA explained to The Ombudsman in October 2002 that the incident was basically a personal dispute widely known to residents at the Quarters concerned. GPA, by copying his letter to the Chairman, hoped that the Chairman could help mediate and resolve the matter. Furthermore, the key target of the complaint was another resident and not the wife of the Chairman. GPA therefore sent a copy of the complaint letter to the Chairman without notifying the complainant or seeking his prior approval.

119. GPA added that as the incident involved the wife of the Chairman, the Quarters Team would have to contact the Chairman for information in the course of investigation. The Chairman would, therefore, sooner or later know about the complaint and guess the identity of the complainant. Besides, as the complainant was himself the Chairman of a residents' association of another disciplined service, his name, address and telephone number were no secret to the Chairman.

120. Upon review, GPA admitted that it would have been better had the complainant's consent been obtained before his complaint was copied to the Chairman.

121. The Ombudsman was of the view that GPA should have considered the rights and interests of the complainant and sought his prior approval. As the complaint involved the wife of the Chairman, there could be a conflict of interests to get him to mediate. It could even invite questions as to the fairness of his handling of the matter. Therefore, the complaint was substantiated.

122. GPA accepted all the recommendations of The Ombudsman and follow-up actions taken are set out below :

(a) a written apology was sent to the complainant on 15 August 2003;

(b) guidelines for staff to get written approval from the complainant before referring a complaint were issued on 30 January 2003; and

(c) a seminar on Personal Data (Privacy) Ordinance was held on 20 April 2004 to acquaint staff with the Ordinance and associated guidelines and the need to follow them strictly in handling referrals involving personal data. The relevant internal circulars relating to personal data privacy and complaint procedures have incorporated guidelines on secrecy of personal data in dealing with complaint cases and in revealing the identity of the complainant. The updated circulars have been uploaded to the departmental electronic bulletin board on 28 April 2004 and will be re-circulated to all staff for reference periodically.

Case No. 2003/2484(I) : Mishandling a request under the Code on Access to Information.

123. The complainant wrote to GPA in June 2003 requesting inspection of the Agency's internal records on a certain estate. However, he failed to specify the details of the records required. After exchanging further

correspondence with the complainant, the Agency had clarified with him the information required. In view of the volume and nature of the records, the Agency had refused the complainant's request for inspection of the files on 20 August 2003. The complainant thus lodged a complaint with The Ombudsman against GPA on 22 August 2003 for mishandling his request for information under the Code on Access to Information (the Code). Finally, through subsequent meeting and correspondence with the complainant on 21 and 28 November 2003 respectively, the Agency provided him with some of the information requested and pointed out that the other information were not in its possession, third party information or records of internal Government meetings/deliberations, etc.

124. After investigation, The Ombudsman did not dispute GPA's decision to decline the complainant's request for information but considered that there had been a delay in issuing the proper reply to him on 28 November 2003 by the Agency. Therefore, this complaint was partially substantiated.

125. GPA has accepted and implemented the recommendations of The Ombudsman as follows :

(a) a letter was sent to the complainant on 16 February 2004 extending GPA's apology to him;

(b) the Access to Information (AI) Officer was advised on 28 January 2004 to take more initiative in the discharge of her duties and to ensure that a request for information is processed promptly in accordance with the Code and departmental instructions. An experience sharing session was held in February 2004 to assist staff of GPA to understand the requirements of the Code and to remind them of the need to refer requests under the Code to the AI Officer immediately; and

(c) a revised circular on the Code was issued to all staff on 31 May 2004 and will be re-circulated quarterly in the future.

Government Secretariat – Education and Manpower Bureau (EMB)

Case No. 2002/4649：Unreasonably rejecting applications by a tutorial school for restructuring of fee regimens and related matters.

126. The complainant was the principal of a tutorial school. In May 2001, the former Education Department (ED) approved applications from the school to collect fees for its courses by six instalments instead of the standard fee structure of ten or 12 instalments stipulated in Regulation 62 (R62) of the Education Regulations. On 1 June 2001, the Education (Amendment) Ordinance 2001 (EAO 2001) came into effect and amended R62 so that the fee for a course shall be calculated on an equal monthly basis. The then ED, therefore, required all schools to submit particulars of course fees for 2001/02 for approval and for issue of new Fees Certificates.

127. The complainant, responding to this requirement, applied for new Fees Certificates for both existing and new courses based entirely on the fee regimens approved in May 2001. ED turned down the applications for non-compliance with the new R62. The complainant felt aggrieved that ED had failed to explain the reason for not granting him exemption as in May 2001. The complainant alleged that an ED officer, at a meeting in November 2001, had without authority offered a "grace period" for him to keep the existing fee structure for one year. He regarded the offer as inducement for him to give up the fee regimens already approved and abuse of power.

128. The complainant further alleged that ED took an unduly long time to process his applications for employing teachers from overseas. In one case, ED took almost a year to approve an application.

129. In May 2002, ED requested all private schools offering non-formal curriculum to provide information on teachers, facilities, courses and insurance policies. Schools were told that part of the information would be uploaded to ED website for public viewing. The complainant contested that ED had no statutory authority to publish such information without consent from schools and ED's omission to mention this was tantamount to deception.

130. The complainant also alleged that ED had failed to take enforcement

action against illegal schools and to consult those in the trade properly prior to the introduction of EAO 2001. In view of the above, the complainant lodged a complaint with The Ombudsman against ED in February 2003 for :

(a) various administrative errors in processing his school's applications for proposed school fee regimens for its existing courses and its application for a Fees Certificate for a new course, such errors including excessive delay, abuse of power in processing the applications and unreasonable decision in rejecting the applications without a satisfactory explanation;

(b) delay in processing his school's applications for teaching permits;

(c) attempt to publish, by uploading onto ED website, privileged information on his school without proper authority and the school's consent;

(d) failure to take enforcement action against illegal schools even when the existence of such schools had been reported; and

(e) failure to conduct prior consultation with his school before new regulatory measures were introduced to the Education Ordinance and Education Regulations which took effect on 1 June 2001, thus prejudicing his school's interests.

131. After investigation, The Ombudsman considered that while ED should not revoke the fee regimens approved in May 2001 for the existing courses, rejection of applications for new courses with fee regimens not compliant with the new R62 was legitimate and proper. However, ED should have explained to the complainant that the exemption granted in May 2001 was at the discretion of the Director of Education who, in view of the new R62, was not prepared to do so for new applications. As for the alleged offer of a "grace period", EMB explained that it was only an exploratory proposal. The Ombudsman accepted EMB's explanation as reasonable. There was no evidence to support the allegation of abuse of power by the ED officer concerned. On balance, complaint point (a) was partially substantiated.

132. Regarding complaint point (b), EMB explained that the vetting of

applications to register as Permitted Teachers involved verification of qualifications with the Civil Service Bureau and, depending on the origin of documents presented, the Bureau might need to consult the Hong Kong Council for Academic Accreditation. Such cases would, therefore, take longer to process. Of the cases quoted by the complainant, there were two instances of minor slippage but The Ombudsman found no undue delay by ED/EMB in processing the applications. The Ombudsman accepted EMB's explanation that the minor slippage had been caused by considerable increase in caseload and reduction in manpower. Complaint point (b) was, therefore, unsubstantiated.

133. As for complaint point (c), The Ombudsman noted that in the circular requesting school supervisors to provide information on their schools, ED had asked supervisors to sign on their returns to acknowledge that they understood that certain information would be uploaded to ED website for public reference. This should adequately discharge ED of any intention to deceive school supervisors. In this light, this complaint point was unsubstantiated.

134. Concerning complaint point (d), The Ombudsman found that ED had followed up with the relevant complaints and ED could not establish that a school was in operation at the places concerned. This complaint point was therefore unsubstantiated.

135. As regards complaint point (e), EMB admitted that private schools offering non-formal curriculum had not been consulted prior to the introduction of Education (Amendment) Bill 2000 into the Legislative Council (LegCo), but it did consult the Board of Education and the LegCo Panel on Education. Furthermore, when the Bill was introduced, there was no organisation representing such schools. While The Ombudsman accepted that there was practical difficulty for ED to consult each and every school, ED as an open and responsible Government department could have consulted members in the relevant sector prior to finalising the Bill. In this light, this complaint point was partially substantiated. Overall, the complaint remained partially substantiated.

136. Pursuant to The Ombudsman's recommendations, EMB has taken the following actions :

(a) the EMB circular requesting information from private schools offering non-formal curriculum was revised in September 2004 to the effect that these schools have been made well aware that the uploading of school information onto the EMB homepage is not mandatory, but is subject to the consent of individual schools; and

(b) it is EMB's established policy to consult relevant parties or stakeholders on major legislative or policy changes. On a recent exercise of legislative changes in the regulatory control of private schools offering non-formal curriculum, apart from consulting the Hong Kong Federation of Private Educators which is an organisation representing the sector concerned, EMB has also consulted the Consumer Council, parent-teacher federations, a parents association and the Committee on Home-School Co-operation.

Case No. 2003/1892：Failing to follow established guidelines in properly handling a complaint lodged against a school that has assessed the complainant as a surplus teacher.

137. The complainant was a teacher librarian of a primary school. She lodged a complaint with EMB on 29 April 2003 against the school for its unfair treatment which had resulted in her being made a redundant teacher. EMB's relevant School Development Section investigated the complaint and found that the school had taken proper procedures in identifying its redundant teachers in accordance with the guidelines set out in EMB Circular Memorandum No. 45/2003 "Arrangement for Redundant Teachers of Aided Primary Schools 2003". As such, the allegation was not substantiated and EMB subsequently sent a written reply to the complainant on 26 June 2003.

138. The complainant was not satisfied with the reply and lodged a complaint with The Ombudsman on 30 June 2003 against EMB for failing to follow established guidelines in properly handling her complaint against her school that had assessed her as a surplus teacher. The complainant alleged that EMB did not properly and fairly handle her complaint lodged on 29 April 2003. Moreover, no acknowledgement had been sent to her within ten days since the lodging of the complaint. Furthermore, the investigating officer of EMB answered her telephone enquiries in a perfunctory way. Lastly, a

potential conflict of interest might arise for a Mr. A who was the Chief Curriculum Development Officer of the Curriculum Resources, Library and Educational Technology Section of EMB and he had given some opinions to the head of the school regarding surplus teacher but his wife was also teaching in the school.

139. After investigation, The Ombudsman confirmed that EMB had followed the complaint handling procedures in handling the case. There was no evidence showing that EMB had sided with the school or the complainant. On the whole, EMB handled the complainant's allegations fairly, although there was still room for improvement in the complaint handling procedures and handling of telephone enquiries. Also, there was no evidence to show that Mr. A was involved in the alleged conflict of interest. On the other hand, since EMB did not send any acknowledgement to the complainant within ten days and it was possible that the complainant's telephone enquiries were answered in a perfunctory way, the complaint was considered as partially substantiated.

140. Separately, The Ombudsman noted that the complainant's husband, an EMB officer, had previous working relationship with the EMB officer who was involved in investigating this case. With such background, the involvement of the complainant's husband might give rise to potential conflict of interest in this case.

141. The Ombudsman also noted that EMB had advised the officers concerned to observe the guidelines in handling complaints and to be mindful of their attitude in handling telephone enquiries. A letter of apology had also been sent to the complainant. On the other hand, in order to avoid any misunderstanding, Mr. A's supervisor verbally advised Mr. A on 2 July 2003 to try his best to avoid having contact with the school head in question in non-official activities. He was also advised not to appear inside the school area or near the school, and not to accompany his wife to school in order to avoid suspicion. Regarding the potential conflict of interest of the complainant's husband, his supervisor had given verbal advice to him and reminded him of the Code of Conduct and the Civil Service Bureau Circular No. 2/2004 on "Conflict of Interest".

142. Also, EMB had advised the school to allow sufficient time for teachers to get prepared and adapt to the school's arrangements for identifying

redundant teachers in the future.

143. In response to The Ombudsman's recommendations, EMB had arranged a meeting for the complainant to meet with the school and EMB officers on 18 October 2003. However, the meeting was cancelled because the complainant and the school could not agree on the membership of the meeting. The complainant insisted that her husband would attend the meeting and had the right to ask questions on her behalf. The Ombudsman commented that the complainant should respond to EMB's follow-up work with a positive attitude. EMB had then arranged another meeting on 30 January 2004, but it was also cancelled since the complainant informed EMB to postpone the meeting.

Home Affairs Department (HAD)

Case No. 2002/4452, 2002/4473：Providing improper assistance to a property owner for forming an owners' corporation.

144. To encourage private property owners to form owners' corporations (OCs), HAD had drawn up internal guidelines for the issuance of an exemption certificate to owners of not less than 5% of the shares of the building so as to enable them to obtain a free copy of owners' records from the Land Registry (LR) for the purpose of OC formation.

145. In this case, two groups of owners in a residential estate separately applied to a District Office (DO) for the exemption certificate. However, since each building will only be issued the exemption certificate once, the second group of owners which approached DO was asked to verify information submitted before they could have sight of the same set of owners' records. This group of owners was thus dissatisfied that they were requested to do more than the other group that came first for the exemption certificate, and lodged a complaint with The Ombudsman in December 2002.

146. After investigation, The Ombudsman noticed that according to the internal guidelines of HAD, it would issue a certificate to the first owner making an application in order to facilitate him to obtain the ownership records from LR free of charge, provided that he had secured 5% of the owners' shares in support. The owner had to sign an undertaking that the information would be used for OC formation only, that he would observe the Personal Date (Privacy) Ordinance and return those records to HAD upon request. HAD issued the certificate to the above owner upon his compliance with those guidelines. However, for the subsequent group of owners with not less than 5% of the shares in support of OC formation which approached HAD, the Department had asked the group to illustrate that an owners' meeting for the formation of an OC is in full swing before offering him assistance to get the ownership records from the first owner.

147. According to the Building Management Ordinance (BMO), before forming an OC, an owners' meeting must be convened to appoint a management committee. Such an owners' meeting would require owners

holding not less than 5% of the shares to act as the "convenor". This requirement differed from that in HAD's internal guidelines, which required only the "support" of owners of not less than 5% of the shares. In this case, before issuing the certificate to the first owner, HAD had not checked whether there were indeed owners of not less than 5% of the shares willing to act as the "convenor".

148. Therefore, The Ombudsman concluded that HAD's arrangements in issuing the exemption certificates were not satisfactory. The complaint was thus substantiated.

149. Pursuant to The Ombudsman's recommendations, HAD has taken the following actions :

(a) revision of the internal guidelines on handling applications for the exemption certificate was completed in September 2003 so that they would conform with the requirements of BMO. The revised guidelines, which took immediate effect, have been issued to District Offices. At present, owners who apply for an exemption certificate have to prove that they have secured the support of owners of not less than 5% of the shares for convening a meeting of owners to appoint a management committee in accordance with BMO; and

(b) HAD staff will verify the particulars of owners in the application forms against the records of LR when processing applications for the exemption certificate.

Case No. 2003/1782 : Entering the complainant's name in the voter register of another village, so that he was disqualified from standing for the Village Representative election.

150. The complainant, an indigenous inhabitant of Village A, submitted a Village Representative (VR) election nomination form to a HAD District Office (DO) to stand for the Indigenous Inhabitant Representative election of his own village. However, DO rejected the nomination because his name was not in the voter register of Village A. Subsequently, the complainant discovered that HAD had entered his name in the voter register of Village B,

thus disqualifying him from standing for election in Village A. He thus lodged a complaint with The Ombudsman in June 2003 against HAD for entering this name in the voter register of another village so that he was disqualified from standing for the VR election.

151. After investigation, The Ombudsman noted that according to HAD's records, the complainant had declared himself an indigenous inhabitant of Village B in his application form for voter registration. Staff of the DO thus entered the relevant Village and Rural Committee codes in the form and HAD accordingly entered his name in the Village B voter register. The complainant subsequently requested HAD to amend the voter register to reinstate his eligibility for election in Village A. On the advice of the Department of Justice (DoJ), HAD rejected his request as the problem was not due to clerical or printing errors.

