

*Issue No. 3 of Reporting Year 2010/11  
(21 December 2010)*

*Office of The Ombudsman, Hong Kong*



*Anonymised Investigation Report*

The complainants of two cases complained to the Water Supplies Department (“WSD”) about high water charges and sought follow-up action. After investigation, WSD found that the water meters of the two complainants’ flats had been mixed up with those of other flats.



Our investigation revealed that in Case 1, WSD had failed to check and verify the meter installation records of the estate in question submitted by the developer. In Case 2, WSD had failed to check and verify the meter installation records submitted by the contractor that had carried out meter replacement project at the building concerned. Although it was the developer or contractor that installed/replaced the water meters and recorded the meter numbers, WSD had the ultimate responsibility to cross-check those data to ensure accuracy. It should not have shifted its responsibility onto others.

We have made a number of recommendations to WSD including setting a timeline for handling cases of water meter mix-up, reviewing its practice in cross-checking meter installation and replacement, strengthening the monitoring of contractors and cross-checking the meter numbers of all flats in the estate/building concerned.

A summary of the investigation reports is at **Annex A**.

***Direct Investigation into Management of  
Non-Emergency Ambulance Transfer Service  
by Hospital Authority***

The Ombudsman has completed a direct investigation into the management of Non-Emergency Ambulance Transfer Service (“NEATS”) by the Hospital Authority (“HA”).



The investigation has revealed that HA needs to set service standards for waiting time by out-patients using NEATS, improve on punctuality and enhance certainty of the service for in-patients. The investigation has also noted the existence of unmet demand for NEATS.

The Ombudsman has made eight recommendations for HA to improve the service and to explore ways to deal with the unmet demand.

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

***Direct Investigation on  
Transport Department Actions  
for Safe Operation of Public Light Buses***

Road safety is about human lives. The Transport Department (“TD”) has the undeniable responsibility for proactively enhancing the safety standard of our public transport services. However, our direct investigation found that prior to June 2009, there had been a lack of due diligence in TD in fulfilling such responsibility regarding Public Light Buses (“PLBs”).

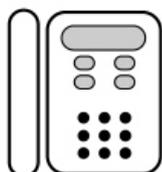


We have made six recommendations to TD for enhancing the safe operation of PLBs, and for improving the planning and monitoring of road safety initiatives in general.

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

***Enquiries***

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**Office of The Ombudsman, Hong Kong**  
**21 December 2010**

*Issue No. 3 of 2010/11*

## Summary of Investigation Report Complaints about Water Meter Mix-up

### Introduction

The following two complaint cases are about delay on the part of the Water Supplies Department (“WSD”) in handling water meter mix-up problems.

### The Complaint

#### *Case 1*

2. In January 2009, the complainant received a water bill for her flat in an estate demanding a charge for \$900. As the flat had been vacant for about six months, she suspected that there was a mistake. She, therefore, went to check the water meter of her flat, only to find that the number of the meter was different from the one stated on her water bill. Also, the reading on the water meter was 936 units less than that on the bill. She subsequently called the WSD hotline and asked for follow-up action. WSD agreed to send a staff member to inspect and cross-check. Meanwhile, the amount of water charge would be suspended.

3. In March, WSD staff carried out a site inspection and checked the water meter. It was confirmed that the meter of the complainant’s flat and that on the lower flat (“Flat A”) had been mixed up. The complainant called WSD to enquire about the progress of her case in March and April. The Department wrote to her only at the end of April to confirm that the meters had been mixed up. Nevertheless, WSD had rectified the record and there was no need for the complainant to pay any water charge for the period concerned. On the other hand, WSD had notified the registered consumer of Flat A of the adjusted water charge.

4. WSD received the complainant’s letters in May and September, alleging that the Department was sluggish in handling her case and did not explain clearly how it would solve the problem of overcharging as a result of meter misreading over the years. She also queried who should be held responsible for the mistake. WSD wrote back to her in June and November respectively to explain the progress and apologised for taking a longer time to process the case. However, the complainant considered that the replies fell short of addressing her queries. She, therefore, complained to this Office.

