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

The Ombudsman has completed a direct investigation into the mechanism of the Marine Department ("MD") for following up on recommendations made in marine incident investigation reports.

Our investigation found that MD had in the past adopted a "lax" approach in its follow-up actions. It would just rely on the officers of relevant divisions under MD and the vessel companies/vessel owners concerned to voluntarily rectify the inadequacies, without any specific mechanism to follow up on and monitor whether the recommendations in the reports were implemented. In some cases, no follow-up action was taken for years after completion of investigation. Moreover, MD had not set up any database for the recommendations or any management information system to monitor their implementation. In order to obtain the relevant information, it had to manually collate and search the old records scattered among different divisions, but the information so obtained was incomplete and confusing.

This undesirable situation continued until June 2013, when MD set up a computer system in response to the Audit Commission's criticism. MD then input the recommendations made in incident investigation reports into the system to facilitate follow-up actions and monitoring work. However, there is still much room for improvement in the new mechanism, especially when in most cases MD is still relying on the vessel companies and related agencies to report their progress in implementing the recommendations, without itself making further verification. To address the inadequacies, The Ombudsman makes five improvement recommendations to MD.

The executive summary of the investigation report is at **Annex 1**.

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Direct Investigation Report
Government's Tree Management Regime and Practices

Hong Kong is a densely populated city. Tree collapse incidents in the past have resulted in casualty and damage to property. This direct investigation aims to examine whether there are any inadequacies in the Government's tree management regime and the effectiveness of its practices.

Pursuant to our in-depth investigation, this Office has found the following major inadequacies in the Government's tree management regime:

(1) the lack of a dedicated grade of officers responsible for tree management within the civil service;

(2) the need for the Tree Management Office ("TMO") to enhance its monitoring of the performance of tree management duties by Government departments;

(3) TMO's failure to effectively oversee Government departments' actions on public complaints/reports;

(4) the current unsatisfactory situation whereby there is no legislation and limited regulation otherwise for management of trees on private land; and

(5) the need to enact legislation on tree management.

The Ombudsman makes 11 improvement recommendations to the Development Bureau, which include urging the Government to clearly and firmly promulgate its intention to legislate on tree management in order to remedy the inadequacies under the current regulatory regime.

The executive summary of the investigation report is at **Annex 2**.

Direct Investigation Report
Government's Handling of Four Stonewall Trees along Bonham Road

On 7 August 2015, the Highways Department ("Hy D") removed from a stonewall on Bonham Road in the Central and Western District four Chinese banyan trees ("stonewall trees") for the sake of ensuring public safety. The incident aroused public debate and challenges.

An investigation by The Ombudsman has found that within a matter of three days between 5 and 7 August, Hy D had discovered a number of new cracks and gaps on the anchorage of the four trees. With a super typhoon approaching, there was a risk that the four trees, which were located near a busy traffic junction, would collapse at any moment and cause dire consequences. Therefore, in the absence of any feasible proposal to mitigate the risk of collapse of the four trees, Hy D had to remove them urgently to ensure public safety. We consider Hy D's decision not unreasonable.

On the day the four stonewall trees were removed, the Central and Western District Office ("DO") particularly telephoned some District Council ("DC") Members to notify them of Hy D's decision and justifications. DO's move was challenged by some people. Our investigation has revealed that the parties who received such telephone notification comprised the Chairman and Vice Chairman of the Central and Western District Council, the Chairman of the relevant Working Group and local DC Members from those constituencies which were more likely to be affected by the incident. We find DO's move appropriate and reasonable. Nevertheless, we recommend that the Home Affairs Department set out clear guidelines for determining whom to be notified by telephone of tree removal decisions so that queries and challenges could be avoided.

The executive summary of the investigation report is at **Annex 3**.