152. However, The Ombudsman considered that the advice from DoJ was not equivalent to a judge's interpretation of the law. The provisions of the Village Representative Election Ordinance did allow for rectification of incorrect name, address or other personal particulars. There was, therefore, inadequate basis for HAD's refusal to amend the voter register to reinstate the complainant's eligibility for election.

153. Moreover, The Ombudsman noticed that while the complainant was at fault in writing down Village B as his address, he had on the other hand stated that his village was under the Rural Committee of Village A. Had DO staff been more alert and checked the details, this incident could have been avoided. Based on the above, this complaint was substantiated.

154. HAD has accepted all The Ombudsman's recommendations and implemented the following actions :

(a) a letter of apology was sent to the complainant on 25 November 2003;

(b) staff have been sternly reminded to process election-related documents with greater care and diligence; and

(c) in order to further improve the voter registration process, a new checking function was added to the computer system for managing the

database of applicants and electors to ascertain that the correct Village and Rural Committee codes are assigned to applicants for registration as VR electors.

Hospital Authority (HA)

Case No. 2002/0278：Improper handling of transfer arrangements for the complainant's critically-ill brother and failing to provide the complainant with the investigation report as promised.

155. On 16 October 2000 at around 6 p.m., the complainant's brother (the patient) was admitted to the Accident and Emergency Department of Hospital A for his chest pain, sweating and shortness of breath. The initial diagnosis was ventricular septal defect, pulmonary hypertension and chest infection precipitating congestive heart failure. This diagnosis indicated that the problems could be treated in Hospital A. He was admitted to medical ward for further examination and observation. At 8:50 p.m. he was examined by the on-call Senior Medical Officer (Cardiology). The patient claimed symptomatic improvement after initial treatment. Urgent spiral CT thorax was suggested by the medical team to rule out pulmonary embolism. Comprehensive echocardiography was planned to be done in the following morning. Cardiac and close haemodynamic monitoring was meanwhile continued.

156. CT thorax was done in the morning and echocardiogram was done before noon on 17 October 2000. The patient was then transferred to Cardiac Care Unit for further treatment. At 2 p.m. echocardiogram was repeated and flail mitral valve with acute decompensation was confirmed. Appropriate medication was prescribed and Hospital A started to liaise with Hospital B on the transfer of the patient with a view for Hospital B to assess the need for surgical intervention. In view of the patient's acute pulmonary edema, Hospital A was advised by Hospital B to continue medical treatment to stabilise the patient's condition first and make necessary preparation prior to the transfer, while Hospital B searched for patient's record and prepared to take over the patient. Thereafter the patient's condition was closely monitored by a medical team comprising cardiologists and reported to Hospital B to facilitate consideration of the need for transfer to Hospital B for surgery. The patient and his relatives were also informed of the possible transfer arrangements.

157. At 6:30 p.m. both hospitals decided to transfer the patient and the transfer took place at 7:15 p.m. The patient arrived at Hospital B at around 8

p.m. Unfortunately, he passed away at 10:45 p.m.

158. The complainant was dissatisfied with the medical treatment and transfer arrangements made for her brother. She thus lodged a complaint with HA in June 2001. Upon receipt of the complaint, HA commenced investigation into the case and promised to provide an investigation report. In January 2002, the complainant lodged a complaint with The Ombudsman against HA for the delay of Hospital A in providing timely and suitable medical treatment for her critically ill brother, delay in the transfer of her brother from Hospital A to Hospital B and failing to provide her with the investigation report as promised. On 20 March 2002, having concluded the investigation, HA sent a detailed investigation report to the complainant with a copy to The Ombudsman. HA explained that the communication between the two hospitals involved highly complicated and difficult clinical judgement and decision.

159. In the course of investigation, The Ombudsman noted that on the issue of retrieving the patient's medical records at Hospital B, the complainant's version was inconsistent with that of HA. Besides, the complainant claimed that Hospital B had refused to admit the patient on 17 October 2000, but there was no such indication in the report describing the sequence of events submitted by HA to The Ombudsman. Since there were different versions from the two sides, The Ombudsman was not able to come to a definite conclusion on what exactly happened, but was inclined to believe that the pre-transfer inter-hospital communication and communication with the patient's relative were not conducted satisfactorily.

160. After investigation, The Ombudsman found that there was room for improvement in the communication between the two hospitals on the transfer arrangements. Also, Hospital A had not explained to the patient's relatives in sufficient detail the on-going communication process between the two hospitals so as to bring them to a full understanding of the hospitals' consideration involved. From the administration point of view, the complainant's allegation of improper handling of transfer arrangements was partially substantiated.

161. On the other hand, The Ombudsman noted that HA had sent the investigation report to the complainant on 20 March 2002. The allegation of failing to provide the investigation report as promised was therefore

unsubstantiated. However, HA should have kept the complainant informed of the progress of the investigation. Overall, this complaint was partially substantiated.

162. Upon review of the case, HA considered that transfer of the patient to Hospital B should be arranged soonest possible in view of his complicated condition with unknown etiology, so that cardiac surgeons could directly assess his clinical condition and decide if surgery was required. This required close communication between the two hospitals. To enhance the inter-hospital communication on transfer arrangements, Hospitals A and B have already adopted new procedures after the incident. When Hospital A requests for the transfer of a patient to Hospital B, any request made over the telephone must be supplemented with a written request together with the patient's latest medical records by fax. Hospital B in turn must reply in writing, and give expert advice and advise Hospital A of its decision on the transfer request.

163. HA has accepted and implemented all The Ombudsman's recommendations as follows :

(a) HA has referred the case to the Risk Management Section (RMS) within HA. RMS, through its established mechanism, shared the lessons learned from the case with all the hospital clusters within HA in March 2004. A working group has since been formed to review and formulate measures to improve the patient transfer process taking into consideration the observations and recommendations of The Ombudsman in this case; and

(b) HA has included the need for better communication with patients and their relatives in its Annual Plan for 2004-05. The relevant standards would be enhanced to improve the current practice.

Case No. 2002/1215 : (a) Impropriety on the part of an HA hospital in asking an in-patient's relatives to perform a medical procedure for treatment of the patient; and (b) Failing to acknowledge a written complaint and address the queries raised.

164. The patient had a history of renal disease requiring daily continuous

ambulatory peritoneal dialysis (CAPD), which was performed by her domestic helper. She was admitted to the Ear, Nose and Throat (ENT) ward of an HA hospital on 21 December 2001 (Friday) for epistaxis after a nasopharyngeal biopsy performed under local anaesthesia in the hospital's outpatient clinic. On 21 and 22 December 2001, nurses of the Renal Unit of the hospital performed CAPD for the patient in the ENT ward as required. After an assessment on the patient's condition on 22 December 2001 (Saturday), a renal doctor decided that CAPD could be spiked off temporarily in the following day (Sunday) if the patient's condition continued to be stable. In that evening, the renal doctor met with the patient's relatives to discuss about the feasibility of a temporary cessation of CAPD for the patient.

165. On 22 December 2001 (Saturday), miscommunication occurred between a nurse of the renal unit and the patient's relatives. The renal nurse told the patient's relatives that some patients' relatives/domestic helpers did volunteer to perform CAPD for patients in the ward on Sunday when the renal unit was closed. Although the nurse had no intention to instruct or force the patient's relatives to perform the procedure for the patient in the ward, this aroused the latter's misunderstanding that they had to perform CAPD for the patient. Subsequently, a renal doctor clarified the situation by explaining to the patient's relatives that CAPD for the patient could be spiked off for the day as the patient's condition was stable. With satisfactory improvement of her clinical condition, the patient was subsequently discharged on 24 December 2001.

166. In the morning of 13 January 2002 (Sunday), the patient was re-admitted to the Acute Stroke Unit of the hospital via the Accident and Emergency Department for fast atrial fibrillation and heart failure. After an assessment on the patient's condition and consultation with a renal specialist, the doctor in-charge decided to switch the patient to Intermittent Peritoneal Dialysis (IPD), an appropriate mode of dialysis therapy for acutely stressed CAPD patients. In order to ascertain the types and concentration of the peritoneal dialysis (PD) fluid that the patient had been using, her relatives were asked to go to the renal ward to confirm the PD fluid. Having confirmed the right fluid, the patient's relatives brought with them the PD fluid on their own accord when they returned to the ward. The nursing staff subsequently performed IPD for the patient. During the patient's hospitalisation till 18 January 2002, the patient's IPD and CAPD were performed by the ward nurses

and never by her relatives.

167. The patient's relative was dissatisfied with the nurses' request to perform CAPD for the patient and collect the PD fluid from the renal ward, and lodged a complaint to the Hospital Chief Executive of the hospital on 23 January 2002 with a copy sent to the Chief Executive, HA. The HA Head Office acknowledged the letter on 30 January 2002 and a substantive reply was issued by the hospital on 22 March 2002.

168. In April 2002, the patient's relative (the complainant) lodged a complaint with The Ombudsman against HA for :

(a) impropriety on the part of an HA hospital in asking the in-patient's relatives to perform a medical procedure for treatment of the patient; and

(b) failing to acknowledge a written complaint and address the queries raised.

169. After investigation, The Ombudsman found that while the hospital's practice to allow patients and/or their relatives to carry out CAPD was considered acceptable provided the patients and/or their relatives volunteered to do so, it would be a different matter if the hospital personnel were to request patients and/or their relatives to carry out a medical procedure, as this may raise questions of accountability and legal liability should something go wrong. The Ombudsman believed that the patient's relatives had been requested though not pressurised on 22 December 2001 to perform CAPD for the patient due to closure of the renal unit of the hospital on Sundays. However, there was no clear evidence that the patient's relatives were requested to collect the PD fluid from the renal ward on 13 January 2002. Therefore, complaint point (a) was partially substantiated.

170. As for complaint point (b), the HA Head Office had followed the established procedures and complied with the performance pledge in handling this complaint. The hospital had also given a detailed reply to the complainant, with information on measures already and to be taken to prevent similar incidents to happen in future. Therefore, this complaint point was unsubstantiated. On the whole, this complaint was partially substantiated.

171. HA has accepted and implemented all The Ombudsman's recommendations as follows :

(a) HA has conducted a review on the practices adopted by the renal units of some of its hospitals. Renal units of all HA hospitals have now been provided with guidelines for reference and consideration of promulgating similar guidelines as appropriate. Separately, renal units of all HA hospitals have already had in place their individual safety procedures pertaining to renal services. Only trained personnel would be allowed to perform CAPD dialysis procedures for in-patients in all HA hospitals; and

(b) renal units of all HA hospitals have been briefed on this case. They have also been made aware of the importance of communication between hospital staff and the patient/patient's relatives with emphasis on not to confuse options open to patients with requirements or advice for patients to follow in order to prevent similar misunderstanding in future.

Case No. 2002/2361：Being inconsiderate in permitting a male operating theatre assistant to be present throughout the complainant's operation and poor staff attitude of a female nurse.

172. The complainant underwent a surgery of excision of anal skin tag under local anesthesia on 12 July 2002. She had requested for a female doctor to operate on her but was informed that only a male doctor could be arranged. She finally consented to the arrangement. When she entered the operating theatre, she saw two nurses and a man who was in green uniform. The complainant alleged that after the nurse had instructed her to take off her trousers for pre-operative preparations, the man in green then stood by the side and at the foot-end of the operation table, embarrassing her by gazing impolitely at her crotch. She complained to the nurse who just said "When will you learn to be conscientious...". The man in green only went to the head-end of the operation table when two doctors entered the theatre. When questioned by the complainant, the man replied that he was doing some odd jobs in the theatre.

173. The complainant lodged a complaint on 15 July 2002 with the Patient Relation Officer of the hospital. The hospital gave her a written reply on 24 July 2002. Dissatisfied with the reply, the complainant lodged a complaint with The Ombudsman in July 2002 against HA for being inconsiderate in permitting a male operating theatre assistant to be present throughout her operation and poor staff attitude of a female nurse.

174. After investigation, The Ombudsman found that the "male orderly" under complaint was actually an operating theatre assistant, and under no circumstances would a male assistant be allowed to stay alone with a female patient in the operating theatre. The assistant was under the supervision of the medical and nursing staff, and his duties included adjusting room temperature and lighting in the operating theatre, and assisting the nurse in arranging the patient's position on the operation table, etc. While the complainant was undergoing surgery, the assistant was executing his routine duties and carrying out the orders of the medical/nursing personnel. However, in response to the complainant's enquiry, he replied that he was "doing some odd jobs" in the operating theatre, thus causing her misunderstanding. On the other hand, the female nurse, with no intention of being rude, engaged the complainant in conversation and discussed with her the content of a television advertisement in order to alleviate her anxiety and nervousness.

175. The Ombudsman concluded that the complaint was unsubstantiated. However, The Ombudsman sympathised with the complainant regarding her mental stress arising from the incident.

176. HA considered that the complaint might have arisen out of the complainant's misunderstanding of the running of the operating theatre. Having accepted all The Ombudsman's recommendations, HA has taken the following actions :

(a) HA has apologised to the complainant in writing for her unpleasant experience in the hospital, and explained to her the running of the operating theatre;

(b) HA has reminded staff to be more sensitive to the need and to take appropriate measures to protect patient's privacy; and

(c) HA has stipulated guidelines for HA staff that when conversing with patients or being enquired about their ranks, they should clearly indicate their respective ranks or positions in order to avoid misunderstanding.

Case No. 2002/2796：(a) Delay in replying to the complainant; (b) Mishandling his complaint; and (c) Impolite attitude of a nursing staff in a public hospital.

177. The complainant's father (the patient) was sent to the Accident and Emergency Department of a hospital in the evening on 18 January 2002 after fainted at home. He required hospitalisation and died early next morning in the medical ward. Since the patient died within four hours of hospitalisation and the doctor was unable to ascertain the cause of his death, his case was reported to the Coroner's Court. Regarding the reporting as the hospital's attempt to shirk responsibility, the complainant called the Police to the hospital immediately and requested the patient's clinical records to be sealed so that no one could add anything onto them. The senior doctor, having regard to the relatives' emotions, exercised discretion and agreed that the records should be sealed after photocopying, and only to be unsealed and reviewed by the pathologist. The nurse on-duty, however, insisted that the patient's resuscitation process should be recorded on the patient's original records first and had a row with the complainant. The nurse then called the hospital security guard and added the resuscitation information onto the records.

178. The complainant lodged a complaint with the HA's Public Complaints Committee (PCC) in February 2002, accusing the hospital for mismanaging the patient, and the nurse for disobeying the supervisor's order and being impolite to the patient's relatives. As the hospital had not yet issued a formal reply to the complainant, PCC, in accordance with HA's established complaint handling procedures, referred the case to the hospital for handling and reply to the complainant. The complainant considered PCC's action inappropriate. The hospital replied to the complainant on 2 August 2002. Dissatisfied with the reply and HA's complaint handling procedures, the complainant lodged a complaint with The Ombudsman in August 2002 against HA for :

(a) delay in replying to him;

(b) mishandling his complaint; and

(c) impolite attitude of a nursing staff in a public hospital.

179. After investigation, The Ombudsman found that according to HA's performance pledge, the hospital should reply to the complainant within three months upon receipt of a complaint. In this case, the hospital did not respond to the complainant or give him reasons for the delay in reply within the expected time. Complaint point (a) was therefore substantiated.

180. Regarding complaint point (b), PCC had acted in accordance with HA's established complaint handling procedures in referring the case to the hospital for investigation first. When the complainant was dissatisfied with the hospital's reply, he appealed to PCC which handled the appeal and replied to him on 10 December 2002. The complainant had not been treated unfairly by HA, and thus this complaint point was unsubstantiated.