## *Case 2*

5. In 2009, the number of persons living in the complainant's flat decreased from four to two. However, there was no significant change in the water charges. The complainant thus lodged a complaint with WSD in mid-September about the high water charges. After a site inspection in early October, WSD staff verbally told the complainant that the meters had been mixed up. However, the complainant did not receive any written reply afterwards. Three months later, WSD replied to the complainant and confirmed that the meters had been mixed up. It also revealed that between December 2008 and December 2009, the complainant had been overcharged by nearly double on his water bills. Dissatisfied that WSD had delayed in handling the meter mix-up and overcharging, the complainant lodged a complaint with this Office.

## **Our Findings**

### *Case 1*

6. WSD could not figure out why the meters had been mixed up or who should be held responsible. It merely attributed the incident to errors when meter numbers were being recorded or during data upload into the computer system. The complainant did not accept this explanation. We checked the meter installation records upon completion of the estate in question and found that such records had been submitted to WSD in early 1996 by the developer, who then submitted an amended version in December that same year. According to the amended version, all the flats within the estate had been renamed and the water meters re-arranged. The meter number of the complainant's flat in the original installation records was in fact the one that was later found to belong to her flat. However, her meter number was changed in the amended records. The problem was that the complainant's original meter number then became the new meter number of Flat A. In fact, we noticed that for some other flats in the estate concerned, the meter numbers in the amended installation records were also different from those in the original records.

7. We believed that WSD had not conducted a site inspection to cross-check the amendments before uploading the data to its computer system. Otherwise, it should have discovered that the meter numbers of the two flats in question were different from those in the installation records.

8. On the other hand, upon receipt of the complainant's dispute about water charges on 7 January, WSD did request its Customer Services Section within two weeks to arrange a site inspection. However, due to heavy workload, an inspection was not conducted until early March and a reply to the complainant only made at the end of April. There was a lapse of more than three

months and WSD still could not explain why the water meters were mixed up or who should be held responsible for the mistake. We are of the view that WSD's delay in handling the case inevitably caused anxiety to the complainant. It also caused unfairness to the consumer at Flat A who had to pay the adjusted water charge.

## *Case 2*

9. In mid-February 2009, WSD hired a contractor to conduct a routine meter replacement project at the complainant's building. The Department believed that the complainant's meter had been mixed up with that of the flat below since the replacement work. It claimed that on completion, the contractor had filled out the serial numbers of the new meters of various flats in the building on a Meter Installation Table but mistakenly swapped the number of the complainant's meter with that of the flat below. As WSD staff only updated the meter information in its computer system according to the installation data submitted by the contractor without cross-checking them, the mistake in WSD's meter records occurred. Since the mix-up happened after 16 February 2009, WSD adjusted the water charges between 16 December 2008 and 15 December 2009 for the two consumers. After adjustment, the amount payable by the complainant was reduced from around \$1,000 to some \$500.

10. The complainant raised the water charges dispute in September 2009. After a site inspection in early October, WSD staff discovered that the complainant's meter had been mixed up with that of the flat below. Although WSD immediately issued a letter to the registered consumer of the flat below to arrange for an inspection, no reply was received. And WSD did not actively follow up. After three months of procrastination, WSD conducted an inspection at the flat in question in January 2010 and confirmed that the meters had been mixed up. To the complainant, it was indeed very frustrating and unfair as he was well aware that the meters had been mixed up but still had to wait for many months before he got the result. Moreover, this incident unavoidably brought unfairness and inconvenience to the consumer at the flat below.

11. We also found that six months after the replacement work, WSD had yet to input the new meter data and update the records in its computer system. As a result, it could not conduct any meter-reading or calculate the water charges for various consumers in the building according to their actual consumption but had to resort to estimation, making it even more difficult to resolve the water consumption dispute arising from the meter mix-up. That was indeed undesirable.

## **Conclusion**

12. This Office considered that whilst entrusting the developers or hiring contractors for installation or replacement of water meters, WSD should verify and ensure the accuracy of all meter data. It must not shift its responsibilities to others.

## **Recommendations**

13. With regard to these two cases, The Ombudsman recommended that WSD:

- (1) review its current practice of cross-checking meter installation and replacement, strengthen the monitoring of contractors and ensure the accuracy and validity of records submitted by contractors and developers (Cases 1 and 2);
- (2) set a timeline for handling cases of water meter mix-up (Cases 1 and 2);
- (3) cross-check the meter numbers of all flats in the estate/building in question and take remedial measures to rectify errors, if any (Cases 1 and 2);
- (4) review its internal monitoring mechanism to ensure that its staff follow established procedures and give timely response to the public (Case 1); and
- (5) review the procedures for updating computer records and formulate improvement measures to avoid delay (Case 2).