Enquiries

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Office of The Ombudsman
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Annex 1

Executive Summary

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

Background

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

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

Investigation of Marine Incidents

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

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

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

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

Follow-up Mechanism on Recommendations in Incident Reports

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

"Lax" Approach under the Old Mechanism

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

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

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

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

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

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

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

Omissions in Following up on Some Recommendations

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

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

Case Information Incomplete and Confusing

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

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

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

The New Mechanism is Still Inadequate

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

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

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

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

Failure to Follow up Rigorously on Each Case

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

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

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

Our Comments

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

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

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

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

New Mechanism Neither Comprehensive Nor Rigorous

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

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

MD Would Not Apply the New Mechanism to Old Cases

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

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

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

Question on Whether There are Still Outstanding Recommendations Unnoticed

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

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

Our Recommendations

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

(1) to actively verify whether all the recommendations in incident reports are implemented, instead of relying on reports by the related agencies or parties, and to include this procedure in the regular routines for following up on implementation of recommendations (**para. 23** above);

(2) to take appropriate follow-up actions on implementation of recommendations regarding cases involving vessels not registered in Hong Kong or not certificated locally (**para. 20** above);

(3) to reconsider applying the New Mechanism to follow up on those 22 recommendations in the incident reports cited in **para. 29**, with a view to ensure marine safety (**para. 31** above);

(4) to consider reviewing the information on cases under the Old Mechanism to prevent the problem of confusing records as shown in **paras. 11 and 15 to 17** above, and to ensure that appropriate actions will be taken to follow up on recommendations made in the incident reports; and

(5) to review regularly the follow-up actions on all recommendations made in incident reports under the New Mechanism and ensure the achievement of expected results.

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

Office of The Ombudsman
June 2016

Annex 2

Executive Summary

Direct Investigation into Government's Tree Management Regime and Practices

Background

Hong Kong is a densely populated city. Falling of branches or collapse of trees could easily result in injuries or damage to property in their surrounding areas. When that happens, the public would tend to blame the Government for failure in risk management; conversely, when the Government removes trees on safety grounds, it would often be criticised for not making enough efforts in tree preservation.

2. This direct investigation aims to examine the Government's tree management regime and practices with a view to identifying any inadequacies. Our focus is on the effectiveness of the Government's work to ensure public safety.

Our Findings

Tree Management Regime

3. Currently, trees on Government land and those on private land are regulated under different regimes.

4. The day-to-day management of trees on Government land is shared by various Government departments according to the management responsibility of the land concerned. Their duties include maintenance, inspection and risk assessment of trees. The Tree Management Office ("TMO") under the Development Bureau ("DEVB") acts as a central coordinator and oversees tree management work.

5. The Expert Panel on Tree Management ("the Expert Panel") under TMO is an advisory group made up of local and overseas tree experts. The Expert Panel advises the Government on policies on tree management and maintenance as well as the implementation of those policies.

6. As regards trees on private land, only some land leases contain a tree preservation clause, which stipulates that, unless there is an emergency, the land owner must obtain written consent from the Lands Department ("Lands D") before he/she can remove or prune any tree within the land boundary.

Manpower Issues in Tree Management

Lack of Registration System for Arborists

7. Landscape architects and arborists are the major professional practitioners in tree management.

8. In Hong Kong, accreditation of landscape architects' professional qualifications is governed by the Landscape Architects Registration Ordinance. That Ordinance empowers the Landscape Architects Registration Board to verify the qualifications of applicants for registration as landscape architects and to deal with the conduct and disciplinary matters of registered landscape architects. That registration system aims to maintain the professional standards in the field as well as to safeguard the rights and interests of organisations/individuals who engage the services of registered landscape architects. Arborists, however, do not have any registration system in Hong Kong. There is no avenue for the public to make a complaint against arborists in case of poor quality of service or misconduct.

No Specific Entry Requirements for Arboricultural Practitioners

9. The expertise and work experience of practitioners who conduct inspections and review inspections are crucial for the prompt and accurate identification of trees that are problematic or at risk of collapse. However, the Government merely requires those practitioners to meet some basic standards in these two aspects. Besides, the relevant training programmes offered by TMO are only two-day courses. It is doubtful whether practitioners who just meet such basic requirements are really capable of conducting proper tree inspection work.

10. As frontline practitioners are responsible for routine tree maintenance work such as pruning, prevention and treatment of insect, pests and diseases, and fertiliser application, their work quality has direct and significant bearing on the health condition of trees. Our investigation has found that those practitioners do not need to meet specific requirements of qualifications or work experience before they take up their jobs.