181. As for complaint point (c), the nurse's acts had violated the pledge between the doctor and the complainant. She had also failed to appreciate the relatives' feeling on losing a family member. This complaint point was thus substantiated. Overall, this complaint was partially substantiated.

182. HA explained that the nurse concerned had no intention of offending the complainant. The nurse was obliged by law to make accurate entries onto the patient's records. HA acknowledged that there was room for improving the handling of the incident by the medical and nursing personnel, but noted that the use of unfriendly language by the complainant was not conducive to constructive communication. HA wished to emphasise the importance of mutual respect and cooperation between patients, their relatives and hospital staff in ensuring smooth operation of hospitals.

183. HA has accepted and implemented all The Ombudsman's recommendations as follows :

(a) HA has apologised to the complainant in writing for his unpleasant experience;

(b) HA has stipulated guidelines to remind the medical and nursing personnel that patients' records are HA's property, and that patients' relatives have no right in interfering with their normal handling by the hospital staff;

(c) HA has reminded front-line staff of the proper way of handling requests for copies of medical records;

(d) HA has reminded hospital staff when handling cases pending the decision of the Coroner's Court and when replies cannot be issued within the time specified according to the performance pledge, the complainants should be given interim replies and reasons for the delay in replying; and

(e) for cases pending the decision of the Coroner's Court, HA hospitals should make monthly enquiry in writing to the Court on their progress so as to ensure that all such cases are followed up properly.

Case No. 2003/0080：Maladministration of a hospital under HA, such that the complainant lost his chance of a liver transplant.

184. The complainant, a liver disease patient, received a call from a hospital at about 5 p.m. on 10 September 2002 informing him to go to the hospital for liver transplant operation. The complainant went to the hospital at once and underwent a series of pre-operation tests and preparations. He was informed at about 10 p.m. by a professor in the presence of three other doctors that due to certain resource problems, the operation had to be cancelled and the liver graft had been sent to another hospital. Considered himself having been treated unfairly and deprived of the chance of liver transplant, the complainant lodged a complaint with The Ombudsman against HA in January 2003 for maladministration of the hospital such that he lost his chance of a liver transplant.

185. HA explained that, when a liver became available for transplant, the hospital would initially identify a patient on the transplant waiting list and notify him to come for pre-operation tests, while the Chief of Service (COS) in

the Department of Surgery would carry out a "comprehensive assessment" to determine whether a transplant could proceed. In principle, only when all the necessary resources (e.g. the surgery team, anesthetists, perfusionists, operating theatre and intensive care unit) were available and the essential hospital services were not affected could the operation be performed. As there was no telling when a liver might be available for transplant, the hospital could not possibly have all the necessary resources for the operation on standby at all times, and any potential organ recipient notified by the hospital should not assume that a transplant would automatically proceed before the "comprehensive assessment" was completed. Due to budget constraints and shortage of perfusionists, COS had informed the liver transplant team in the form of a standing instruction of the Department that his prior approval was required before any transplant could proceed.

186. In the course of carrying out "comprehensive assessment" on that day, the COS concerned was aware that two core members of the transplant team, including the patient's Surgeon in-charge (Surgeon I/C), had not had enough rest after performing a very complicated operation two days ago and another one that very same day (each taking more than ten hours). Moreover, perfusionist support was not adequate that night. To proceed with the transplant would mean the postponement of several scheduled surgical operations, including three for patients in critical conditions. COS therefore decided at around 7 p.m. that the operation should not proceed and informed Surgeon I/C of his decision. The latter, however, did not concur with him.

187. Surgeon I/C further commented that while notifying a patient after the "comprehensive assessment" might assure him better of the operation, a liver graft could not be preserved for long and the potential recipient had to fast at least six hours before the operation. If for some reasons that the patient identified was found unfit for the transplant, another recipient had to be found. Time would then be even tighter for all parties concerned. Hence it was the view of Surgeon I/C that to notify the patient for admission before COS finished his "comprehensive assessment" was not inappropriate.

188. After investigation, The Ombudsman considered that whether the members of the liver transplant team were mentally and physically ready to perform the operation and what kind of personnel would be required to provide technical support involved professional medical judgment and were matters

outside the jurisdiction of The Ombudsman. In this light, The Ombudsman would not comment on the different views of COS and Surgeon I/C on these issues. However, due consideration should be given to the actual circumstances in determining when a patient should be notified for admission into hospital, and while notifying the patient, the staff concerned ought to have alerted him that the transplant might not take place under certain circumstances (such as lack of support personnel) lest the patient be disappointed. Neither Surgeon I/C nor other staff had put this point to the complainant that day.

189. Moreover, the complainant was not informed of the COS's decision not to proceed with operation until around 10 p.m. (i.e. three hours after making the decision). The delay was caused by disagreement between COS and Surgeon I/C and their repeated discussion over the issue while the complainant was left waiting for an extra three hours. Notwithstanding the good intention of Surgeon I/C in fighting for a transplant for his patient, the delay revealed the lack of an effective mechanism for resolving differences of opinions and for reaching a consensus quickly for the benefit of patients.

190. Separately, liver transplant is an expensive and complex surgery, not funded by HA in the hospital concerned. Members of the liver transplant team knew that limited resources meant limited technical support, such as perfusionists, for such operations. As a liver transplant had just taken place two days before then, Surgeon I/C should have discussed with COS the availability of resources beforehand. This would have been much fairer to the complainant and not give him false hope.

191. This case highlighted that there were internal conflicts and insufficient coordination over liver transplant services within the hospital concerned. The Ombudsman concluded that while the complaint was not substantiated, there were other matters of maladministration on the part of the hospital.

192. HA has accepted The Ombudsman's recommendations and taken the following actions :

(a) HA has formulated a policy that all future liver transplant operations are performed by the liver transplant team of one hospital only, and has set up a "Central Liver Registry" whereby all waitlisted patients are put under one central waiting list. Objective criteria have been

adopted for prioritisation of patients for receiving cadaveric livers; and

(b) HA has also promulgated guidelines on communication with the waitlisted patients elucidating the conditions under which they would be notified for admission into the hospital and the circumstances under which the transplant operation may be cancelled.

Housing Department (HD)

Case No. 2002/1084：(a) Misleading the owners of an HOS estate on the division of management reserve fund between two owners' corporations; (b) Delay in handling division of the management fund; (c) Discourtesy to the owners' corporations; (d) Delay in arranging for renovation of the estate management office; and (e) Mishandling the delineation of boundaries between the two owners' corporations.

193. The complainant was the owners' corporation (OC) of a block in a Home Ownership Scheme (HOS) estate. The block was ready for occupation in 1992 while six other blocks in the same estate had been occupied earlier in 1987. There were therefore two different Deed of Mutual Covenant (DMC) for the former and the latter. The estate also formed two separate OCs. The OC of the complainant's block was set up in July 1999, while the OC of the other six blocks was formed in June 2001. With the formation of two OCs, HD had to split the management fund between them.

194. The complainant claimed that a staff member of HD's estate management office had misled some owners at a meeting in March 1999 that the splitting of the management fund would be completed in three months upon formation of their OC, without specifying that this was subject to the remaining six blocks forming their OC. As a result, the complainant made a wrong decision not to take over the management of the block while waiting for the splitting of the management fund.

195. The complainant lodged a complaint with The Ombudsman in May 2002 against HD for :

(a) misleading some owners of the estate in saying that the management fund could be split in three months after the formation of their OC;

(b) delay in splitting of the management fund;

(c) disrespect of the OC by sending directly to individual owners two letters regarding estate management rights and management supervision fees;

(d) delay in fitting-out of the new management office; and

(e) unnecessarily redefining the agreed boundary without consulting the two OCs.

196. After investigation, The Ombudsman considered that the HD officer concerned was unduly too optimistic about the timing of the splitting of the management fund but she had no intention to mislead. She did not cause the complainant to lose the opportunity of taking back the management of the block. Complaint point (a) was therefore unsubstantiated.

197. For complaint point (b), The Ombudsman's investigation revealed that the major cause of the problem in the splitting of the management fund was that HD had always kept the income and expenditure of all the blocks in one single account. HD started to prepare proposals for the splitting of the management fund only after the complainant's OC had been formed. However, the complainant did not accept any of HD's four proposals. He also questioned the fairness of those proposals and requested HD to provide all invoices and receipts for verification. As HD had not provided the invoices and receipts to the complainant on time and therefore delayed the response to the complainant's legitimate request, it failed in performing its duty as a DMC manager. Hence, this complaint point was substantiated.

198. Regarding complaint point (c), HD had sent standard letters to individual owners in September 2000 and February 2001 directly, urging the owners to incorporate themselves and take back the management of their block as soon as possible. The complainant took HD's action to be an act of disrespect. HD subsequently apologised to the complainant for the misunderstanding caused. The Ombudsman accepted HD's explanation. This complaint point was unsubstantiated.

199. Complaint point (d) was also considered unsubstantiated as the complainant had changed the design and floor plan several times, therefore the fitting-out of the new management office was delayed.

200. Concerning complaint point (e), HD did not redefine the boundary separating the two OCs. Its surveyor just enhanced the accuracy of the

boundary on the survey plan to prevent any future disputes over the OCs' management and maintenance responsibilities. Therefore, this complaint point was also unsubstantiated. On the whole, this complaint was partially substantiated.

201. HD has fully accepted The Ombudsman's recommendations and implemented the following actions :

(a) a written apology for the delay of the provision of invoices and receipts was sent to the complainant on 7 May 2003;

(b) after examination, HD found that there were three more HOS estates with more than one DMC and having income and expenditure in a single account. Proposal on splitting of the account of one of the estates was made to the two OCs of the estate concerned for consideration. The OCs of the other two estates also agreed on the way to split the accounts. These two cases will be completed after going through the procedural formalities;

(c) a departmental circular was issued by HD on 28 May 2003 to remind frontline staff to keep proper accounting documents with supporting vouchers, and provide copies of them to any owner upon request after collection of reasonable copying charge;

(d) a departmental circular was issued on 13 October 2003 by HD on the guidelines on the procedures for the formation of OCs. The information and assistance available from HAD in this aspect were also highlighted in the circular. Besides, a briefing on the formation of OCs and self-management of HOS estates by OCs was held by HD on 29 October 2003 to update frontline staff on the latest experience and guidelines; and

(e) HD would continue to cooperate and liaise closely with HAD in the course of assisting owners to set up OCs. Informative leaflets and booklets on OC formation prepared by HAD were distributed to owners for reference by HD.

Case No. 2002/3628, 2003/0650：Shirking responsibility in the back-flow of sewage into the lift pit of an aided school on three occasions; and failing to follow up the blockage of public drainage to prevent recurrence of back-flow of sewage.

202. Please refer to Case No. 2003/0649 under Architectural Services Department.

Case No. 2002/4610：Ineffective supervision of a property services company which resulted in prolonged booking of venues in a public housing estate.

203. A community organisation (Organisation A) lodged a complaint with The Ombudsman in December 2002 against HD for ineffective supervision of the property services company (PSC) at a public housing estate. As a result, the PSC unfairly allowed two local individuals to use several public venues in the estate for a prolonged period, thereby depriving other organisations of the chance to use those venues.

204. The PSC was appointed by HD in mid-2002 to manage the estate and one of its duties was to handle the bookings of all open areas. Two local individuals applied to the PSC for the use of five of the nine venues in the estate in July 2002 to conduct a residents' opinion survey over a period of seven months. The PSC approved the application without consultation with HD. Organisation A therefore complained to HD and the PSC. The PSC subsequently advised Organisation A to use other venues in the estate.

205. After investigation, The Ombudsman noted that HD regarded venue booking as part of the daily routine of estate management. PSCs should possess adequate knowledge on estate management to ensure reasonable allocation of venues without HD's prior instructions. However, The Ombudsman did not accept HD's explanation and considered that even though the management of the estate had been contracted out, HD still had the overall responsibility to ensure public resources were fairly and reasonably used. The Ombudsman considered that HD should have formulated guidelines for PSCs to process bookings of venue properly. This complaint was therefore substantiated.

206. HD has fully accepted and implemented The Ombudsman's recommendations as follows :

(a) Best Practice Notes titled "Register for Use of Venue in Public Rental Housing Estates Managed by Property Service Company (PSC)/Management-Buy-Out Company (MBO)" has been issued to all PSCs on 18 August 2003. HD staff will review regularly the performance of the PSCs/MBOs to ensure that applications for venue booking are handled effectively in accordance with the criteria and procedures concerned; and

(b) a letter of apology has been issued to the complainant on 14 July 2003.

Case No. 2003/1786：Delay in the investigation of a case of using a forged document to apply for public housing leading to prosecution being time-barred.

207. The complainant reported to HD in June 2001 that an ex-employee of his company had forged an employer's certificate to apply for public housing. According to the Housing Ordinance, proceedings against an offence of giving a false statement when applying for a public housing may be brought up at any time within six years after commission of the offence or within one year after discovery thereof by an authorised officer, whichever period expires first. Upon receipt of a report of such an offence, the Housing Manager/Prosecutions of HD would first confirm the discovery date of the offence and determine the statutory time-barred date (STBD) as stipulated in the Ordinance. An Assistant Housing Manager/Prosecutions would check the STBD and then pass the case to a Housing Officer for processing in accordance with the STBDs chronologically. The Housing Officer should start screening the cases at least four months before their STBDs, completing scrutiny with recommendations preferably one month before. This would allow time for senior officers to decide whether or not to prosecute.

208. In this particular case, HD's Applications Section received the report on the forged document on 13 June 2001. However, the Assistant Housing Manager, who happened to be also Acting Housing Manager/Prosecutions,

mistook 17 July 2001 as the discovery date. The STBD thus fell on 16 July 2002 instead of 12 June 2002 and no checking was done.

209. When the Housing Officer started processing the case on 25 March 2002, it was just under four months from the July STBD. She reported the case to her new supervisor on 11 July 2002 and recommended prosecution. It was just five days before the STBD, and not the preferred minimum of one month.

210. Her supervisor then found out that the STBD should fall on 12 June 2002. As a result, prosecution was time-barred. Upon learning this, the complainant lodged a complaint with The Ombudsman in June 2003 against HD for delay in investigation of the case leading to prosecution being time-barred.

211. After investigation, The Ombudsman considered that HD's mistake was due to :

(a) wrong setting of the STBD;

(b) failure in checking the STBD;

(c) late submission of the case for prosecution; and

(d) inadequacy in monitoring of cases for timely submission.

212. In view of the above, the complaint was concluded as substantiated.

213. HD accepted and implemented all the recommendations of The Ombudsman as follows :

(a) HD has issued a letter of apology to the complainant on 24 December 2003;

(b) HD has investigated into the accountability of the officers involved in handling the case. HD found that a mis-judgment in setting the STBD, together with some weaknesses in the system, were the major causes for the case being time-barred. HD did not consider that an

isolated case of mis-judgment by an officer warranted disciplinary action;

(c) HD has taken various measures to improve the existing system. HD has reviewed the existing guidelines, procedures and practices for processing cases of suspected offence and monitoring of progress of prosecution cases;

(d) new departmental guidelines have been promulgated on how to deal with a suspected offence with information and guidelines on the setting of the STBD and follow-up actions required in handling cases of suspected offence, both in situation where prosecution action is completed and in situation where prosecution is not possible for lack of evidence or other reasons. Guidelines have also been given on the determination of the discovery date of an offence for the purpose of setting the STBD. All divisions and units that may deal with cases of suspected offence have issued detailed operational instructions (with built-in monitoring system) for their staff to follow in dealing with cases of suspected offences; and

(e) HD has investigated all prosecution cases in the last five years (i.e. between April 1998 and March 2003) which were time-barred from prosecution. Where appropriate, actions have been taken against officers who failed to measure up to the required standard.

Case No. 2003/1989：Delay in resolving persistent ceiling seepage problem.

214. A public housing tenant reported to HD on the ceiling's seepage of her unit in 1996 and then in 1999. Although HD had carried out repairs many times in her unit, the problem still persisted. HD staff considered that the seepage probably originated from the unit upstairs.

