

Executive Summary of the Investigation Report on the Management of Government Crematoria

Introduction

In early 2000, extensive media reports about thefts from coffins at Cape Collinson Crematorium (CCC) led to a huge public outcry. In view of public concern, this Office initiated a preliminary assessment of the administrative issues associated with these incidents to determine whether a formal investigation against the Food and Environmental Hygiene Department (FEHD) under section 7(1)(a)(ii) of The Ombudsman Ordinance was warranted.

Purpose and Ambit of the Investigation

2. In the course of the preliminary assessment, FEHD provided this Office with information and comments about improvement measures introduced in the wake of publicity over the CCC thefts and theft-related arrests of CCC staff. Close scrutiny of the department's claims revealed a number of factual inconsistencies and coincidences. This made this Office suspicious that FEHD had only partially disclosed information on remedial measures implemented in the light of the reported thefts. Against this background, The Ombudsman decided to conduct a full investigation to examine critically the following administrative matters associated with the operation of the crematoria –

- (a) the particulars and extent of improvement measures introduced, or intended to be introduced since the CCC incident;
- (b) the circumstances and manner in which such measures had been formulated and introduced; and
- (c) the need for further improvement;

The CCC Incidents and Improvement Measures

3. FEHD was set up on 1 January 2000 to replace the Urban Services Department (USD) and the Regional Services Department (RSD). Its Cemeteries and Crematoria (C&C) Section manages the following six crematoria -

- (a) Cape Collinson Crematorium (CCC) on Hong Kong Island;
- (b) Diamond Hill Crematorium (DHC) in Kowloon;
- (c) Wo Hop Shek Crematorium (WHSC) in Fanling;
- (d) Fu Shan Crematorium (FSC) in Shatin;
- (e) Kwai Chung Crematorium (KCC) in Kwai Chung; and
- (f) Cheung Chau Crematorium (Ch CC) on Cheung Chau Island.

4. In September 1996, USD's management first received a report from an Artisan alleging thefts from coffins at CCC. The allegations were concluded as unsubstantiated after a police investigation. In February 1999, the Civil Service Bureau (CSB) received reports containing similar allegations and also complaining about other acts of impropriety. CSB referred these to the department for action. USD initiated an internal investigation, and subsequently made a report to ICAC in March 1999.

5. USD's management approached ICAC for post-incident advice and also conducted an internal review of its staff monitoring, supervision as well as security system in use at the crematoria, particularly CCC. The following improvement measures were introduced or proposed:

- (a) installation of CCTV cameras at strategic locations at all crematoria, except Ch CC, to provide visual monitoring and videotaping of the transportation of coffins from the service halls to the cremators. Installation was considered unnecessary at Ch CC because of its physical setting and low usage;
- (b) introduction of an Inspection Register to record details of inspection by supervising officers and a separate register for viewing CCTV tapes;
- (c) publication of updated guidelines for C&C staff;
- (d) introduction of a staff rotation programme; and

- (e) putting up posters to advise families of the deceased not to place valuables inside coffins.

Investigation

6. During investigation, this Office identified a number of factual inconsistencies and co-incidences in the administrative actions FEHD claimed to have taken. This confirmed this Office's earlier suspicions that the department had only taken remedial actions in response to the thefts at CCC. Enhanced supervisory measures were not extended to the other crematoria until prompted by specific inquiries from this Office.

7. The following illustrates some of such inconsistencies and co-incidences:

- (a) Inspections Register by supervisory staff was implemented at CCC in October 1999. This practice was only extended to the other crematoria in March 2000.
- (b) The format of the Register was only standardised with effect from 9 June 2000. This was after the Investigation Officers of this Office visited the CCC and FSC on 2 May, 2000 and suggested the need for a standardised Register format.
- (c) We have serious misgivings about FEHD's conflicting claims regarding actions it had taken on the Staff Rotation Scheme. FEHD claimed in its reply of 22 February 2000 to this Office that the scheme had already started. The department's subsequent replies confirmed that this was not the case. The so-called Staff Rotation Scheme had all along been only a proposal. Up to now, no substantive progress had been made in implementing the Staff Rotation Scheme.
- (d) This Office rejected FEHD's claim that staff postings for operational reasons in the past year signaled the commencement of the Staff Rotation Scheme. Replacement of seven Artisans at CCC interdicted from duty for suspected thefts from coffins, were redeployment arrangements necessitated by circumstances and were not part of any Staff Rotation Scheme as claimed by the department. FEHD eventually admitted in its reply of 7 July 2000 that "we are monitoring staff's mood and would be in a better position to draw up a firm

timetable for implementation in early 2001”.

- (e) WHSC did not implement a separate register to record the viewing of CCTV videotapes by supervisory staff until 17 May 2000. We have serious misgivings about the reason for this delay that FEHD gave in its reply of 7 July 2000. FEHD claimed that the delay was caused by the high demand for cremation at WHSC for the period of March to early May in 2000. As the CCTV surveillance system had been installed in WHSC since November 1998, we consider FEHD’s excuse to be rather lame.

8. We have no evidence, nor do we wish to believe, that FEHD attempted to mislead our investigators at least into believing that more remedial efforts had been made than was in fact the case. FEHD’s response to our criticisms regarding the above inconsistencies and contradiction were that they were the results of “misunderstanding”. Accepting the department’s excuse at face value, this reveals serious communication lapses within the department. However one views the department’s actions, they can hardly be held up as examples of good and proper administration.