Manpower Resources Planning for Tree Management Being Long Overdue

11. TMO has organised training courses for Government employees responsible for tree management and also encouraged tertiary and training institutions to offer tree management programmes. However, it was not until mid-2015 that TMO started to study the manpower resources for tree management in Hong Kong for long-term planning purposes. We consider that long overdue.

Issues Regarding Management of Trees on Government Land

Deployment of Officers for Tree Management Resulting in Wastage of Experience

12. Currently, within the civil service, there is not a dedicated grade of officers responsible for tree management. The work is carried out by officers who are also responsible for other tasks (for example, the Leisure Services Managers in the Leisure and Cultural Services Department). Officers in those grades are often deployed to posts not quite related to tree management, resulting in wastage of professional knowledge and experience. That is not conducive to tree management work, (including supervision of contractors), which requires specialised knowledge and expertise.

Need for TMO to Enhance Monitoring Work of Government Departments

13. When planting trees, it is essential for Government departments to select the right species and planting locations with adequate growing space for the trees. All these factors have a direct impact on the well-being of the trees and their safety in the future.

14. We consider that while the various departments responsible for tree management duties are not hierarchically under TMO, the Office should enhance its communication with them. It should require the departments concerned to properly carry out their duties and monitor their performance in scrutinising the landscape design at the planning stage of works projects and following the DEVB guidelines in selecting the right tree species and planting locations to prevent tree collapse and obviate the need for hasty removal of dangerous trees in the future.

Inadequate Criteria for Risk Assessment

15. We also find it necessary for TMO to revise the criteria adopted in its "Form 2" designed for conducting risk assessment of tree. The incident of the collapse of a stonewall tree on Bonham Road on 22 July 2015 has shown that while the condition of a tree itself and its growing environment are separately recorded in "Form 2", the assessment criteria in "Form 2" have not taken into account the combined risk factors caused by the two together (for example, whether the weight of the tree itself plus external loading can cause a problem).

TMO's Failure to Effectively Oversee Government Departments' Actions on Public Complaints/Reports

16. We are always very much concerned about whether Government departments and their contractors respond quickly to public reports of hazardous trees. In the three cases we cited, there was serious delay on the part of both Lands D and its contractors in handling reports by the public. While it is the responsibility of the departments concerned to act on public complaints/reports about dangerous trees, TMO, being the

central body for regulating and coordinating the tree management work of various departments, should certainly step up its monitoring of their performance in this regard. TMO may even consider positioning itself as the reviewing body for any inadequacies in Government departments' handling of public complaints/reports, thereby directing them to take appropriate improvement measures.

Need to Enhance the Expert Panel's Transparency and Accountability

17. DEVB has set up the Expert Panel under TMO to take account of opinions from independent professionals on matters relating to tree management. To enhance its transparency and accountability, we consider that DEVB should keep proper records of the opinions from the Expert Panel/Panel members and make them available to the public.

Lack of Legislation and Limited Regulation for Management of Trees on Private Land

18. Compared with trees on Government Land, the regulation of trees on private land appears to be even more inadequate. Even for those private leases that contain a tree preservation clause, it is outside the regulatory scope of the clause as to whether and how the owners have maintained their trees. There is also no law at present to require owners of private land to inspect and maintain the trees within their property. In other words, currently, the Government has no power to intervene even if the land owners have not properly maintained their trees to mitigate the risk of tree collapse. Even if a problematic tree is found, the Government generally can only ask Lands D to advise the owner to adopt appropriate measures to mitigate the risk. If the owner refuses to cooperate, the problematic tree will continue to exist, with the risk increasing with time.

19. Cases have shown that tree collapse on private land as a result of improper management can have very serious consequences.

Necessity of Legislation on Tree Management

20. Tree legislation in other jurisdictions and related information indicate that tree management laws could help cope with certain tree management problems in Hong Kong, for example, formulating basic criteria for planting, pruning and removal of trees, conferring powers on government authorities to make it compulsory for private land owners to prune or remove dangerous trees on their land, requiring specific works relating to tree care and other tree management aspects to be carried out, as well as publishing the names of approved training providers and training courses on tree management.