215. However, the tenants upstairs refused to co-operate with HD to inspect her unit. She claimed that she had previously let HD carry out repairs in her unit which led to the damage of her bathtub, thus she had little confidence in HD works. Moreover, because of chronic illness and a busy job, she could not allow HD staff to enter her premises again. During the four

years that followed, HD had issued a total of 61 letters (including eight warning letters) to the tenant upstairs.

216. In July 2003, the complainant lodged a complaint with The Ombudsman against HD for delay in resolving persistent ceiling seepage problem. Meanwhile, the tenant upstairs also lodged a complaint with The Ombudsman complaining that HD was unfair to her and tried to evict her through the "Marking Scheme for Tenancy Enforcement".

217. On 1 August 2003, HD implemented the above Marking Scheme whereby tenants who "deny HD staff or staff representing the HD entry for repairs responsible by the HD" should be allotted seven points as warning. HD invoked this rule and urged the tenant upstairs to co-operate. As she had repeatedly ignored HD's warning letters, the Department allotted her a total of 14 points. Under the Marking Scheme, a tenancy would be terminated if the tenant has been allotted 16 points.

218. After investigation, The Ombudsman considered that the tenant upstairs had clearly not complied with the Tenancy Agreement. As for HD's allotting of points under the Marking Scheme as warning, The Ombudsman considered that the tenant upstairs deserved it. In view of the above, The Ombudsman considered the complaint lodged by the tenant upstairs unsubstantiated.

219. On the other hand, the 61 letters issued by HD during the four years of handling the case were repetitive in contents, reiterating only the terms of tenancy without indicating any substantive actions to be taken. They had no deterrent effect on the tenant upstairs. HD had also failed to exercise its authority under the Tenancy Agreement to secure cooperation from the tenant upstairs and had not actively considered issuing a Notice to Quit in accordance with the terms of tenancy. Consequently, the tenant downstairs had to suffer the nuisance from the seepage year after year. The Ombudsman, therefore, considered the complaint by the tenant downstairs substantiated.

220. HD has fully accepted and implemented The Ombudsman's recommendations as follows :

(a) HD has sent a written apology to the tenant downstairs on 25 February

2004;

(b) HD has issued a final warning letter to the tenant upstairs on 4 March 2004 to allow works staff of HD and its representatives to enter her unit on 25 March 2004 for inspection and necessary repairs. It was stated in the letter that if the tenant failed to do so, actions by HD under the Marking Scheme would be strictly enforced, including termination of tenancy. Subsequently, the tenant was co-operative and allowed the works staff of the estate office to enter her unit and carry out inspection and repair on 25 March 2004. Since then, there has been no more sign of seepage in the unit of the tenant downstairs; and

(c) the tenant downstairs submitted an application to HD for transfer on 12 March 2004 and was offered another unit in the same estate on 8 June 2004. However, the tenant withdrew the transfer request on 29 June 2004 and remained in the original unit.

Judiciary

Case No. 2002/2738：Providing the complainant with misleading information on bankruptcy of his ex-employer.

221. The complainant filed a claim against his ex-employer with the Small Claims Tribunal (Tribunal). His claim was granted, but his ex-employer failed to pay according to the Award of the Tribunal. The complainant then called a staff of the Tribunal to enquire about the possibility of enforcing the court order. The staff, after reading information from the computerised case management system, told him that the Tribunal had received a document from the Official Receiver and that his ex-employer might have been bankrupt. At the request of the complainant, the staff provided him with the number of the bankruptcy case.

222. The complainant then went to the Official Receiver's Office (ORO) to make enquiry and found that the bankruptcy case was only related to a staff of his ex-employer but not the ex-employer himself. The complainant was very dissatisfied and lodged a complaint with The Ombudsman in August 2002 against the staff of the Tribunal for providing him with misleading information on bankruptcy of his ex-employer.

223. After investigation, The Ombudsman considered that the way in which the staff of the Tribunal handled the enquiry was not only indiscreet and improper, but was also imprudent in that the staff, without having first ascertained whether the document received from ORO was related to the defendant, informed the complainant of the said information right away and suggested that the complainant should make further enquiries with ORO. The Ombudsman was of the view that the incident could have been avoided if the staff had ascertained what the document was about before giving a reply to the complainant. Therefore, the complaint was concluded as substantiated.

224. The Judiciary Administrator (JA) has accepted The Ombudsman's recommendations and taken the below follow-up actions :

(a) JA has personally sent a written apology to the complainant on 13 August 2003 for providing him with unverified and unconfirmed

information;

(b) staff of the Tribunal have been reminded of the importance of handling and answering enquiries with care and attention. In particular , they have been advised to avoid disclosing information which is –

    (i) related to a third party;

    (ii) unconfirmed or unverified; or

    (iii) restricted or confidential within departments; and

(c) the complaint case will be used as a case study in the training and experience sharing sessions with staff.

Lands Department (Lands D)

Case No. 2002/0935：(a) Misinterpreting the original lease conditions of a site; and (b) Adopting without justification a higher plot ratio than allowed under the relevant outline zoning plan and the Mid-levels Administrative Moratorium.

225. The redevelopment potential of the subject site in the Mid-Levels was determined by: (a) the lease; (b) Building (Planning) Regulations; and (c) the outline zoning plan (OZP). The Mid-Levels Administrative Moratorium (the Moratorium) is an administrative measure intended to ease traffic congestion in the Mid-Levels by restricting the intensity of building development and redevelopment.

226. The subject site was part of a lot which originally contained one main residence and two outhouses. The lot was subsequently divided into two portions sharing a common lease that allowed a total of three houses, each to be not more than 35 feet in height. The owner of each portion took one outhouse and half of the main residence. One of the portions became the subject site.

227. In 1960-61, the owner of the other portion (the adjacent site) redeveloped her half of the main residence and the outhouse into a residential block and a garage with accommodation for drivers.

228. The complainant believed that Lands D had incorrectly and/or improperly determined that the adjacent site had only one house on it, thus allowing two houses to be redeveloped on the subject site, with consequent increase in the permitted plot ratio. He thus lodged a complaint with The Ombudsman against Lands D in March 2002 for :

(a) misinterpreting the original lease conditions of the site leading to unreasonable approval of lease modification; and

(b) adopting without justification a plot ratio in contravention of the relevant OZP and the Moratorium.

229. After investigation, The Ombudsman found that while Lands D had

always tried to abide by the restriction for “three houses” in the lease, it had displayed inconsistency and uncertainty over how to count the number of houses on the adjacent site. This was due to changes in Lands D’s operational definition of “house” and rationalised by the current definition, adopted in October 1999. According to the latter, the adjacent site contained two houses, while in November 1999, Lands D approved a redevelopment proposal for the subject site consisting of only one house, up to ten storeys high over carports.

230. According to the Building (Planning) Regulations, the plot ratio of the subject site for a building under 15 metres in height is 3.3. The maximum permitted height for a building on the site, as determined by the OZP, is ten storeys above carports or the height of the existing buildings, whichever is the greater. Since the original lease imposed a height limit of 35 feet on any house erected on the subject site, Lands D’s approval of a lease modification was necessary to build up to the height allowed under the OZP.

231. Lands D determined the scale of redevelopment permissible on the subject site by way of a “notional scheme” submitted by a developer, i.e. hypothetical designs to determine the extent of (re)development permitted within the limit of the lease before proceeding further with design and submission of building plans. Having obtained approval for the notional scheme, the developer then applied to Lands D for a lease modification to “stretch” the same gross floor area to fit into a high-rise building. In this regard, Lands D has treated any storey containing carparking spaces as “carport” and granted exemption for machine rooms, recreational facilities and lobby.

232. While the proposal appeared prima facie to be representing more intensive redevelopment in contravention of the principle of the Moratorium, Lands D pointed out that the Moratorium was only an administrative measure with no restrictive effect on existing property rights. Such rights were further taken to mean the maximum plot ratio (i.e. 3.3) and gross floor area permitted on the site before redevelopment. “More intensive development” was thus measured against the notional scheme, not any pre-existing building.

233. Having regard to the above, neither complaint point was substantiated.

234. While sensitive to the need for commercial confidentiality on lease

modification matters, The Ombudsman considered that Lands D would need to be more logical, consistent and transparent in its decision-making processes. Moreover, the scope of Lands D's authority would need to be further examined. There was also a need to examine the effectiveness of the Moratorium and Lands D's ability to implement it. The Ombudsman, therefore, considered this complaint not substantiated. Nevertheless, The Ombudsman considered that there were other practices and actions by Lands D that might constitute maladministration.

235. In response to one of The Ombudsman's recommendations, Lands D now makes known information and advice relating to lease modification applications, etc. to property professionals through the issue of practice notes by Lands D. However, Lands D has not accepted The Ombudsman's recommendations to :

(a) cease the practice of considering development proposals or applications for lease modification which are tabled or presented verbally, so as to ensure proper documentation for decision-making and record purposes; and

(b) open its meetings on development proposals and applications for lease modifications to the public and make the papers/minutes available, insofar as commercial confidentially permits.

236. The reasons for not accepting the above recommendations are set out below :

(a) to categorically cease considering tabled cases would be overly bureaucratic and result in longer case processing time. It should be noted that such cases would be properly recorded and covered by conference decision. Moreover, any new application is subject to formal submission according to current practice; and

(b) opening meetings on development proposals and applications for lease modifications to the public is not acceptable, because Lands D in such meetings does so as a landlord, not an administrative agent of the Administration. Lot owners negotiate with the Government on the basis of their contractual relationships under their leases. As such,

they do not expect their own information or data be made known to third parties.

Case No. 2003/1718：Delay in processing an application for Livestock Keeping Licence for quails.

237. Please refer to Case No. 2003/0945 under the Agriculture, Fisheries and Conservation Department.

Case No. 2003/2039：(a) Shirking responsibility when handling the complainant's enquiries and failing to give him a reasonable reply; and (b) Failing to attend properly to the issue of inadequate passenger facilities at a public pier.

238. The complainant was a ferry passenger. On knowing that Lands D had rejected an application of a ferry operator for leasing the public pier in question to install some passenger facilities in May 2003, the complainant made enquiries to Lands D and the Transport Department (TD) about the reasons in June and July 2003. In reply to the complainant's enquiries, Lands D officer said that they could not grant the lease of the public pier unless TD gave its approval, whilst TD officer informed the complainant that TD had already given Lands D its support for the application. The complainant later repeatedly sought clarifications from the two Departments. The Lands D officer said that TD's support was not sufficient for Lands D to grant the lease, and considered TD could take over the public pier and grant the lease to the ferry operator directly. However, the TD officer said that as constrained by its jurisdiction, TD had no authority to do so. The complainant thus lodged a complaint with The Ombudsman against Lands D and TD in July 2003 for :

(a) shirking responsibility when handling his enquiries and failing to give him a reasonable reply; and

(b) failing to attend properly to the issue of inadequate passenger facilities at a public pier.

239. Lands D observed in the ferry service licence issued by TD to the

ferry operator that there was a condition stating that the ferry operator could have exclusive use of the public pier. Lands D opined that TD should not have granted such exclusive use of the public pier to the ferry operator without first consulting Lands D and that TD should take over the public pier and grant the lease directly. TD indicated that since April 2002, TD had informed Lands D of the ferry operator's plan to lease the public pier and install additional passenger facilities thereon. Having received no response from Lands D on the matter, TD assumed that Lands D would agree to lease out the public pier to the ferry operator by an appropriate means. It was not until August 2003 that TD learned that it was not possible.

240. The Ombudsman considered that the two Departments lacked communication and coordination in handling the complaint. The officers concerned had expressed only the stance of their own Departments when answering the complainant's enquiries, without realising that they were actually responding to the same issue on behalf of the Government. The two officers concerned had failed to give the complainant a consolidated reasonable reply on behalf of the Government. Complaint point (a) was therefore substantiated.

241. On complaint point (b), the complainant said that there were no seats and toilets at the public pier and the guard railings erected along the public pier were improper which might pose a safety hazard to children. The Ombudsman considered that the public pier in question, like other public piers, was already provided with basic facilities and equipped with sufficient safety features. It was only out of commercial consideration that the ferry operator wanted to lease the public pier for installing additional passenger facilities. It did not necessarily mean that the facilities at the public pier were inadequate. Complaint point (b) was therefore unsubstantiated. On the whole, this complaint was partially substantiated.

242. The Ombudsman commented that TD had failed to check the land use restrictions of the pier before granting its exclusive use to the ferry operator. The Ombudsman also considered Lands D as too bureaucratic and inflexible, lacking alertness and a spirit of cooperation.

243. In response to The Ombudsman's recommendations, Lands D and TD have taken the following actions :

(a) Lands D has issued a Technical Circular to all staff which contains guidelines stipulating that when handling enquiries, if the case concerned involves other Government departments or if the policies of the respective departments are found not in tune with each other, the responsible officers should give the enquirer an interim reply and seek advice from their supervisors immediately, with a view to reaching a consensus with the other departments and giving the enquirer a co-ordinated reply. On the other hand, TD will revise its Departmental Instruction on "Complaint Handling Procedures and Guidelines" by incorporating a new section advising its staff of the proper procedures in handling enquiries or complaints involving other Government departments and/or cases where the stances of other departments are inconsistent with that of TD;

(b) Lands D has reminded all staff of its Administrative Circular which contains guidelines on the handling of documents copied to Lands D including those for information only, so that actions can be taken in a proactive and flexible manner as and when necessary;

(c) Lands D has organised several seminars and introduced ongoing training programmes for staff covering effective measures to eliminate bureaucracy, cultivate proactive service culture and promote team spirit when working with other Government departments as part of its "Change Management Programme"; and

(d) TD will revise the guidelines on issuing of ferry service licences, which will address the need to check land use restrictions on piers to be allocated to ferry operators. TD will also enhance the supervision over the work related to issuing of ferry service licences.

Legal Aid Department (LAD)

Case No. 2003/1737：(a) Delay in registering a charging order nisi and replacing it with a charging order absolute; (b) Failing to deliver court documents by other alternatives; and (c) Putting incorrect information in the affirmation.

244. The complainant (representing Madam A) complained that there was delay in the registration of a charging order nisi and making the charging order absolute. Madam A had been granted legal aid to enforce a maintenance order. In early May 2002, the Court approved LAD's application on behalf of Madam A and granted a charging order nisi so that she could register a charge against the property of her ex-husband (the respondent) in the Land Registry. LAD did not submit the draft order to the Court for approval until one year later. In mid-May 2003, the Court issued a sealed charging order nisi and set down the date of hearing. Meanwhile, LAD registered the charging order nisi with the Land Registry and tried to deliver the court documents to the respondent on 19 and 23 May 2003 but to no avail.

245. When LAD learned that Madam A had passed away on 12 May 2003, it stopped further attempts to deliver the documents to the respondent because LAD could not continue the proceedings without her instructions. The complainant complained that LAD failed to use other alternatives to serve the court documents on the opposite party.

246. In late May 2003, LAD sent the relevant documents to the legal representative of the executor of Madam A's will including an affirmation bearing "2 June 2003" as the date it was filed. The complainant considered this date misleading. In fact, the affirmation had been dated in advance and for filing to the Court that day.

247. Subsequently, the complainant lodged a complaint with The Ombudsman against LAD in June 2003 for :

(a) delay in registering a charging order nisi and replacing it with a charging order absolute;

(b) failing to deliver court documents by other alternatives; and

(c) putting incorrect information in the affirmation.

248. After investigation, The Ombudsman considered LAD to be at fault in omitting or delaying to submit the draft order to the court for approval. Therefore, complaint point (a) was substantiated. As for complaint point (b), The Ombudsman considered that since LAD could no longer represent Madam A, it was appropriate for it not to deliver the court documents to the respondent. This complaint point was thus unsubstantiated. Regarding complaint point (c), The Ombudsman accepted LAD's explanation that as the affirmation was scheduled for filing to Court on 2 June 2003, it was appropriate to put this date on the affirmation in advance. This complaint point was therefore unsubstantiated as well. On the whole, this complaint was partially substantiated.