Observation and Opinions

- 9. The Ombudsman has the following observations and opinions –
 - (a) There were serious administrative deficiencies in the supervision of crematoria. The thefts from coffins at CCC were syndicated crimes made possible by supervisory deficiencies at the crematorium.
 - (b) No credible inspection system existed in CCC before October 1999 or in the other crematoria before March 2000. An inspection system would have helped to deter acts of impropriety on the part of crematorium staff or would at least have made it more difficult for them to collude on corrupt practices on an appreciable scale.
 - (c) Given that the then USD management received allegations of thefts from coffins as early as 1996, this Office considered that this should have prompted those in charge of the C&C Section to tighten supervisory control and to formalize the inspection system. This had not happened.

- (d) We recognize that despite the new FEHD organizational structure introduced since 1 January 2000, the district setup and staffing had remained unchanged. The FEHD management had inherited many operational problems from its two predecessors, namely USD and RSD. We do not under-estimate the magnitude of the task facing FEHD's senior management, given the wide range of departmental activities that require rationalization and coordination as a result of the amalgamation of USD and RSD.

- (e) Overall, this Office considers that FEHD management's response to the CCC thefts from coffins had not been as well planned or executed as one might expect. Throughout our investigation, the C&C Section appeared to have responded in a knee-jerk manner. Although it tried hard to give an impression that a series of improvement measures had been undertaken to remedy deficiencies identified by the CCC incidents, close scrutiny revealed that this was not so. What improvement measures it had introduced, was done in an ad hoc manner. It was only when confronted by specific questions from this Office on their applicability to other crematoria, that FEHD took action to apply such improvement measures to the latter. Actions taken by the C&C Section over the CCC incidents and post-incident management, suggested that the crisis management capability of FEHD needed strengthening.

Conclusion

10. Based on the preceding observations and opinions, The Ombudsman has come to the following conclusion –

- (a) Over a period of many months after the CCC incidents, FEHD introduced improvement measures to prevent the recurrence of similar malpractices. These include, amongst others things, installation of CCTVs and the introduction of videotape viewing registers to tighten supervisory control over crematorium operations.

- (b) Despite these, there is room for further improvement as some of the proposed measures have not yet been implemented. An example is the introduction of the proposed Staff Rotation System.

- (c) Some improvement measures appeared to have been made in response to specific inquiries or suggestions from this Office.
- (d) There were many co-incidences and inconsistencies in the sequence of administrative actions FEHD claimed to have taken. We suspected that there were attempts to lure this Office into believing that the department had undertake more remedial measures than was the case.

Recommendation

11. The Ombudsman has made the following recommendations for the consideration of FEHD –

(a) Strengthening Monitoring Mechanisms and Control Measures

- (i) To devise comprehensive monitoring mechanisms and control measures to facilitate the implementation of the various improvements measures.
- (ii) To draw up a specific timetable for the implementation of the Staff Rotation Scheme, and the recommendations in the comprehensive review completed by FEHD in February 2000 and ICAC's post-CCC incident management advice.
- (iii) To continue to review the design, format and contents of the Inspection Registers for use by all crematoria staff to record tape movements and inspections.
- (iv) To continue to consolidate and incorporate all relevant updated guidelines on inspections to crematoria and checking of tapes of CCTV into the Operational Manual to facilitate internal reference by the staff concerned.

(b) Staff Awareness and Communication

- (v) To inculcate a culture among staff to encourage frank and uninhibited reporting by staff and to prompt rectification by the

management in any case of maladministration or potential maladministration identified in the course of the operation of the crematoria.

- (vi) To further strengthen staff supervision and enhance communication about crematorium operation through inspections and staff meetings.
- (vii) To increase staff awareness on the need to ensure accuracy of the information provided to this Office and if necessary, to issue specific guidelines for compliance.
- (viii) To continue closer supervision on and to enhance the supervisory accountability of the crematoria staff.
- (ix) To conduct regular management reviews of the operation of the crematoria with a view to making continued improvement in their services to the public.

Response from FEHD

12. FEHD indicated that it had no objection to the observations and opinions of The Ombudsman in the investigation report. The department also took the opportunity to assure The Ombudsman that it had always acted in good faith and with due diligence when responding to The Ombudsman's inquiries and that its staff had never intended to mislead The Ombudsman.

13. FEHD commented specifically on the Staff Rotation Scheme and the supervisory system of crematoria. It stressed that reactions from staff would need to be carefully handled if the Staff Rotation Scheme were to be implemented successfully. This as well as other considerations had contributed to the delay in the implementation of the scheme. With regard to the supervisory system of crematoria, particularly CCC, FEHD admitted that the C&C Section should have implemented earlier the realignment of the inspection register and updating of guidelines to all crematoria staff.

Final Remarks

14. The Ombudsman noted that FEHD accepted all the recommendations in the

Investigation Report. In view of the department's assurance, The Ombudsman would expect FEHD to handle all future inquiries from this Office in a cooperative spirit and professional manner. Finally, The Ombudsman would like to express her appreciation for the assistance rendered by FEHD throughout this investigation.

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Office of The Ombudsman

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