## **Follow-up Action by WSD on Our Recommendations**

14. WSD has accepted our findings and recommendations. The current implementation actions are as follows:

- (1) WSD has reviewed the timeline for handling cases of meter mix-up and amended its guidelines. As from August 2010, its Customer

Services Section will take follow-up action within 21 days upon receipt of a complaint.

- (2) As at mid-December 2010, WSD has inspected 257 out of the 328 flats regarding Case 1 and inspected 136 out of the 138 flats regarding Case 2. Apart from these meter mix-up cases involving the two complainants and the two affected flats, no similar mistakes were found in other flats so far.

15. Other recommendations are being followed up.

**Office of The Ombudsman  
December 2010**

## EXECUTIVE SUMMARY

### Direct Investigation on Management of Non-Emergency Ambulance Transfer Service by Hospital Authority

#### Background

In view of complaints handled on the Non-Emergency Ambulance Transfer Service (“NEATS”) by Hospital Authority (“HA”), The Ombudsman decided to initiate a direct investigation on 28 September 2009 to examine the reasons for the delay and uncertainty of the service and identify possible improvements. The ambit of the investigation includes:

- (a) the booking system and scheduling of the NEATS fleets;
- (b) mechanism for monitoring the service; and
- (c) areas for improvement.

#### Operation of NEATS

2. Eligible users of the NEATS service include stretcher-bound patients; wheelchair-bound patients living in a place inaccessible by lift; and mentally or sensorily impaired patients without escort on discharge from hospital. Users of the NEATS service are broadly classified into two categories: out-patients and in-patients.

- (a) Out-patients include patients attending specialist out-patient clinics or day hospitals for scheduled appointments. Bookings for out-patients are made in advance on a first-come-first-served basis. There is a quota system under which each clinic or day hospital is allocated a pre-set quota daily to transfer patients between their residence and clinics. Out-patient requests are always met.
- (b) Requests by in-patients are for transfer between hospitals and on discharge at the end of a hospital stay. Such requests are usually made on the day of transfer or discharge. There is no pre-set quota for in-patients.

3. There are eight foremen in HA who are responsible for accepting requests, scheduling ambulance routes and deploying staff. They draw up routes by matching accepted requests with ambulances and staff available. Every day they will draw up routes for out-patients first before adding requests from in-patients received to the routes planned. If this is not possible, they will

re-arrange the routes by regrouping patients as the day progresses. While the scheduling process aims to maximise utilisation of ambulances and staff, availability of service to in-patients is difficult to confirm at the time of service request.

## **Views of Stakeholders**

4. We collected 34 questionnaires from patients who had used the service through the assistance of two patient groups. Ten respondents had the experience of using vans illegally fitted out to accommodate wheelchair users due to long waiting time. We also collected 150 questionnaires from HA staff involved in the NEATS service. There were 97 comments received that patients were dissatisfied with the NEATS service. Most of the reasons were “waiting too long”, “long travel time” and “uncertain waiting time”.

5. In addition, we have examined three complaints on NEATS handled by our office and HA. They revealed problems of long waiting time for out-patients and uncertainty of service for in-patients. In one case, the in-patient still suffered inconvenience despite that advanced booking for NEATS service had been made.

## **Problems Identified and Our Observations**

### ***Long Waiting Time***

6. HA’s performance exceeds its service standards for NEATS service to in-patients: a waiting time of 90 minutes or less for 85% of the patients on inter-hospital transfer and 75% of the patients on discharge (**para. 2(b)**). We suggest that HA review if the current service standard may be shortened.

7. In addition, service standards should be set for waiting time by out-patients. For outbound trips, out-patients will usually be informed in advance of the scheduled arrival time of the ambulance. Long waiting time results when there is large discrepancy between the scheduled arrival time and the boarding time of the ambulance. For return trips, out-patients start waiting when they are ready to get on the ambulances. The new service standard should gauge the duration of such waiting time.