249. In response to The Ombudsman's recommendations, LAD has taken the following actions :

(a) with the upgrading and enhancement of its computer system in mid-2003, all draft orders for Court approval have been systematically recorded and would be duly brought up to avoid omission; and

(b) LAD has revised its existing guidelines to provide more effective instructions to staff and ensure that all necessary procedures would be followed properly in the future.

Leisure and Cultural Services Department (LCSD)

Case No. 2002/4088：(a) Delay in sending a notice to the complainant for the collection of reserved books from a public library; and (b) Poor attitude of a library staff attending to the complainant's enquiry.

250. The complainant reserved a book from the public library through the LCSD "Reservation of Library Materials" service but she only received the collection notice in the evening of the collection deadline. She was, therefore, unable to collect the reserved book in time and went to the library for clarification the next day. While the duty librarian was politely discussing a possible solution with her, the complainant alleged that another library staff nearby rudely accused her of delaying the collection of the book on purpose and refusing to pay the reservation fee. She thus lodged a complaint with The Ombudsman against LCSD in November 2002 for :

(a) delay in sending a notice to her for the collection of reserved books from a public library; and

(b) poor attitude of a library staff attending to her enquiry.

251. After investigation, The Ombudsman noticed that on receiving an application for "Reservation of Library Materials", LCSD staff would hold the requested material and send a notice to inform the reader to collect it within a specified period. Before issuing the notice, the staff would impress the postage and date-stamp on the notice and despatch it to the designated post office on the same day for delivery. The computer records of LCSD and the date-stamp impressed on the notice received by the complainant showed that the Department had despatched it to the designated post office 12 days before the collection deadline. According to the Post Office (PO), the notice was returned for re-delivery one day before the collection deadline. Since there was no indication of the reason for the return of the notice, PO could not ascertain why there was delay in delivery. Therefore, complaint point (a) was unsubstantiated.

252. As regards complaint point (b), according to the other library staff on duty on the day of the incident, the complainant asked how the matter could be

resolved because the notice was late. The library staff under complaint raised her voice and insisted that the complainant had to pay the fee whether she had picked up her item or not. The Ombudsman noted from LCSD's guidelines that a fee of $2.50 would be charged for the reservation of each item of library material and the fee was payable once the requested item was available for collection. However, LCSD staff could consider waiving the fee upon the supervisor's approval in accordance with internal guidelines. In this case, The Ombudsman considered that the library staff under complaint was inflexible and failed to observe that LCSD might exercise discretion to waive the fee. Nevertheless, The Ombudsman believed that she did not intend to be rude to the complainant but was just speaking rather loudly. Complaint point (b) was thus unsubstantiated. On the whole, the complaint was unsubstantiated.

253. Separately, The Ombudsman noted that the complainant had praised the duty librarian for her positive attitude and flexibility in handling the matter.

254. Pursuant to The Ombudsman's recommendations, LCSD has taken the following actions :

(a) the Hong Kong Public Libraries have issued a memo to all Librarians and Assistant Librarians requesting them to remind library staff on duty to check carefully the proof of address of the applicants when processing applications for library cards;

(b) at the operational meeting of the Hong Kong Public Libraries held on 9 July 2003, Senior Librarians, Librarians, and Assistant Librarians from all public libraries discussed thoroughly the procedures for handling applications for library cards, including the need to draw up clear guidelines on the checking of applicants' proof of address. Based on the views put forth at the meeting, the procedures for reader registration as contained in the Staff Manual have been suitably revised and promulgated to all public libraries; and

(c) the sincere and customer-oriented attitude of the duty librarian concerned has been openly commended at the operational meeting of the Hong Kong Public Libraries and an internal meeting of the library that she belongs to, so that other staff members may follow her example.

Marine Department (MD)

Case No. 2003/2451：Delay in investigation of a marine accident and perfunctory action.

255. The complainant went diving in Hong Kong waters in May 2003. While emerging from the water, she was hit and injured by a speedboat. She was taken to hospital and was consequently hospitalised for over 40 days and went through two surgeries. The accident was initially handled by the Licensing and Port Formality Section (LPF) of MD, which after analysing the relevant facts, recommended not to prosecute the master of the speedboat because of insufficient evidence. The case was put on file and then forwarded to the Marine Accident Investigation Section (MAI) for further analysis and assessment.

256. On 11 August 2003, the complainant called MAI to enquire about her case. MAI responded that it was not aware of the accident and had not received any relevant file. The complainant then wrote to MD to complain about the incompetence and attitude of its staff. In the reply to the complainant, MAI apologised for its mistake in saying that it had not received the file. MAI also indicated to the complainant that it supported the LPF's recommendation not to prosecute. The complainant wrote to MD again to make another complaint. MAI replied and reiterated the reasons for its investigation result.

257. The complainant thus lodged a complaint with The Ombudsman on 20 August 2003 against MD for delay in investigation of the accident and its perfunctory action.

258. After investigation, The Ombudsman noted that :

(a) in the guidelines issued to MD frontline staff, marine accidents were categorised into "major accidents" and "non-major accidents". However, the guidelines issued to MAI grouped marine accidents into four categories, namely "very serious accidents", "serious accidents", "less serious accidents" and "other accidents". The different guidelines on handling marine accidents issued to frontline staff and

MAI would lead to different interpretation of the seriousness of an accident and hence different treatment of a case;

(b) in this incident, the frontline staff relied on information given by the complainant's friend and subjectively classified the accident as a "non-major accident". The incorrect classification was due to staff's inadequate understanding of the definition of "serious injury" and because the Department had not provided frontline staff with sufficient details;

(c) there was no clear procedure for investigation of "less serious accidents" (which may include serious injury cases);

(d) MD had not given any instruction to frontline staff on the confirmation and recording of personal injuries. No space was provided in the "Report of Marine Accident" form to account for the injury of the victim; and

(e) there was delay in handling accident report files. MD could have redeployed staff to deal with the heavy workload instead of leaving files unattended.

259. In view of the above, the complaint was concluded as substantiated.

260. MD agreed to The Ombudsman's recommendations and has taken the following actions :

(a) MD has sent a letter of apology to the complainant on 16 February 2004;

(b) MD has reviewed the procedures for marine accident investigation and has clearly set out the criteria for classifying serious injuries and major accidents in the "Marine Accident Investigation Guidance Notes" (Guidance Notes) for MAI. Relevant parts in the Guidance Notes have been disseminated to MD frontline staff in order to assist them to classify accidents;

(c) guidelines for handling and carrying out investigation on "less serious

accidents" have been provided in the Guidance Notes;

(d) instructions as to how to ascertain, assess and record the seriousness of personal injuries have been provided in the Guidance Notes;

(e) a new section on "Nature of Injury" has been added in the "Report of Marine Accident" form to record information about injuries, in order to facilitate frontline staff and MAI to ascertain extent of the injuries and seriousness of the incident;

(f) MAI has issued instructions to filing personnel setting out the procedures for proper handling and registration of marine accident report files; and

(g) MD has devised manpower contingency measures to cope with sudden increase of accident cases and to prevent accumulation of files. Procedures for receipt and distribution of files have been disseminated to filing personnel.

Social Welfare Department (SWD)

Case No. 2002/4371：Evasive attitude of staff members in handling a report on suspected fraud case of CSSA claims, and divulging personal data of the complainants.

261. The complainants, a married couple, had leased their flat to Mr. A. In December 2002, the complainants found a letter sent by the Social Security Field Unit (SSFU) of SWD to their flat about Comprehensive Social Security Assistance (CSSA). However, the addressee Mr. B was not their tenant. The complainants called SSFU and an officer there confirmed that the mailing address was correct. Suspecting that Mr. B might have used the address to make fraudulent claims for CSSA, the complainants followed the SSFU officer's suggestion and called the Report Fraud Hotline (hotline) of the Fraud Investigation Teams (FITs).

262. The complainants alleged that the hotline duty officer did not take down details of their report and advised them to report in person with documents such as the tenancy agreement to SSFU. Next morning, the complainants went to SSFU but the officer concerned was evasive and told them to call the hotline directly to report. Later, the officer's immediate supervisor showed them the tenancy agreements and rental receipts submitted by Mr. A and Mr. B, which caused the complainants to suspect that they were both making fraudulent claims for CSSA. However, the supervisor also suggested that they should report to FITs directly if they wanted prompt action.

263. That afternoon and next morning, the complainants received calls from Mr. A and his girlfriend, telling them to mind their own business. The complainants therefore suspected that SWD staff had disclosed to Mr. A that they had reported the case to SWD. In December 2002, the complainants lodged a complaint with The Ombudsman against SWD for :

(a) evasive attitude of staff members in handling their report on suspected fraud case of CSSA claims; and

(b) divulging to the suspected offender that they had reported the case to SWD.

264. After investigation, The Ombudsman considered that there was insufficient evidence to prove that SWD staff had been evasive. As for the hotline duty officer, it was confirmed that she had recorded the details reported by the complainants. As all SWD staff including hotline duty officer denied contact with Mr. A and other parties concerned before the complainants received telephone calls from Mr. A and his girlfriend, The Ombudsman could not tell how Mr. A learned of the complainants' report to SWD. The Ombudsman came to a final conclusion that the complaint was unsubstantiated. Besides, The Ombudsman pointed out that SSFUs and FITs lacked a mechanism for mutual notification, and did not remind the public not to repeat reporting fraudulent acts through different channels.

265. In response to The Ombudsman's recommendations, SWD has taken the following actions :

(a) the existing practice has been that, on receiving complaints and enquiries directly from the public, staff of SSFUs and FITs (including hotline) would inform the complainants that their complaints would be followed up. However, SWD accepts that there was room for improvement and has carried out a review in the light of The Ombudsman's recommendation to consider adopting a "one-stop" approach in receiving CSSA fraud claims reports from the public, and providing clear guidelines to the staff of SSFUs and FITs (including hotline) for actively receiving and handling the enquiries and CSSA fraud claims reported by the public. A clear guideline has now been formulated and promulgated to staff ensuring that they will explain to the informant that there is no need for repeated reporting through different channels. SWD will also include relevant explanations in "A Guide To CSSA" and on the SWD website;

(b) copies of the Information Form on Fraudulent Claims for CSSA have been made available in all SSFUs and the District Offices of the Home Affairs Department since May 2000 for use by the public. A remark has now been added to the Information Form to make it clear to the informant that duplicate reporting is unnecessary;

(c) for informants' convenience and to facilitate provision of

supplementary information, SWD now gives each fraud report a reference number. There is a new guideline instructing staff of SSFUs to notify the informant of the fraud report reference number;

(d) SWD has adopted new procedures to improve the communication between SSFUs and FITs, and enhance the effectiveness of the mechanism in receiving and handling fraud reporting; and

(e) SSFUs have been instructed to adopt practices similar to those followed by FITs in order to prevent leakage of informants' personal information.

266. Separately, SWD agrees with The Ombudsman that staff in SSFUs may have a better understanding of the background of individual cases. However, experience has shown that on balance it is more effective if fraud investigation is centralised in FITs which have developed specialist skills in this area. Besides, SWD has doubts about the practicality of setting performance pledge for different stages of investigation of reports as cases differ greatly in complexity. This issue will be considered in greater depth in an overall review of FIT operations by the end of financial year 2004-05. SWD has already communicated its views on these issues to The Ombudsman who noted and accepted the explanations.

Transport Department

Case No. 2003/2040：(a) Shirking responsibility when handling the complainant's enquiries and failing to give him a reasonable reply; and (b) Failing to attend properly to the issue of inadequate passenger facilities at a public pier.

267. Please refer to Case No. 2003/2039 under the Lands Department.

Water Supplies Department (WSD)

Case No. 2002/2161：Failing to reply to a complaint and to send correspondence to the complainant's designated address.

268. In July and November 1999, WSD found that the meter at the complainant's metered premises in Kowloon had registered excessively low water consumption for two consecutive periods. WSD then removed the meter for examination and found that it was out of order. In accordance with regulation 31 of the Waterworks Regulations, WSD calculated the water and sewage charges for the period when the meter was defective (i.e. from 30 March 1999 to 17 December 1999) on the basis of past water consumption of the consumer. However, as the metered premises happened to have been vacant during the period concerned, the water consumption assessed by WSD using the aforesaid method deviated from the actual consumption.

269. The complainant approached one of the Customer Enquiry Centres (CEC) of WSD on 12 May 2000 and disputed the water charges of the metered premises. On that day, the complainant also requested that a reply on the WSD's investigation result be sent to her other address in the New Territories.

270. Having made a downward adjustment of the water charges, WSD sent a letter to the complainant informing her of the investigation result. However, the water bill and the reminder for payment of water charges were both sent to the metered premises instead of the New Territories address of the complainant. Having no knowledge of the matter, the complainant did not pay the water charges incurred. WSD thus disconnected the water supply to the metered premises on 15 August 2000.

271. When the complainant applied for reconnection of water supply to the metered premises on 12 April 2002, WSD requested the complainant to employ a licensed plumber to repair the water pipe of the metered premises, which was blocked at that time, before water supply to the premises could be resumed.

272. The complainant lodged a complaint with The Ombudsman in July 2002 against WSD for failing to reply to her and failing to send correspondence to her designated address.

273. After investigation, The Ombudsman opined that the complainant's allegation that WSD had failed to reply to her complaint was not substantiated. However, as to the allegation that WSD had failed to send the letter to the complainant's designated address as requested by her, there was indeed room for improvement by WSD and therefore the allegation was substantiated. As such, this complaint was partially substantiated.

274. Following The Ombudsman's recommendations, WSD has taken the following actions :

(a) WSD has issued a written instruction to all CEC staff, reminding them to take the initiative to confirm with the consumers about the change of mailing address whenever the latter declare that their premises are vacant;

(b) WSD has reminded Customer Account Section and Customer Service District staff to make clarification and to take follow-up actions when the enquiry/complaint referral proforma contains a mailing address of the consumer that is different from the one on record; and

(c) WSD's hotline pre-recorded message and website have already contained information on the procedures for change of mailing address for ease of reference by customers.

Case No. 2002/2733：Failing to allowing the complainant sufficient time for paying the water deposit when issuing her a notice of disconnection of water supply.

275. In April 2002, WSD received applications for change of consumership referred by the Housing Department. The applications were lodged by the occupiers of a newly completed estate and one of the applications was lodged by the complainant. Upon receipt of the applications, WSD's billing system automatically issued demand notes to all the applicants during the period from 23 to 29 April 2002. Since the payment of the complainant was outstanding, the billing system issued a reminder to her on 28 May 2002. However, the complainant claimed that she had never received the two notices. After the

payment deadline had lapsed, the billing system issued a Workmen's Note (disconnection order) on 13 June 2002. Meanwhile, WSD also deployed a staff member to serve a final notification (Notice on Conditions for Withholding Disconnection) to the complainant's premises on 24 June 2002. The final notification had a one-day payment deadline. As the premises were unattended at the time of visit, the notice was put into the letter box of the premises.

276. The complainant found the final notification when she was off duty on 25 June 2002 and paid the deposit at one of the Customer Enquiry Centres at 2:05 p.m. on the following day. However, as the computer record of 26 June 2002 showed that the complainant's payment was still outstanding, WSD disconnected the water supply to her premises at 3:15 p.m. on the same day.

277. According to the information provided by WSD, the consumer's payment information would not be updated in the computer record until the next working day after the payment was made. Hence, on the day when the complainant made the payment, WSD was not aware of the matter. As a result, the complainant had to pay the reconnection fee for reconnection of water supply. She lodged a complaint with The Ombudsman in September 2002 against WSD for failing to allow her sufficient time for paying the water deposit when issuing her a notice of disconnection of water supply.