21. It is already an integral part of Government policy to promote professional and quality tree management. And it is clear that the public has high hopes for the Government to strengthen tree management to prevent injuries or fatalities caused by tree collapse. We consider that the Government should promulgate its intention to introduce tree legislation to remedy the inadequacies of the current regulatory regime. The Government cannot just rely on giving the public education/advice/guidance, as that is unlikely to be able to achieve in the foreseeable future what society wants. Besides, studying for and drafting of legislation take time. The Government should, without further ado, start the necessary preparations. Once its intention to legislate is promulgated, that may help change the public's mindset and heighten their awareness of tree management responsibility. Moreover, business opportunities, and hence job openings relating to tree management, will emerge in the market as a result. This will in turn help nurture professionals and practitioners in the field to meet future demand for manpower resources after the enactment of legislation.

22. Meanwhile, when making preparations for legislation, the Government can consider further enhancing the status of the Expert Panel, as well as its participation and accountability. For instance, it can, based on the model of the Antiquities Advisory Board, convert the Expert Panel into a statutory body as part of the proposed tree legislation, thus enabling the Expert Panel to provide the Government with more authoritative and representative opinions.

Recommendations

23. In the light of the above findings, The Ombudsman urges DEVB/TMO to:

Manpower Resources

(1) consider setting up a registration or certification system for arborists;

(2) raise the professional knowledge and work experience requirements of arboricultural practitioners, especially those responsible for inspection and review inspections;

(3) step up technical training for frontline staff;

(4) speed up manpower resources planning;

Management of Trees on Government Land

(5) review the current deployment and training arrangements for staff with tree management duties, or even consider central deployment of dedicated tree management officers to various departments;

(6) step up the monitoring of tree planting arrangements of Government departments;

(7) supplement the criteria for tree risk assessment;

(8) set up a mechanism to strengthen the monitoring of Government departments' handling of public complaints/reports;

(9) enhance the transparency and accountability of the opinions offered by the Expert Panel, record the opinions of the Expert Panel/Panel members and make such records available to the public;

Management of Trees on Private Land

(10) continue to step up publicity and education on tree maintenance for owners of private land;

Legislation on Trees

(11) clearly and firmly promulgate its intention to legislate and complete the necessary preparations as soon as possible to form a basis for such legislation for comprehensive and more effective regulation of tree management and preservation in Hong Kong.

Office of The Ombudsman
June 2016

Annex 3

Executive Summary

Direct Investigation into Government's Handling of Four Stonewall Trees along Bonham Road

Background

On a masonry retaining wall ("the stonewall") between Bonham Road and St Stephen's Lane in the Central and Western District, there were originally six Chinese banyan trees ("stonewall trees", "T1" - "T6"). On 22 July 2015, T2 suddenly collapsed, causing personal injuries and damage to property. After the incident, the Highways Department ("Hy D"), which was responsible for maintaining those six stonewall trees, removed the remaining five for the sake of public safety (T3 was removed on 22 July; T1, T4, T5 and T6 on 7 August).

2. Hy D's removal of the four stonewall trees on 7 August aroused extensive media coverage and public debate. The Ombudsman, therefore, initiated this direct investigation to probe whether Hy D's removal of those four stonewall trees had sufficient grounds, whether the departments concerned had followed established policies and procedures in removing the trees and in conducting prior consultation, and whether they had acted in an open and fair manner. The ambit of this investigation covered Hy D, the Development Bureau ("DEVB") and its Tree Management Office ("TMO"), and the Home Affairs Department ("HAD").

The Events

Expert Assessment, Maintenance of Stonewall Trees and Mitigation Measures

3. As early as in 2012, Hy D had commissioned a tree expert to assess the structure and health condition of the six stonewall trees. According to the expert, T4 and T5 were rated at "high risk level"; and T1, T2, T3 and T6 at "low risk level". Hy D then carried out major pruning works on T4 and T5 in 2013 to mitigate the risk of tree collapse. Since then, Hy D's contractor conducted half-yearly inspections. None of the inspections revealed any health problem with the trees.