### ***Uncertainty of Service***

8. Uncertainty of service arises where an in-patient, having been informed that he is to be discharged or transferred, is not informed of whether and when an ambulance will be available to him. In two of our case studies, the in-patients were due for discharge from hospital but they were

not informed of when an ambulance would arrive on the day of discharge (**para. 5**). One went home by other means while the other spent an extra night in the hospital.

9. Uncertainty of service can cause much difficulty or inconvenience to patients and their relatives in making arrangements in preparation for the discharge or transfer. HA should explore ways to enhance certainty of service to patients such as setting a timeframe for notifying patients whether their requests for service can be met on the day.

### ***Punctuality of Service***

10. HA has set a service standard on punctuality for out-patients, by measuring the arrival time of patients at hospitals or clinics against the scheduled appointment time. HA has failed to meet its standard since 2007. For the past three years, over half of the out-patients using NEATS were late to attend medical appointments for over 30 minutes.

11. HA should look into the reasons of the low compliance rate of punctuality as it may be due to a variety of factors. This may require collecting and collating necessary data to assist HA to devise appropriate measures to improve its ability to meet the laid down service standard.

### ***Unmet Demand for NEATS***

12. We consider that a more fundamental problem to the above is that the existing provision of the service cannot meet the demand for NEATS. HA's statistics on NEATS show the number of requests received and met. All the remaining cases are classified as "cancelled cases", which may conceal demand turned away where the cancellation is by patients frustrated by long waiting time and uncertainty of service.

13. HA's overall rate of cancelled cases is around 17% in the past years. For quotas allocated to out-patients (**para. 2(a)**), the cancellation rate is over 25%. Besides, there are patients seeking alternative transport service on the one hand and commercial or even illegal services in the market catering for the need on the other (**para. 4**).

14. The above suggests the existence of unmet demand for the NEATS service. HA should collect more data in this respect and analyse them more systematically so as to have a better understanding of the size of the unmet demand and introduce measures to deal with it.

### ***Meeting Demand for NEATS***

15. The overall demand for the NEATS service has been increasing and is expected to continue, given an ageing population and the fact that the service is free. In addition to enhancing its operational efficiency and increasing resources, HA should consider alternative measures.

16. One possibility is to tap resources from non profit-making organisations providing similar services. Arrangements may be worked out to engage, for example, the ambulances of Hong Kong St. John Ambulance and the Accessible Hire Car Service provided by the Hong Kong Society for Rehabilitation for patients with less severe mobility impediment, possibly at a fee. Commercial transport services should be explored as a supplement for those who are financially better off.

17. In addition, HA should strive to prioritise requests according to the degree of patients' reliance on NEATS and urgency for transport service. Priority should be given to patients who, either because of the severity of their disability or because of their lack of familial support, cannot resort to any alternative modes of transport except NEATS. Another alternative to prioritise requests is to apply a means test, especially when commercially run services are available.

18. The need for and provision of non-emergency transport service generally is an issue the scope of which is much wider than HA's sphere of responsibility. It should be examined in a holistic approach by Government. In this connection, HA should bring out the issue with its policy bureau in the Government to map out an overall and long-term strategy.

## **Recommendations**

19. The Ombudsman makes the following recommendations to the Chief Executive of the Hospital Authority:

- (i) review the current standards of waiting time for discharge or transfer cases;
- (ii) introduce a new service standard for the waiting time of out-patients;
- (iii) explore ways to enhance the certainty of service;
- (iv) look into the reasons of the low compliance rate of punctuality;
- (v) collect more data for unmet demand and analyse them more systematically to understand the size of the problem and introduce measures to deal with it;
- (vi) explore the possibility of engaging non profit-making organisations and commercial operators in providing supplementary service;
- (vii) prioritise the service targets of the NEATS service, having regard to the severity of their mobility impediment and their financial means;  
and

- (viii) discuss with its policy bureau in the Government to map out an overall long-term strategy for the provision of transport service for people with mobility impediment requiring medical services.

**Office of The Ombudsman**  
**December 2010**

## EXECUTIVE SUMMARY

### Direct Investigation Transport Department Actions for Safe Operation of Public Light Buses

#### Background

Road safety is paramount. The Transport Department (“TD”) has the undeniable responsibility for proactively enhancing the safety standard of our public transport services.