278. After investigation, The Ombudsman considered that WSD had followed the established procedures in this case. Besides, there was no evidence showing that WSD had neglected to issue the water bill and reminder. Therefore, The Ombudsman considered this complaint unsubstantiated.

279. In response to The Ombudsman's recommendations, WSD has taken the following actions :

(a) WSD has extended the payment deadline on the final notification to two working days;

(b) as for displaying up-to-date payment record in the new computer billing system, WSD has conveyed the request to the system integrator responsible for the design and development of the new computer system. However, since there are various methods for payment of

water and sewage charges, and since the business operator handling the payment may need one to three working days to sort out the payment information and upload it to WSD's new computer system, the integrator believes that one to three working days are needed before the payment information can be displayed on the customer's account record. Hence, the new computer system will not be able to display the current day's payment record; and

(c) in view of The Ombudsman's recommendation that the time required for transfer of payment information through different payment channels should be listed out in the Notice on Conditions for Withholding Disconnection, WSD has added the following details in the notification: "If payment is not confirmed, water supply will be disconnected on the third working day after the date of this letter. Since payment through other means (such as ATM, PPS or the Internet) takes three working days or more for the transfer of payment information to the customer's account records, it will not be in time to cancel disconnection. Please pay in CASH at offices with collection counter services." The relevant WSD Department Instruction has been updated accordingly and promulgated.

Case No. 2003/2110：Failing to take immediate follow-up action on a leaking fire hydrant.

280. The complainant phoned the Customer Telephone Enquiry Centre (CTEC) of WSD at around 8 a.m. on 4 July 2003, 2 a.m. on 5 July 2003 and 11 p.m. on 6 July 2003 to report on a dripping fire hydrant.

281. Upon receipt of the fault report of 4 July 2003, WSD staff attended the case immediately. After closing the control valve of the fire hydrant tightly, the water dripping ceased. For the fault reports of 5 and 6 July 2003, they were received outside office hours. Fault reports or complaints received at such hours were handled in slightly different ways according to their seriousness. For serious cases requiring immediate attention, staff of CTEC would telephone the WSD standby staff to request them to attend to the cases. Meanwhile, a fault complaint report would be sent through a computer system to the respective WSD regional office, together with a fax copy to the standby

room where the standby staff were stationed. For other cases, the referral to the regional office would be done only by sending the fault reports through the computer system.

282. For the two fault reports made by the complainant on 5 and 6 July 2003, CTEC considered that they were not emergency cases and could be attended to on the following working day by the regional daytime staff. Therefore, the fault reports were sent to the regional office through the computer system and the standby team had not been instructed to attend to the fault complaints immediately. Unfortunately, some confusion occurred in downloading the messages from the computer system on the following day and there was a misunderstanding that the fault complaints had already been attended to by the standby team outside office hours. Consequently, no daytime staff were sent out to attend to the cases. On finding that WSD did not attend to his fault reports, the complainant lodged a complaint with The Ombudsman in July 2003 for failing to take immediate follow-up action on a leaking fire hydrant.

283. After investigation, The Ombudsman considered the complaint substantiated.

284. On review of the case, WSD considered that the misunderstanding could have been avoided by strengthening the guidelines and procedures on handling minor fault reports or complaints. WSD had immediately issued revised guidelines on handling fault complaints in order to avoid recurrence of similar incidents.

285. In accordance with The Ombudsman's recommendations, WSD has taken the following actions :

(a) the revised guidelines on handling fault complaints have been incorporated into WSD's operating instructions; and

(b) in order to enhance the computer knowledge of the staff for effective monitoring of the progress of handling fault complaints, WSD has organised four relevant computer training courses in May 2004 and about 120 staff attended the courses.

Part II
Direct Investigation Cases

Government Secretariat – Education and Manpower Bureau (EMB)

Enforcement of the Education Ordinance on universal basic education

286. In the wake of reports of children of school age (six to 15) being kept from school and local children of ethnic minorities not getting school places, The Ombudsman decided to conduct a direct investigation into the mechanism for enforcing compulsory education in November 2002. The investigation report was published in May 2003.

287. After investigation, The Ombudsman has the following observations and opinions :

(a) The Ombudsman accepts that absenteeism of pre-school children is insignificant according to enrolment statistics. Reminding parents of their legal obligation to send their children to school through publicity programmes is appropriate and adequate;

(b) The Ombudsman welcomes EMB's assurance that there are sufficient school places for children of ethnic minorities. However, more publicity is needed for promoting awareness of the Government's offer of assistance in school placement;

(c) The Ombudsman notes EMB's reservations over the issue of warnings and orders in handling dropout cases. However, the legislation has been introduced to safeguard children's right to education and the law should be observed. Undue lenience puts such right at risk and the law in disrepute;

(d) The Ombudsman notes that schools have not always complied with EMB's guidelines in notifying its Student Guidance Section (SGS) of dropout cases through the "Early Notification System";

(e) counseling is at times clearly unlikely to be fruitful. Requiring SGS to continue with counseling for six months before referring the case to the Internal Review Board simply delays enforcement. With EMB's apparent hesitation (or, in its view, "cautiousness") towards stronger action even after referral, some difficult dropout cases have dragged on for years;

(f) the Internal Review Board takes months to issue a warning letter and is even more reluctant to issue attendance orders. In the four cases The Ombudsman has studied in the course of the investigation, the Department of Justice commented on two occasions that the time lapse between dropout and the recourse to legal action had been too long. Careful planning is no excuse for dilatoriness; and

(g) it is common belief that compulsory education was prompted by exploitation of child labour. This problem no longer exists. These days, the community is more affluent, labour legislation more comprehensive and the Government's assistance to the needy and vulnerable much enhanced. The Ombudsman sees the time as appropriate for the Government to review the need for enforcing schooling by law and to go for an administrative policy of "free universal basic education". However, this is an issue of education philosophy and policy and The Ombudsman leaves it to EMB and the community.

288. The Ombudsman has also made a number of recommendations. EMB has taken the following actions in response :

<u>General</u>

(a) EMB issued on 24 August 2003 a press release entitled "Local Children Entitled to Free Education" to remind parents that under the law, children between the age of six and 15 must attend school to receive education for their all-round development. In September 2003, EMB reminded parents through the press, television and radio that children aged six or above by September 2004 are required to attend primary schools and the minimum age of entry to primary one is five years and eight months. Parents are advised to submit

application forms in mid-September 2003, which are available free of charge from kindergartens, child care centers, District Offices of the Home Affairs Department, as well as the Regional Education Offices and School Places Allocation Section of EMB;

Children of Ethnic Minorities

(b) since October 2003, leaflets in Hindi and Urdu have been issued by EMB to publicise the universal basic education, placement service and Initiation Programmes for Newly Arrival Children for reference of parents of non-Chinese speaking children. Leaflets in simplified Chinese on universal basic education and education services provided by the Government of the Hong Kong Special Administrative Region such as the Initiation Programmes for Newly Arrived Children, and application forms are also made available free of charge for new arrivals at Lo Wu Terminal;

(c) EMB organised an experience sharing session on 1 November 2003 for Non-Governmental Organisations (NGOs) and schools with a relatively high intake of ethnic minority children to enhance the co-operation among parties concerned in delivering services to ethnic minorities. The event provided good opportunity for school heads, teachers, social workers, parents and NGO representatives to share their experience in supporting these children;

Dropouts

General

(d) over the last few months, EMB has re-engineered existing practices and worked out a time frame and flow chart to cut short the time taken for intervention and provision of support services for non-attendance cases. The flow chart has included the guiding principles and time frame for investigation, counselling and support for dropout students. In brief, the first three months of intervention after the students' absence will be devoted to counselling work by student guidance personnel or school social workers and when counselling is not effective in bringing the students back to school, the issue of warning

letters and attendance orders to the parents by EMB will be considered in the fourth and seventh months of intervention respectively;

Guideline to schools

(e) in October 2003, EMB issued a circular to schools on enforcement of universal basic education which outlines the statutory requirements of universal basic education; the responsibilities of schools in identifying potential school dropouts, making reports promptly to EMB on dropout cases, supporting non-attending and potential non-attending students; and the measures that schools should take to prevent students from dropping out of school. The emphasis is on prevention, early intervention and partnership with parents. The circular further encourages schools to develop school attendance and related policies that promote good student attendance, positive student behaviour, harmonious teacher-student relationship, effective parent-teacher partnership and a caring school atmosphere.

To improve collaboration with schools in the reporting and handling of dropout cases, with effect from 1 October 2003, EMB has designated a number of staff of the Non-attendance Cases Team to serve as named persons to liaise with schools on a regional basis in respect of dropout cases. Close liaison will be maintained with the responsible teachers in primary and secondary schools for prompt follow-up actions on suspected dropout cases.

Starting from December 2003, Inspectors of EMB has conducted random checking of students' attendance records through surprise school visits. This is to ensure that schools report suspected potential dropouts promptly. Inspectors would take the opportunity to promote and to discuss with teachers and schools the formulation of school attendance policy in their schools.

Up to October 2003, over 380 schools have installed the new web-based School Administration and Management System. The new system facilitates schools to have instant access to the personal particulars and absence pattern of dropout cases, and to send data to EMB for follow-up actions; and

Counselling, Warning and Legal Action

(f) the intervention strategy has been enhanced so that the time allocated for counseling is shortened to a period of three months from the date of the student's absence. The case will be brought to the Internal Review Board for discussion and consideration of the issue of warning letters and attendance orders in the fourth and seventh months of intervention respectively.

289. EMB did not accept The Ombudsman's recommendation which required the Bureau to review the need for enforcing compulsory education by law. EMB has reaffirmed the position that schooling for children aged between six and 15 should continue to be enforced by law and a review is not necessary. The Ombudsman noted EMB's position and respected its professional judgment and prerogative on how universal basic education should be enforced.

Government Secretariat – Efficiency Unit (EU)

Operation of the Integrated Call Centre

290. The Integrated Call Centre (ICC), managed by EU, was set up to provide a round-the-clock one-stop enquiry service to the public. Starting from July 2001, ICC has progressively taken over 60 hotlines formerly operated by 13 Government departments. ICC has also introduced the "1823 Citizen's Easy Link", a one-number hotline which handles enquiries and complaints for all the participating departments.

291. To ensure that a quality and convenient enquiry service is provided to the public, EU and the participating departments have entered into Service Level Agreements which stipulate clearly the roles and responsibilities of both parties and the performance targets that ICC needs to achieve, e.g. more than 80% of calls to be answered within 12 seconds; call abandoned rate to be kept at below 10%, etc.

292. ICC has adopted latest computer telephony and information technology. After selecting language, callers will be directed to operators who use a sophisticated system to look up the required information in the knowledge base in order to provide an immediate response to callers. Cases which require follow-up will be forwarded to the relevant departmental subject officers for action. Case progress will be tracked and timely reminder and escalation will be sent to officers.

293. The Ombudsman has received a number of complaints about ICC's handling of public enquiries and complaints which triggered the direct investigation declared in October 2002. The Ombudsman completed the investigation and published the investigation report in July 2003.

294. After investigation, The Ombudsman has the following observations and opinions :

<u>Maintenance of the knowledge base</u>

(a) rigidity of data-entry templates delayed the updating of information,

which resulted in misassignment or misdirection of calls;

Misassignment of cases, staff training and work allocation

(b) call agents have to serve many departments and functions. This has led to errors of misassignment and misdirection of cases. ICC's performance level drops as the number of client departments increases;

Call centre identity, accountability and personal data privacy

(c) ICC answers calls in the name of client departments. This raises concern about transparency, accountability and personal data privacy. Some departments felt that their reputation might be affected by proxy if ICC mishandled their calls;

One-stop service

(d) the Government intends to move to a single-number hotline for all enquiries and complaints. This has been partly achieved by integrating over 60 departmental hotlines into ICC but there is yet no timetable for full migration; and

Management culture and working relationship

(e) ICC's organisational culture is more task-oriented than people-oriented. Some client departments consider ICC as dominating, rather than accommodating, their requirements. There is a case for review and realignment for more cordial and cooperative partnership between ICC and client departments.

295. The Ombudsman has also made a number of recommendations. EU has taken the following actions in response :

(a) in addition to the annual updating programme conducted with departments, the knowledge base is updated and kept current through regular monitoring and inclusion of information on issues of interest/concern to members of the public;

(b) EU has examined the proposal of linking the knowledge base to the Geographical Information System (GIS) datamap in detail, and concluded that the installation of the GIS datamap into the ICC system would not achieve the desired results of enhancing situational awareness of "memory" of the system. EU's concern is that ICC would never be sure whether a complaint received for the same location is in fact the same as those captured in the GIS datamap. As it is too risky to so assume, the case must be reported to the client department for verification/investigation;

(c) ICC analyses the causes of case mis-assignment on a weekly basis, and appropriate remedial actions (including coaching, training, updating of assignment guidelines, etc.) are taken immediately. Dedicated case assignment team has also been established to assign cases to departmental subject officers;

(d) a case tracking system has been installed to monitor case progress and send timely reminder to subject officers of departments concerned. ICC has also revised the case referral procedures so as to minimise premature escalation of cases. A Web Case Information System will be launched enabling subject officers to access the case details including action required and deadlines through the Internet;

(e) ICC has conducted annual knowledge base update which reviews the overall sufficiency and accuracy of information and also the organisation of the information in order to facilitate call handling by ICC agents. ICC agents and departmental officers are all involved in the review and re-engineering processes to ensure that the knowledge base meets the operational requirements;

(f) in order to provide one-stop service, EU does not consider it desirable both from the customer service and operational points of view to organise the agents and supervisors into specialist teams in handling the inbound calls. However, building on the backend team which is already in existence, ICC has set up a specialised case assignment team. Moreover, ICC has strengthened the backend team to handle and co-ordinate cases which are complicated and cannot be resolved

at first time of call;

(g) ICC has strived to provide a clean and tidy environment, and cultivate a friendly working atmosphere for the staff. Measures implemented include the provision of lockers, common room facilities with TV, newspapers and magazines; organising tea gatherings, team meetings, lunch gatherings, social and recreational activities to enhance performance and promote team spirit; and a Staff Motivation Scheme to motivate staff and encourage good performers. Moreover, departmental officers are also invited from time to time to conduct briefings on major departmental policies and measures with a view to enhancing the working knowledge and performance of ICC agents;

(h) ICC answers calls in the name of 1823 Citizen's Easy Link for 1823 calls. During the time of The Ombudsman's direct investigation, calls transferred from departmental hotlines were dealt with by ICC agents in the name of departments concerned, which was in line with private sector practice.

EU consulted participating departments on The Ombudsman's recommendation on the issue of answering calls transferred from departmental hotlines in the name of ICC. 12 departments have agreed and hence callers calling these departmental hotlines are now informed of ICC's identity before the calls are connected to ICC agents for handling in the name of 1823 Citizen's Easy Link. However, one department did not agree to the proposed approach.

On publicity, a major campaign was launched in mid-2003 to promote the 1823 service. Another publicity drive is being planned towards the end of 2004 to tie in with ICC's service extension;

(i) statistics on complaints and complements on ICC services are provided to departments on a monthly basis;

(j) ICC will not transfer personal data of the callers to participating departments or third parties if the callers so request;

(k) ICC has requested departments to publicise 1823 together with the

departmental hotline numbers in their publicity materials. With 1823 becoming more popular amongst the public, EU's long-term aim is to migrate to a single hotline number;

(l) ICC has strengthened the backend team and set up a specialised case assignment team, which has proved very effective in reducing the number of cases requiring referral and cases of mis-assignment;

(m) EU has regular liaison meeting with participating departments on their call handling needs and ways to further improve performance;

(n) before proposing to departments on ICC taking over their departmental call centres/hotlines, EU will conduct a feasibility study to establish the cost effectiveness and overall benefits of such a move;

(o) ICC has regularly reviewed staff and management issues with an aim to improving the working relationship;

(p) ICC has maintained close communication with departments. Apart from the liaison meeting, ICC staff have regular and frequent contact with the subject officers at the working level to discuss and monitor the progress of the cases and to ensure that the knowledge base is up-to-date; and

(q) call centre professional training has been provided to management staff of ICC in order to improve their knowledge.