4. Meanwhile, Hy D studied various proposals to stabilise or support the stonewall trees. It eventually concluded that none of those proposals were feasible. The installation of anchorage structures for the trees was rejected mainly because of the narrow carriageway and footpath, heavy vehicular traffic, presence of major underground utilities, and the question of extra loading to the adjacent building structures.

Collapse of T2

5. On **22 July 2015**, when the amber rainstorm warning signal was in force, T2, the tree rated at "low risk level", suddenly collapsed. Later in the evening, Hy D found five cracks on the parapet wall behind T3 (the parapet wall was built along the footpath on St Stephen's Lane near the crest of the stonewall). Hy D and TMO considered that the cracks indicated anchorage instability and T3 was then at the risk of imminent collapse. Hy D, therefore, removed T3 that evening.

Hy D's Assessment of the Remaining Four Stonewall Trees

6. As for the remaining four stonewall trees (T1, T4, T5 and T6), Hy D monitored their condition almost daily after 22 July. On 3 August, Hy D and TMO, together with TMO's Expert Panel, which consisted of local and overseas tree experts, conducted a site inspection and held a meeting. The attendees were of the view that the trees were not at any risk of imminent collapse and the stonewall showed no sign of instability. On that occasion, members of the Expert Panel put forward three proposals on supporting or stabilising the trees. Hy D concluded that none of those proposals was feasible.

7. Between 5 and 7 August, Hy D continued to discover new cracks and gaps on the parapet wall, i.e. the top part (tension part) of the tree anchorage. After assessment, the Department considered that those were "warning signs" of tree anchorage instability, outward shift of the tree anchorage, and weakened resistance against toppling.

8. Hy D's assessment showed that upon failure of any one of T4, T5 or T6, the falling tree would generate a traction force through the probably interwoven roots, resulting in the collapse of all three trees at once. The collapse could cover an extensive area, leaving little chance for pedestrians (especially those waiting at the bus stop underneath the trees) and vehicles on Bonham Road to escape and thus possibly resulting in injuries or even deaths. As the trees were quite tall, the residential flats and ground level shops of the opposite buildings might also be severely damaged. As for T1, since it was located at a rather high point, the risk of causing injury or death and significant damage to property, in the event of collapse, could not be underestimated either.

Decision to Remove the Four Stonewall Trees

9. On 7 August, Hy D decided to remove the four stonewall trees to ensure public safety in view of the following urgent developments:

(1) shortly after the extensive pruning of the four trees, new cracks/gaps had been found at the parapet wall/some spots on the stonewall close to where these trees were situated;

(2) it was difficult to estimate the tipping point between resilience and collapse of the four trees;

(3) the four trees might collapse anytime and with dire consequences;

(4) there was no feasible proposal to mitigate the risk of collapse of the four trees; and

(5) with a Super Typhoon approaching, the weather would remain unstable according to the forecast of the Hong Kong Observatory ("HKO").

Hy D and HAD Informing Relevant Parties of the Decision to Remove the Trees

10. Having decided to remove the four stonewall trees, Hy D sent an email to the Central and Western District Office ("DO") of HAD that afternoon (7 August), requesting DO to forward a letter ("notification letter") to the Chairman of the Working Group on Environmental Improvement, Greening and Beautification Works ("the Working Group") under the Food, Environment, Hygiene and Works Committee of the Central and Western District Council ("DC") to inform him of Hy D's decision and justifications. Hy D also copied the notification letter to DEVB by fax.

11. DO then forwarded the notification letter by email to all Members of DC, including the Chairman of the Working Group. The DO also **notified by telephone** six DC Members, namely, the Chairman and Vice Chairman of DC, the Chairman of the Working Group, and the Elected Members of the three constituencies (i.e. the University, Centre Street, and Tung Wah Constituencies) which were more likely to be affected by the ensuring road closure and traffic diversion.

Our Comments

12. After careful examination of the causes and consequences of the whole incident and all relevant information, we have the following comments.

(1) Decision to Remove the Stonewall Trees Not Unreasonable

13. With regards to the challenges from some in the community to Hy D's justifications for removing the four stonewall trees, we accept the clarification/explanation given by the Department:

(1) The Department has explained in detail why the "warning signs" concerning the risk of collapse of the four stonewall trees were credible.