2. Public Light Buses (“PLBs”) are one of the most popular modes of public transport in Hong Kong. The number of PLBs has been frozen at 4,350 since 1976. Statistics show that the incidence of accidents involving PLBs is significantly higher than that of other classes of motor vehicles (**Annexes I and II** of the report).

3. In 2000, after several fatal accidents involving PLBs, TD undertook to examine and develop safety enhancement measures for PLBs. However, little progress was made in the following nine years, reflecting neither due diligence nor sense of urgency on the part on TD. Study and implementation of the installation of speed limiter and vehicle monitoring system (commonly know as “blackbox”) on PLBs were only accelerated after two major fatal accidents involving PLBs in June and July 2009. The Ombudsman, therefore, initiated this direct investigation in January 2010.

#### Enhanced Safety Measures Already Introduced

4. Major safety enhancement measures for PLBs introduced by TD before January 2010 include:

- enhanced monitoring and training of PLB drivers;
- mandatory installation of Speed Display Device on all PLBs; and
- mandatory installation of passenger seat belts and high back seats on all PLBs registered on or after 1 August 2004.

## Passenger Seat Belts and High Back Seats

5. As at 30 September 2010, 2,415 out of 4,350 PLBs (i.e. 55.5%) are equipped with passenger seat belts and high back seats, in contrast to TD's prediction in mid-2006 that over 60% of all PLBs would be equipped with such equipment by mid-2008. Responding to this investigation, TD states that it is now unable to give an estimate on when all PLBs will be fitted with the equipment. Details of the PLBs with such retro-fitment are indicated below.

<i>Registration Year</i>	<i>Number of PLBs</i>	<i>PLBs with Passenger Seat Belts and High Back Seats</i>
On or after 1 August 2004	2,074	2,074 (100%)
Before 1 August 2004	2,276	341 (15%)
<b>Total</b>	<b>4,350</b>	<b>2,415 (55.5%)</b>

Age distribution of the 2,276 PLBs registered before 1 August 2004 and still running on road as at 30 September 2010 is shown in **Table 3** of the report.

6. As at 30 September 2010, 50% of the 2,093 PLBs having been scrapped by owners since August 2004 were aged from 11 to 14 years, and 86% of all the PLBs replaced were aged below 15 years. Yet, the oldest one replaced was aged 20. **Table 4** of the report indicates the age distribution of these 2,093 PLBs.

## Speed Limiter

7. TD intends to submit legislative amendments in 2010/11 to make it a statutory requirement to install speed limiter on all PLBs. The related events are summarised below.

<i>Date</i>	<i>Event</i>
October 2003	TD enquired of the major Japanese manufacturers of PLBs operating in Hong Kong about the application of speed limiter regulations in Japan.
17 November 2005*	TD asked the two major manufacturers specifically about: (a) the lead time required for provision of speed limiter on their PLBs; and (b) the possibility of retrofitting a speed limiter on current models.  On (a), one manufacturer indicated that a lead time of two to five years would be required for different types of PLBs. On (b), both manufacturers claimed that it was not possible.
19 December 2005 & 23 June 2006	Based on the above responses, TD explained to the Legislative Council Panel on Transport ("LegCo Panel") the difficulties of stipulating the installation of speed limiters on PLBs.

November 2006 & May 2008	TD enquired of the PLB manufacturers on the latest development of the issue. The manufacturers gave similar responses as above in January 2007 and June 2008 respectively.
17 June 2009 <sup>#</sup>	TD communicated with the two major manufacturers on the issue again. While pointing out, for the first time, on 18 and 23 June 2009 the availability of certain standalone speed limiters in local market, the manufacturers maintained that it would need a few years to provide built-in speed limiter.
26 June 2009	At the LegCo Panel meeting, the Administration maintained that there were difficulties to stipulate the installation of such device on PLBs.
27 July 2009 <sup>@</sup>	TD announced its intention of introducing compulsory installation of speed limiter on PLBs.
30 July 2009	The two major manufacturers confirmed with TD that they had no objection to fit external devices on their PLBs.
24 August 2009	TD released the specification of speed limiter for reference by all potential device suppliers.
By November 2009	TD approved 6 models from 3 local suppliers.
5 March 2010	TD notified all PLB owners and licence holders of addition of a new licence condition that, with effect from 7 June 2010, a PLB would be required to be installed, within three months from the date of issue or renewal of licence, with a speed limiter.  Given that the validity of a vehicle licence is one year, all PLBs are expected to be installed with speed limiters by September 2011.