Home Affairs Department (HAD)

Assistance provided by the Home Affairs Department to owners and owners' corporations in managing and maintaining their buildings

296. In March 2003, The Ombudsman completed a direct investigation into how HAD facilitated the formation of owners' corporations (OCs). While investigating, The Ombudsman noted considerable community concern over the adequacy and effectiveness of the assistance provided by HAD to owners and OCs in managing and maintaining their buildings. The Ombudsman, therefore, decided to conduct another direct investigation in July 2003 focusing on that issue. She completed the investigation and published the investigation report in November 2003.

297. After investigation, The Ombudsman has the following main observations and conclusions :

(a) over the past 30 years, Government had devoted much efforts to promote good building management. In recent years, the Government amended the Building Management Ordinance (BMO) and drew up proactive strategies and positive policies to further assist owners and OCs. The Government's intentions and efforts were commendable;

(b) HAD had also put in commendable efforts to promote and support good building management and to organise more training for owners and OCs. However, the Department still fell short of providing advice and proactive assistance to owners and OCs;

(c) the deletion of all Housing professional grades and posts for building management services had frustrated Secretary for Home Affairs (SHA)'s policy objectives declared and resourced in 2001, which was tantamount to turning the clock back to the pre-2000 era;

(d) while HAD had to achieve efficiency savings under the Government's economy drive, it must not allow services to slip or deteriorate. To this end, HAD must re-examine its role, re-adjust its priorities and

re-deploy its resources;

(e) while HAD should continue to enlist the voluntary services of professional bodies and professionals in private practice, the Department must build up its own building management expertise for service enhancement and legislation reviews;

(f) despite HAD's continued publicity and education, some owners and OCs were still under the misconception that the Government had a duty to solve all their management problems. That had created unnecessary difficulties for and undue burden on HAD;

(g) Temporary Community Organisers in District Building Management Liaison Teams (DBMLTs) were not trained or meant to advise owners and OCs, but many owners/OCs thought they were;

(h) HAD and other Government departments had produced a wide range of materials relating to building management. Public access to such materials should be enhanced;

(i) HAD had extended the opening hours of Building Management Resources Centre (BMRC)/Kowloon and upgraded the telephone redirection and recording services which operated after opening hours, which was a welcome move;

(j) HAD had, since September 2002, arranged for professional bodies to provide free mediation service at BMRCs on a pilot basis. However, only four mediation sessions had been conducted since;

(k) HAD had in 1985 set up Building Management Coordination Committees (BMCCs) to identify problematic buildings and coordinate inter-departmental efforts in resolving these buildings' management and maintenance problems. The scheme, however, had problems of interfacing with the Buildings Department (BD)'s Coordinated Maintenance of Buildings Scheme (CMBS) established in 2000; and

(l) Government policies on building management were found to be

fragmented, and responsibilities scattered among a number of bureaux and departments. The situation was complicated by the Team Clean asking the Housing, Planning and Lands Bureau (HPLB), instead of the Home Affairs Bureau, to formulate policy on mandatory formation of OCs and appointment of property management companies.

298. HAD is pleased to note The Ombudsman's recognition and commendation of its efforts in continuously improving its services in building management. The Ombudsman has made a number of recommendations. HAD has accepted all of them and made good progress in the implementation of the various recommendations as follows :

Staff Deployment

(a) HAD has critically reviewed its building management staff complement with its 18 District Officers (DOs) and concluded that there is no operational need to retain Housing grade staff for building management purposes. Whilst Housing grade staff generally possess experience in managing public housing estates which may be of some relevance to private building management, the tasks undertaken by Housing grade officers in HAD (e.g. organising seminars, serving the District Fire Safety Committees, identifying target buildings, etc.) did not really require much professional input. Over the years, through intensive training and practical experience, Liaison Officers (LOs) in HAD have been able to attain expertise and experience in building management and perform their duties properly.

HAD shares the view that it would be ideal for it to have an in-house counsel. However, having considered the practical difficulties of having only one Government Counsel grade post in HAD, HAD considers it acceptable for its Senior Government Counsel (SGC) to be stationed in the Department of Justice (DoJ). This would enable the Civil Division of DoJ to achieve better deployment of counsel and make better leave arrangement for the SGC assigned to provide legal advice on building management.

Separately, HAD considers that BD is providing satisfactory technical support to its work on building management and there is no need for

secondment of BD staff to HAD. In fact, following the consultation on "Building Management and Maintenance", HAD has had discussions with HPLB and BD and the parties concerned have agreed to work together closely on the subject of building management and maintenance;

(b) HAD's publicity leaflet "Home Affairs Department and Management of Private Buildings" was updated in March 2004 to publicise the different roles of LOs and Community Organisers in building management matters;

Means of Service Delivery

(c) HAD has uploaded building management publications onto and provided hyperlink access through the Department's building management website. HAD would also include other relevant publications and hyperlinks in the future;

(d) HAD has revamped the building management website by adding thematic sections, e.g. "formation of owners' corporations", "daily operation of building management" and "fire prevention", etc. The new webpage has been launched on 5 March 2004;

(e) HAD has based on BMO worked out a detailed checklist outlining the proper steps and procedures that should be taken to convene an owners' meeting for the purpose of appointment a management committee. The checklist aims to highlight to owners the legal requirements for an owners' meeting and seeks to facilitate compliance. More checklists would be produced in the future as and when needed;

(f) HAD has continued to carry out regular customer surveys, monitor the feedback of clients and review the services of BMRCs as appropriate. One of the proposed changes is to merge the Public Enquiry Service Centre (PESC) of the Central and Western District with BMRC (HK) so that more members of the public who visit PESC would be aware of the services of BMRC;

(g) both the Hong Kong Mediation Council and the Hong Kong Mediation Centre have agreed that the pilot mediation scheme provided at BMRCs would be extended and be evaluated after ten cases have been completed. HAD has now processed five cases, of which two have been resolved after mediation and the other three failed. HAD will continue to publicise the pilot project to OCs, residents' organisations and the owners;

(h) since March 2003, HAD has provided owners and OC members with more training courses on the legal aspects of BMO. From January to June 2004, HAD's DBMLTs and BMRCs have organised a total of 20 training workshops/courses on the legal aspects of BMO for OC members. HAD will continue to do so and improve the course contents taking into consideration the needs and interests of the owners;

(i) it was decided in August 2003 that BMCCs should be subsumed under the District Management Committees (DMCs) of the various districts and be gradually disbanded. The DOs have been given the discretion to decide how best to implement the new arrangement. As at 30 June 2004, there were only five BMCCs remaining. To complement this change, the remaining BMCCs have ceased to select new target buildings onto the BMCC list. Where buildings which require improvements and a joint effort of various departments are identified, the DOs would include them as nominations to BD's CMBS. In this regard, BD is also considering to conduct a review of CMBS after three years of implementation;

Support and Control

(j) HAD has finished preparing the manual on the maintenance of private buildings which will be sent to its staff for reference. Separately, the fourth edition of the Frequently Asked Questions has been forwarded to HAD's SGC in DoJ for comments;

(k) HAD's staff training and development plan for 2004-05 would include "Legal Aspects of Multi-storey Building Management Part II", "Training Course on Mediation Practice", "Experience Sharing

Workshop on Building Management" and "Training Course for Community Organisers";

(l) HAD attaches great importance to the training and development of its staff to meet new challenges. HAD provides on-the-job training for its staff to equip them with the necessary skills and knowledge. HAD also provides leadership development, change management and overseas training courses for their career development. Moreover, HAD will sponsor LOs to study building management related subjects in recognised local institutions.

In addition, to groom officers of good potential and to broaden their horizons, HAD would send up-and-coming LOs on overseas training programmes. For example, two LOs were sent to the National University of Singapore to attend a course on "Strategic Management Programme" from 10 to 14 May 2004. Subject to the availability of resources, HAD plans to send other officers to this course as well as other overseas training programmes later in the year;

(m) with effect from January 2004, a set of standard classification of building management themes and sub-themes for consistent reporting of management information has been adopted for DBMLTs and BMRCs to report on a quarterly basis;

(n) working groups/committees to study building management matters have been set up under 13 District Councils to deliberate on building management matters; and

<u>The Administration</u>

(o) a public consultation exercise on "Building Management and Maintenance" launched by HPLB was completed on 15 April 2004. HPLB is now analysing the comments received. HAD is also working closely with HPLB to discuss the way forward for promoting proper building management and maintenance, including the possibility of adopting a more coordinated Government approach to address the often neglected problems of building management. Meanwhile, SHA as the Authority under BMO, will continue to

oversee the policy of private building management and HPLB will continue to oversee the policy of building safety and maintenance.

Social Welfare Department (SWD)

Prevention of abuse of the Comprehensive Social Security Assistance Scheme

299. The Comprehensive Social Security Assistance (CSSA) scheme provides a safety net for the needy and vulnerable. The community supports assistance for the less fortunate but is concerned over possible abuse of the scheme. SWD has the responsibility to establish the mechanism to deter abuse and to investigate suspected cases. As any system with scope for abuse and malpractice could constitute maladministration, The Ombudsman decided to conduct a direct investigation in May 2003 against this background. The Ombudsman completed the investigation and published the investigation report in December 2003.

300. After investigation, The Ombudsman has the following observations and opinions :

Grants on offer

(a) the adjustment of standard rates to reflect deflation had lagged behind the fall in wage level of the lower-income group;

(b) front-line officers did not have a guide on the rental levels in different districts for assessing the reasonableness of claims for rent allowance;

(c) the working guidelines on the processing of discretionary special grants were too vague, resulting in disparity and inconsistency of treatment;

(d) for single parents, non-monetary support would be more meaningful than a monetary supplement;

Eligibility

(e) there was no limit on the number of dependent children in a recipient family;

(f) the new residence requirement (from one to seven years with effect from 1 January 2004) should be widely publicised to help avoid unrealistic expectations from one-way permit applicants. Discretion to relax this new requirement should be exercised sparingly;

(g) SWD's tolerance of abuse could unwittingly condone fraudulent exploitation of the CSSA scheme;

(h) there might be scope to raise the level of disregarded income or to allow CSSA recipients to accumulate income, provided the asset limit was not exceeded;

(i) the basis to allow applicants to keep the current level of assets was obscure. The non-inclusion of self-occupied properly as assets in most cases was a possible loophole for abuse. Non-disclosure of property outside Hong Kong was another area of abuse as it was difficult to detect non-disclosure;

(j) dissemination of information gleaned from the Special Investigation Section (SIS) investigations could alert staff to common features of potential abuse and usual tactics for concealing information;

(k) case studies revealed serious delays in the investigation process; and

(l) SWD did not readily resort to criminal sanction against fraud and deception.

301. SWD has accepted most of the recommendations made by The Ombudsman. In accepting The Ombudsman's recommendations, SWD noted that operational aspects of the CSSA Scheme have been kept under constant review in order to minimize abuse. Marked improvements have been made over the past few years in the prevention of fraud and abuse and these efforts will continue. On those observations of The Ombudsman which have policy implications, such as reviewing benefits for single parents, the level of disregarded earnings (DE), and the effectiveness of Active Employment Assistance (AEA) and Community Work (CW) programmes, SWD pointed out that the Administration has already undertaken to conduct reviews of these

aspects. On other observations such as adjusting rates to reflect fall in wage level and limiting the number of dependent children in a family for assistance, SWD noted that these proposals represent considerable departure from existing policy and must be examined carefully. A detailed response on the actions taken and other observations are as follows :

(a) <u>General</u>

(i) SWD has all along been promoting a positive perception of the CSSA Scheme especially in view of public interest in recent years in connection with the increasingly significant portion of General Revenue devoted to CSSA. Detailed information about CSSA and the Support for Self-reliance (SFS) schemes is widely available through the scheme pamphlets and Guide to CSSA, which are also uploaded on SWD homepage. Video tapes about the CSSA Scheme and AEA/CW programme are played at all Social Security Field Units (SSFUs). In addition, there have been publicity programmes to promote a positive perception of the SFS Scheme, e.g. success stories reported in the media. These efforts will be continued and will be made a particular focus in October 2004 when SWD launches the next round of Intensive Employment Assistance Projects accompanied by appropriate publicity;

(ii) under SWD's current practice, all CSSA applicants/recipients will be reminded of their obligation to provide full and truthful information and the legal consequences of providing false information. It is a standard practice that all successful applicants will be given an information package which include, among other things, a CSSA Scheme pamphlet and a notification which reminds applicants of their obligation to report changes in circumstances. Posters are also mounted in all SSFUs giving a warning that obtaining CSSA by deception will be liable on conviction to ten years' imprisonment. To step up publicity, information boards displaying anti-fraud materials (which include the number and outcome of prosecutions) are being set up in all SSFUs. These information boards also emphasise the applicant's obligation to report changes timely and the serious

consequence of obtaining welfare benefits by deception; and

(iii) from time to time, SWD mounts publicity to increase public awareness of the consequences of fraudulent abuse of social security, and actively encourages the public to join in their efforts in combating welfare fraud. In addition to the fraud report hotline, the public can use a standard complaint form for reporting welfare cheats;

Grants on Offer

(b) The Ombudsman has recommended SWD to review regularly all the different components of the grants so that they remain proportional to the household expenditure of the relevant income sector. SWD has pointed out to The Ombudsman that it has never been the case that the standard rates have "different components" which are "proportional to the household expenditure" of a particular income sector. Currently standard rates are adjusted according to the movements of the Social Security Assistance Index of Prices (SSAIP). SSAIP is compiled by the Census and Statistics Department (C&SD) by reference to the findings of the Household Expenditure Survey on CSSA Households which is conducted every five years to produce a weighing system to reflect the expenditure patterns of CSSA recipients. It reflects the actual expenditure pattern of CSSA households. To take account of accumulated deflation as reflected by the SSAIP, the Administration has already taken a decision in February 2003 to adjust the CSSA rates downwards by 11.1%;

(c) As regards The Ombudsman's recommendation to subsume the standard special grants into the standard grant, SWD has pointed out to The Ombudsman that they could not verify a need and make payment without requiring recipients to apply for disbursement. All special grants, standard or otherwise, are made on a need basis. Subsuming a special grant under the standard rate would mean that the special grant would be payable at a flat rate to all recipients, including those not in need of the special grant. There is also the question of how to set the level of the special grant to be subsumed under the standard rate. Some will get less than what they need if

the level is set too low, and some will get more if the level is set too high. On the other hand, if the level is set high enough to ensure that no recipient will be worse off, this would result in additional Government expenditure;

(d) under the CSSA Scheme, there is a Maximum Rent Allowance (MRA) which is adjusted based on the private housing rent index in the Consumer Price Index (A) compiled by C&SD. This rent index is a broad indicator of trends in rental movements for private housing. The rent allowance ceilings under the CSSA Scheme, which are not excessive and are adjusted from time to time in accordance with the movement of the rent index for private housing of the CPI(A), already ensure the reasonableness of claims for rent allowance. SWD considers that it is not desirable to over-complicate the existing CSSA system by drawing up indices to reflect the rental levels in all districts;

(e) guidelines on the circumstances for approving discretionary special grants are laid down in the Social Security Manual of Procedures. Following the 1998 CSSA Review, SWD sent a clear message to all frontline staff to tighten up the administration of discretionary special grants. SWD recognises that some inconsistency is inherent in the nature of a discretionary power. At the same time, SWD is keenly aware of the need to adopt a prudent approach and to maintain as far as possible a consistent standard in approving discretionary special grants. For this reason, SWD has limited the approving authority in respect of able-bodied recipients to 13 District Social Welfare Officers who are directorate officers at D1 rank. As the circumstances of each case may vary and there are different factors to be considered on the merits of individual cases, reasonable flexibility has to be allowed for the approving officers who are sufficiently senior to be relied upon for making a prudent decision on individual cases. Discretionary special grants constituted only 0.06% of total CSSA expenditure in 2002-03, reflecting that SWD officers do exercise their discretionary power sparingly and prudently.