(2) There were views that Hy D should not have removed those trees on grounds of instability especially since the Civil Engineering and Development Department ("CEDD") had confirmed the structural

integrity of the stonewall. In response, Hy D has clarified that CEDD's assessment was premised on the stability of the stonewall itself, not of the trees that were growing on it. Even though the stonewall itself was stable, the tree anchorage had already deteriorated, meaning that there was still a risk that the trees would collapse.

(3) Hy D has pointed out that studies on various proposals for installing structural supports to reinforce the four stonewall trees had been conducted, but the proposals were all found in feasible.

14. We appreciate that those who care about the four stonewall trees must have felt disappointed and sad about Hy D's abrupt decision to remove the trees. Nevertheless, the parapet wall and tree anchorage had indeed shown signs of imminent deterioration within a matter of three days between 5 and 7 August 2015, and the situation should not be taken lightly as the trees might collapse anytime. Moreover, in view of the continually unstable weather as forecast by HKO and the potential risk of casualty, it was not unreasonable of Hy D to adopt a cautious attitude to ensure public safety. Hy D had provided justifications in its consideration of the removal of the trees and its assessment of the potential risk of collapse of the trees. In addition, we have consulted engineering experts, who concerned with Hy D's decision to remove the trees and its justifications. Having taken into account the views of different parties, we have then overall examined this controversial issue from an administrative and rational perspective. Our conclusion is that: there is no substantive evidence to show that Hy D's decision to remove those four stonewall trees was rash or unreasonable.

(2) Involvement of the Expert Panel Should be Strengthened

15. There were views that Hy D's failure to notify members of the Expert Panel prior to removal of the stonewall trees was disrespectful to the Panel.

16. We noticed that Hy D had previously reported to the Expert Panel on all the proposals, and their infeasibility, to stabilise/support the six stonewall trees. TMO had also consulted the Panel members on the health and stability of the four stonewall trees in question. When Hy D decided to remove those four trees, it had followed established procedures and informed DEVB (TMO). The fact is that TMO had not made use of the hour or so before the removal to inform the Expert Panel to allow them to voice their last-minute opinions. This was a case of TMO failing to make the best use of the Panel's expertise and professional views. Conceivably, this has fallen short of the expectation of both Panel members and the public.

17. We consider that in future Government should as far as possible allow members of the Expert Panel to voice their opinions on its decision to remove trees involving controversy or of special value. Their opinions should be clearly recorded and made known to the public in order to enhance the transparency and accountability of the Government's decisions.

(3) Not Unreasonable of DO to Notify Selected DC Members by Telephone

18. DEVB does not make it mandatory for Government departments responsible for tree management to consult the public on cases of tree removal. In this incident, besides notifying all the Members of DC by email of Hy D's decision to remove the trees and its justifications, DO had also separately telephoned the Chairman and Vice Chairman of DC, the Chairman of the Working Group as well as the DC Members whose constituencies were more likely to be affected by the incident. We consider DO's action reasonable and appropriate. The DC Members concerned, having received early notification, could help explain the situation to the residents affected. We did not find that the DO, in notifying those DC Members by telephone, had given them preferential treatment based on irrelevant considerations.

(4) Public Awareness Should be Heightened of the Potential Danger Posed by Certain Kinds of Trees

19. Because of their size, form/shape or special environment of their locations, some trees might actually be potentially less stable, thus posing a bigger risk to public safety. In this incident, for instance, sizable trees had been growing not on the ground but on a vertical wall. Some of those trees had already been rated as posing "high risk". The public's awareness of such kinds of risk needs heightening.

Recommendations

20. In the light of the above, The Ombudsman recommends that:

(1) DEVB should clearly record opinions of the Expert Panel and make them known to the public to enhance transparency and accountability;

(2) DO should accumulate experience and formulate clear and specific criteria for deciding in future whom to be specially informed by telephone of the Government's decisions to remove trees, so as to avoid arousing suspicious; and

(3) TMO should find ways to heighten public awareness of the potential danger posed by certain kinds of trees.

Office of The Ombudsman
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