\* 4 days after an accident in Sheung Shui involving a PLB, resulted in 2 deaths and 5 injuries

# 5 days after an accident in Mongkok involving a PLB, resulted in 2 deaths and 8 injuries

@ 2 days after an accident in Yuen Long involving a PLB, resulted in 4 deaths and 17 injuries

8. Prior to July 2009, TD had not commissioned, or been involved in, any trial on speed limiters. Some device suppliers revealed to this Office that various models of speed limiter and blackbox had been introduced to Hong Kong for at least five years. Over the years, at least one supplier and one PLB operator had tried out a speed limiter in 2006 and 2007, and had verbally informed TD frontline staff of such trials. However, TD indicated to us that it only knew of such trial through media reports in early August 2009.

## **Blackbox**

9. TD informed the LegCo Panel as early as December 2003 that it would conduct trials on the use of blackboxes on PLBs. However, instead of commissioning trials by itself, TD facilitated blackbox suppliers to run three trials from 2004 to mid-2009. All were found unsuccessful. In February 2007, in response to TD's enquiry, the Hong Kong Productivity Council ("HKPC") made

a face-to-face presentation to TD on HKPC's proposed in-vehicle monitoring system tailor-made for PLBs. HKPC informed TD in writing in March 2007 that system development and trial on road, each needed about six months, would cost around \$2 million. TD did not follow up the matter. It explained that it had received no formal proposal from HKPC since then.

10. In August 2009, having regard to technological maturity in blackbox design and manufacturing and experiences in Europe and Mainland China, TD proposed to mandate the installation of blackbox on new PLBs. It intends to submit the necessary legislative amendments in 2010/11.

### **Mandatory Pre-Service Training for PLB Drivers**

11. TD first informed the LegCo Panel in June 2006 that the PLB trade was generally supportive of the proposal of requiring applicants for a PLB driving licence to attend pre-service training courses that focus on driving behaviour and attitude. Having discussed with the Police and the Department of Justice since July 2008, TD now plans to introduce the necessary legislative amendments in 2010/11.

12. As regards the reasons for taking over four years for the preparatory work, TD explains that it needs to develop a detailed legislative proposal, to formulate content and assessment criteria for the training programme, to stipulate qualifications for course providers and trainers, to put in place arrangements for ensuring authenticity of attendance records and certificates issued, and to enhance the related computer system.

### **Observations and Opinions**

#### ***Lacking Due Diligence and Sense of Urgency***

13. Evidence indicates that at least for the measures listed below, there had been a lack of due diligence and sense of urgency in TD to explore their feasibility until mid-2009, when two fatal accidents involving PLBs happened on 12 June and 25 July 2009.

14. **Speed Limiter.** TD's enquiries with the major Japanese manufacturers of PLBs regarding the installation of speed limiters only started in November 2005, four days after a fatal PLB-related accident had happened. Thereafter, TD's follow-up enquiries with the manufacturers in November 2006 and May 2008 were no more than routine requests for update. Again, it was not until another fatal PLB-related accident had happened did TD follow up the issue with the

manufacturers again in June 2009. TD has been taking prompt follow-up actions since then. Nevertheless, the issue had been put on the back burner for some four years.

15. **Blackbox.** TD did not directly commission trial on the use of blackbox on PLBs, but only facilitated three trials volunteered by suppliers. Owing to its passive role, TD had no control over the timing and direction of the trials.

16. TD did ask HKPC for advice in early 2007. However, subsequent to HKPC's elaboration on its proposed trial, TD did not pursue the matter further, leaving the task simply untouched. TD's explanation for not following up the matter (**para. 9**) is hardly convincing.

17. **Training of PLB Drivers.** The government-subsidised PLB driver training courses have been introduced for more than six years. However, up to end of 2009, only 1,138 drivers had attended such courses, representing only about 10% of the 11,000 to 12,000 active PLB drivers. The promotion efforts of TD, particularly those targeting PLB drivers directly, have been minimal.