On The Ombudsman's recommendation for SWD to set up a committee to review discretionary special grants approved,

standardise the more common or frequent applications and draw up guidelines for approving officers, SWD suggests the alternative of adopting the Independent Commission Against Corruption (ICAC)'s earlier recommendation (in the context of a study on authorisation and payment of CSSA) of maintaining a dossier of typical cases on SWD's internal computer system for ready reference of all approving officers. SWD believes that this arrangement which has already been put into practice, together with sharing sessions from time to time, would be the best possible means of ensuring the integrity of the overall approach;

(f) following the recommendations of the 1999 Audit Report on The Administration of the Comprehensive Social Security Assistance and Social Security Allowance Schemes, SWD has already built in a special function in the Computerized Social Security System (CSSS) to keep track of and report unusual and frequent claims for discretionary special grants by individual CSSA recipients. CSSS would generate on-line warning messages to alert officers who are considering such claims. SWD has also reminded approving officers to be more stringent in considering repeated claims for discretionary special grants and other claims where the recipient has a personal responsibility;

(g) SWD embarked on a review of single parents on CSSA in March 2004 to explore the best way to help this group to achieve self-reliance. SWD will look at the eligibility criteria for the single parent supplement as part of the review, which is expected to be completed by the end of 2004.

Apart from the different charitable/trust funds and community resources/assistance in kind available to help the needy single parent families to tide over their financial hardship, SWD and Non-Governmental Organisations (NGOs) also provide a wide range of support services including family life education, volunteer training, outreaching service, mutual support groups, counselling, etc. to the single parents through the network of the existing family services centers/integrated family service centers (IFSCs). Besides, a wide range of flexible child care services such as occasional child care

service and extended hours child care services are available to meet the various needs of parents including single parents. In 2004-05, SWD will re-engineer the existing family service resources to form 61 IFSCs by phases. An IFSC, comprising three components, viz. a family resource unit, a family support unit and a family counselling unit, and providing a continuum of preventive, supportive and remedial service, will be more able to meet the changing needs of individuals and families (including single parent families) residing in a designated locality in a holistic manner. As at end of June 2004, eight IFSCs have commenced full operation and 53 IFSCs are coming on stream by phases within 2004-05;

<u>Eligibility</u>

(h) on The Ombudsman's recommendation for SWD to review the limit on the number of eligible members with a view to lowering the amount of standard rate for additional family members, SWD considers that putting a limit on the number of eligible members and lowering the amount of standard rate for additional members are two separate issues.

Putting a limit on the number of eligible members may contravene Article 36 of the Basic Law, which stipulates that "Hong Kong residents shall have the right to social welfare in accordance with law". Such a policy could also be regarded as discriminatory on grounds of family status under section 5 of the Family Status Discrimination Ordinance (Cap. 527).

Arising from the 1998 CSSA Review, SWD has since June 1999 rationalised the benefit levels for larger households by reducing the standard rates for able-bodied adults/children in households comprising three such members by 10% and in households comprising four or more such members by 20%. SWD will keep in view the need to review the benefit levels for larger households as part of the ongoing review of the CSSA system;

(i) SWD has enlisted the assistance of Guangdong officials in publicising the details of the new seven-year residence requirements for applying

CSSA, the details of which have been made available at one of the Guangdong Provincial Government's websites for public information. Apart from publicising the new policy through its homepage, press interviews and other means, SWD has printed a leaflet in simplified Chinese characters, traditional Chinese characters and in English to alert potential migrants to the new residence requirements. It has also asked NGOs providing pre-migration services for mainland residents to help in this regard. The Legislative Council (LegCo) Panel on Welfare Services has been briefed on the publicity measures taken;

(j) as regards the practical implications of the seven-year residence requirement, SWD will keep this under review as part of its ongoing review of the operation of the CSSA Scheme;

(k) SWD is taking forward the recommendation of the interim report on the Evaluative Study of the Pilot Projects on IFSCs submitted by The University of Hong Kong in May 2003. In light of positive outcomes of the service delivery model of IFSC and with the support of the Social Welfare Advisory Committee and LegCo Panel on Welfare Services, SWD will re-engineer the Department's and NGOs' existing family services centers/counseling units to form 61 IFSCs as mentioned in paragraph (g) above. IFSCs will be providing services to meet the multifarious needs of individuals and families including new arrival families. In fact, in the 15 IFSC pilot projects, an average of about 12% of new/reactivated cases come from new arrival families with some pilot projects having a higher percentage up to 26-28%. Between April 2002 and March 2004, the 15 IFSC pilot projects organised a total of 282 groups and programmes specifically for over 5 000 new arrivals. These imply that the services of IFSCs have been used by many new arrivals;

(l) guidelines on the exercise of discretion to waive the seven-year residence requirement for CSSA have been drawn up and issued to staff. SWD has taken one step further by publishing Frequently Asked Questions including circumstances under which discretion is normally given;

(m) following a review of the provision of DE, SWD introduced improvements to the provision of DE under the CSSA Scheme on 1 June 2003 as part of the intensified SFS measures on a time-limited basis for three years subject to further review. Specifically, SWD increased the maximum level of monthly DE from $1,805 to $2,500 and its "no deduction limit" from $451 to $600 for all categories of CSSA recipients.

SWD will carry out a comprehensive review of the provision of DE under the CSSA Scheme before June 2006. The Ombudsman's observations will be taken into account;

(n) as stated in the 1996 CSSA Review Report, the savings which CSSA recipients are allowed to keep are meant to enable them to meet emergencies and to build their lives when an opportunity to move from welfare dependency to financial independence arises. Arising from the 1998 CSSA Review, SWD has already tightened the asset limits for cases involving any able-bodied adult since June 1999. The Department will examine the need to further rationalise the asset limits as part of the ongoing review of the CSSA system;

(o) SWD considers that it is not an observed phenomenon that someone would transform all his/her assets into a luxury property and then apply for CSSA. Furthermore the costs of maintaining a luxury property also make the above prospect unrealistic. Arising from the 1998 CSSA Review, SWD has already tightened the policy on treatment of an owner-occupied property since June 1999. There would be understandable objection if by tightening the asset limits further SWD was to force the elderly, the disabled and the sick out of their homes. There is also difficulty in setting limits to be commensurate with the standard of living of most recipients as it would be difficult for SWD to judge whether the value of a property is commensurate with the standard of living of most recipients. SWD will consider the need to review the existing policy on treatment of an owner-occupied property as part of the ongoing review of the CSSA system;

(p) SWD does not believe that there is a serious problem with

"non-disclosed possession of property outside Hong Kong" by CSSA recipients. The Department believes that such cases should be small in number. In the process of application for CSSA, all applicants are required to declare their assets, including the ownership of properties (either in Hong Kong or elsewhere), if any. The declaration is based on an honour system. It would not be practicable or cost-effective to establish a mechanism to verify whether CSSA recipients, who are supposed to be financially vulnerable groups, are in possession of properties outside Hong Kong.

Furthermore, the experience shared by ICAC and the Police with SWD's SIS is that investigation of properties on the Mainland might be feasible for cases involving serious crimes such as smuggling or trafficking of illegal weapons, etc. There is however no existing channel for detection and checking of unreported properties for cases involving relatively minor offences such as welfare cheats. SWD will continue to explore whether there is any channel for easy access to information on property ownership in the Mainland;

(q) a review of the effectiveness of the intensified SFS measures introduced from June 2003 has been carried out recently and results suggested that the intensified SFS measures are meeting the objectives of assisting able-bodied recipients to become more self-reliant. In particular, a decrease in unemployment caseload emerged in October 2003. SWD will constantly review the effectiveness of AEA programme;

(r) subsequent to the approval of funding for creation of time-limited posts for an addition of 100 CW Organisers, strenuous efforts have been made to acquire sufficient CW opportunities for AEA participants. The number of CW Teams has been greatly increased from 60 per week before October 2003 to the present 150 per week. SWD will constantly review the number of CW opportunities to meet the operational needs;

(s) SWD will constantly review the development of CW programme and will consider ways and means to enhance CW programme for CSSA able-bodied unemployed. In May 2004, CW programme has been

extended to AEA participants aged below 50. Under the existing policy, CSSA single parents with the youngest child aged below 15 are not required to participate in AEA Programme under the SFS Scheme in view of their need to take care of children. Nevertheless, a comprehensive review of the CSSA single parent issue is being conducted. Requiring the single parents to spare time to serve the community as suggested will be considered in the review;

(t) SWD is committed to assisting and encouraging employable CSSA recipients and near-CSSA recipients (including victims of redundancies) to find and sustain employment and move towards self-reliance. With the improvement of the economy, introduction of intensified SFS measures since June 2003 and implementation of the Intensive Employment Assistance Projects since October 2003, a decrease in unemployment cases has been seen in recent months. SWD is engaging in closer partnership with the Labour Department (LD), e.g. LD's job placement information is now available in SWD's SSFUs;

(u) to ensure that the frontline staff are well equipped in discharging their duties, SWD's training centre provides a series of training programmes on skills in handling fraud cases including investigation, verification and fraud detection techniques. To provide more training in this respect, SWD has enlisted assistance from the Police and ICAC to reserve training places for its staff on programmes that cover basic investigation techniques. In addition, SIS will continue to hold experience sharing sessions with the district staff to share with them the investigation methodology being adopted by SIS;

(v) it will not be feasible to circulate to frontline staff the reports handled by SIS, since information contained in the investigation reports is confidential and can be seen only by the staff concerned. However, the minutes of the Internal Committee on Fraud Cases (ICFC) meeting, which provides information on the fraudulent acts and the decisions of ICFC, are being circulated to all frontline supervisors for information. SWD also holds regular sharing sessions for staff on possible causes of fraud and abuse and during such sessions the Department will draw on the experience of SIS generally;

(w) before signing the declaration in the CSSA application form, it is a standard procedure that the case officers will remind the applicants of the importance of reporting true facts and the legal consequence of providing false information. SWD has improved the layout of the CSSA application form such that the applicants are required to report and declare specifically whether they are in possession of properties, including those in Hong Kong, the Mainland or other countries;

(x) in the absence of an established mechanism and bearing in mind that the market price of properties varies from place to place and the information service may not always be reliable, it would not be practical to draw up guidelines on the valuation of properties in the Mainland. As necessary and wherever possible, SWD will try to obtain relevant information from property agents. On the other hand, deliberate non-disclosure of information regarding possession of properties outside Hong Kong will be subject to the same penalty as other cheats for CSSA;

(y) a Police Superintendent has been seconded to SWD for nine months from July 2004 to provide professional advice on measures to improve SWD's current mechanisms for prevention, detection and investigation of fraud and abuse in the social security system;

(z) SWD has developed a system to ensure timely and systematic referrals of suspected fraud cases received by SSFUs to SIS;

(aa) for monitoring the progress of investigations, SIS has now set a target time of seven days for initial investigation on screening. For internal control purposes, the target time for completion of high-risk cases is three months; for normal cases, the target time is within 12 months in addition to a half-yearly progress review.

On the mechanism for checking compliance with the performance pledge, there will be a half yearly progress review. For every case assignment, a remark "Subject Investigation Officer is required to report case progress to the Officer-in-charge in 3 months NOT later than DDMMYY once the investigation work is still underway." is

added to remind the investigation officer to comply with the performance pledge. Every pending case exceeding three months will have to undergo a half yearly review conducted by the Officer-in-charge to ensure case completion; and

(bb) in general, SWD considers that ICFC, which is chaired by the Assistant Director (Social Security), is already a high-level mechanism to decide on the treatment of all established fraud cases. SWD's guidelines for deciding which cases should be referred to the Police for consideration of prosecution have been agreed with the Department of Justice. Substantially more cases than previously are now referred for prosecution (based on statistics up to the latest months in 2003/04). All the same, SWD has to pay some heed to the characteristics of CSSA recipients. Owing to the low educational standards, etc., some may genuinely misunderstand the requirements of the CSSA scheme. The sad personal circumstances of others genuinely merit some sympathetic consideration. SWD is always clear that remorse and willingness to repay are not of themselves sufficient grounds not to refer cases for prosecution. SWD does take action to recover overpayment, both in cases that are referred for prosecution and those that are not.

Hong Kong Examinations and Assessment Authority (HKEAA)

Handling of examination scripts under marking

302. About two million scripts have to be marked every year. In the last five years, 77 scripts were lost. Noting media reports on incidents of missing examination scripts under marking, The Ombudsman announced its decision to conduct a direct investigation in November 2003. This direct investigation examined the measures for the safe custody of examination scripts and its remedial action in case of loss. The Ombudsman published the investigation report in March 2004.

303. After investigation, The Ombudsman has the following observations and opinions :

(a) the loss of even one script would be too many;

(b) HKEAA's lack of transparency (i.e. not informing the affected candidates) was out of step with present-day accountable governance. Some may even see this as an indictment on HKEAA's dereliction of duty to the candidates. On a broader front, it is a breach of the public faith in its administration of the examinations system;

(c) the total absence of proper investigation to ascertain responsibility among those concerned and a penalty system commensurate with the level of responsibility was incredible;

(d) it was not satisfactory that HKEAA did not have guidelines to markers on prevention of loss or on due caution. As markers were remunerated for marking, they should not expect to be exonerated because HKEAA had not issued reminders or guidelines; and

(e) candidates affected had a right to be informed of the loss of their scripts and to decide on remedy in view of the impact of the loss on their future.

304. The Ombudsman has also made a number of recommendations and

HKEAA has implemented the following corresponding actions :

General

(a) both HKEAA and markers have adopted a more responsible and transparent attitude towards loss of scripts;

Follow-up Action on Loss

(b) HKEAA will maintain a file for each case of loss — for documentation of the investigation process, for record of all deliberations and any other data;

(c) HKEAA will properly investigate each and every report of loss (requiring from the marker and/or invigilators a full account of the circumstances surrounding the loss), analyse causes for the loss and consider remedial measures;

(d) HKEAA will arrange for each and every case of loss to be discussed by its School Examinations Board for the purpose of apportioning responsibility, awarding penalties, analysing causes for the loss and determining precautionary measures;

Penalty System

(e) HKEAA has devised a system of deterrent and penalty for loss of scripts;

Prevention of Loss

(f) HKEAA has included in the instruction guide to markers a firm reminder of the importance of safe custody for scripts and appropriate advice against risk of loss in transit and marking;

(g) HKEAA will circulate extracts of reports on the investigation of loss among markers to promote and enhance their awareness;

(h) HKEAA has reviewed the invigilation process, in the context of the

procedures for collection of scripts from candidates on departure from the examination centre. HKEAA has also strengthened the guidelines for centre supervisors and invigilators in this respect;

Marker Ethics

(i) HKEAA will impress upon markers their duty to candidates;

Remedial Measures

(j) HKEAA will notify candidates affected soonest possible in the future, on availability of assessed grade;

(k) HKEAA will offer candidates the option of re-sitting for an examination or accepting the assessed grade; and

(l) HKEAA has set up proper mechanism for appeal against remedial measures taken.

305. HKEAA has not accepted The Ombudsman recommendation to appeal for school principals' cooperation in providing markers with safe storage for scripts because markers should not mark scripts in public places and school premises might be seen as public places.

306. By its statutory remit to plan and conduct two public examinations, namely the Hong Kong Certificate of Education Examination and Hong Kong Advanced Level Examination, HKEAA has the responsibility to uphold the credibility of the two examinations and ensure the operation of the examinations is smooth. The Education and Manpower Bureau supports HKEAA in its effort to enhance transparency and develop a more rigorous system of handling examination scripts under marking.