18. TD's explanation for taking more than four years to prepare the mandatory pre-service training for PLB drivers (**para. 12**) is again unacceptable. Most of the details of the scheme have been readily available, given that the training content, assessment criteria, trainer qualifications and other administrative arrangements are to be modeled on existing similar programmes mentioned above.

### ***Want of Timely Review***

19. As at 30 September 2010, there were still 1,935 PLBs registered before 1 August 2004 running on the road without passenger seat belts. If we rely solely on attrition of the "pre-August 2004" PLBs to be replaced, it may well take at least eight years for all PLBs to be equipped with such equipment. By any estimation, five years later, by the end of 2015, it is very likely that there will still be about 1,000 PLBs running on the road without such safety equipment. This is only a rough estimation based on the statistics of PLBs replaced in the past six years (**Table 4** of the report) versus the age distribution of the existing PLBs (**Table 3** in report). Thus, passengers will continue to face a higher risk posed by these PLBs for at least another eight years. This is unacceptable. With the mandatory scheme introduced for six years now, we consider it important for TD to review the issue and resolve the problem without delay. The feasibility of setting a time table or cut-off date for mandatory installation of the equipment on all "pre-August 2004" PLBs should be considered.

20. There are concerns over the technical feasibility and the cost burden borne by the trade if mandatory installation is to be extended. However, only about 20 existing PLBs aged over 15 years cannot be retrofitted with such equipment, and they are all approaching the end of their service life. While the cost of retro-fitment must be considered, the Administration should also give public safety due consideration in the overall assessment.

### *Consultation Spectrum Too Narrow*

21. Prior to June 2009, TD relied mainly on its consultation with the major PLB suppliers and manufacturers to determine the technical feasibility of installation of speed limiter. On the technical aspect of installing blackboxes on PLBs, throughout all these years, TD had only consulted HKPC but had taken no follow-up action on HKPC's proposal. On the apparent sluggishness, TD repeatedly cited the need for suppliers and manufacturers to confirm that retrofitment of such equipment would not affect the product guarantee and technical support they offered.

22. TD should have adopted a broader approach by contacting other resourceful players in the field, such as academic and professional bodies, and acquiring more independent opinions. Such opinions are essential in making a thorough and balanced assessment on whether, when and how to proceed with the introduction of safety enhancement measures. While product guarantee is a valid concern, over emphasising its importance may impose unnecessary constraints in exploring alternative solutions or even become an excuse for inactivity.

### *Inertness towards Market Information and Overseas Experiences*

23. TD was apparently inert to the availability of various models of speed limiter and blackbox in the local market. Neither was it sensitive enough to pick up relevant intelligence, such as trials on speed limiters voluntarily conducted by members in the trade (**para. 8**).

24. Shortly after TD had published its tailor-made specifications for speed limiters in August 2009, at least three local suppliers had submitted applications – with six of their product models approved quickly afterwards. Such prompt response clearly showed the maturity of the technologies and immediate availability of such products in the local market.

25. Moreover, under the regulations of the European Community and the United Kingdom on installation of speed limiter, vehicles similar to PLBs in Hong Kong were required to retrofit speed limiter in phases between January 2005 and January 2008. This shows that retrofitment of external device is technically feasible, at least for certain types of passenger vehicles. Hong Kong has undeniably lagged behind other advanced countries in introducing this safety enhancement measure.

### ***Tampering of Device***

26. TD has the responsibility to ensure compliance with the regulation on installation of speed limiter and blackbox and to deter mis-use or tampering of the devices. Besides relying on the annual examination of the vehicles at TD's centres, we consider that TD should take more monitoring measures such as conducting surprise and random checks.

### ***Blackbox Data Use***

27. Installation of blackbox can help deterring the driver from improper driving. However, other than for accident investigation, the Administration should consider enabling relevant Government experts to access, use and analyse such data under justifiable circumstances or conditions. The data collected from individual vehicles can be used in the monitoring of its operation. Statistics generated from the data of different vehicles may also be useful for reviewing the effectiveness of various safety measures, and for forward planning.

### **Recommendations**

28. Road safety is about human lives. However, prior to June 2009, there had been a lack of due diligence in TD in fulfilling its responsibility to enhance safety of PLB operation proactively. From our findings, The Ombudsman makes the following recommendations to the Commissioner for Transport:

#### ***For Safe Operation of PLBs***

- (1) to review and consider whether the requirement for installation of passenger seat belts and high back seats should be extended to PLBs registered before 1 August 2004, so as to reduce significantly the number of PLBs not retrofitted with such equipment within a reasonable timeframe;
- (2) to work out specific measures against tampering of speed limiter and blackbox installed, including surprise check or random check of vehicles;
- (3) to consider the use of data stored in blackboxes for the purposes of monitoring driving behaviour, as well as for reviewing and planning of various safety enhancement measures;

### ***For Road Safety Initiatives in General***

- (4) to set out work plans, with time schedule, for monitoring progress of each and every safety measure under study, instead of merely reacting to outburst of public pressure following each tragic traffic accident;
- (5) to consider seeking assistance from academic or professional institutions/bodies, where necessary, in assessing the feasibility of safety enhancement measures to be introduced, and in regularly reviewing the effectiveness of the measures after their implementation; and
- (6) to set up and maintain an intelligence network with relevant trades and sectors, so as to keep abreast of the latest developments of technology, regulatory mechanism and market information in and outside Hong Kong.

29. TD has accepted recommendations (2) to (6). As to recommendation (1), TD's response is not forthcoming. TD agrees only to discuss with the PLB trade and PLB suppliers on possible and viable ways to speed up the replacement progress as far as practicable.

30. We maintain the view that the slow progress over the past six years on retrofitting PLBs with passenger seat belts and high back seats has shown that TD's prediction in mid-2006 that over 60% of PLBs would be equipped with such safety equipment by mid-2008 is over-optimistic and the voluntary retrofitment scheme has been less than effective. Without more vigorous measures, it would take at least eight years for all PLBs to be equipped with passenger seat belts; and there would still be about 1,000 PLBs running on the road without such equipment by the end of 2015. We should not put more lives of PLB passengers at risk. We strongly urge the Administration to reconsider our recommendation.

**Office of The Ombudsman**  
**December 2010**

**Road Traffic Accident Statistics by Class of Vehicle 2009**

Class of vehicle	No. of accidents <sup>*</sup>	No. of involvements	No. of casualties <sup>#</sup>			
			Killed	Serious	Slight	Total
Motor cycle	2,508	2,556	14	392	2,388	2,794
Private car	4,994	6,085	31	625	6,307	6,963
<b>PUBLIC LIGHT BUS</b>	<b>1,068</b>	<b>1,110</b>	<b>21</b>	<b>187</b>	<b>1,461</b>	<b>1,669</b>
Light goods vehicle	2,246	2,527	26	332	2,684	3,042
Medium goods vehicle	738	840	22	139	954	1,115
Heavy goods vehicle	63	67	5	8	96	109
Public bus	2,229	2,322	22	305	2,818	3,145
Taxi	3,342	3,801	24	428	4,138	4,590
Bicycle	1,793	1,882	10	229	1,629	1,868
Tram	72	76	0	9	92	101
Light rail vehicle	8	8	2	3	8	13
Private light bus	75	76	1	11	103	115
Private bus	23	23	0	7	46	53
Handcart	47	47	3	6	39	48
Trailer	12	15	2	4	15	21
Village vehicle	1	1	0	1	0	1
Special purpose vehicle	3	4	0	1	3	4
Golf-cart	6	6	1	3	6	10
Others <sup>@</sup>	220	235	0	38	236	274
All classes of vehicles	14,316	21,681	139	2,096	15,903	18,138

Notes : \* In a single accident, there may be more than one class of vehicle involved.

# Casualties include pedestrians and vehicle occupants of other vehicle class involved. Hence, the sum of casualties for individual class of vehicle will be larger than the overall number of casualties.

@ Including unknown vehicle types.

Source: Transport Department

**Annex II  
(para. 2.8)**

**Road Traffic Accident Involvements and Involvement Rates  
by Selected Class of Motor Vehicle (1999 - 2009)**

Class of motor vehicle	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
<b>PUBLIC LIGHT BUS</b>											
No. involved in accident	1,049	1,055	1,040	1,098	1,008	1,154	1,132	1,069	1,173	1,080	1,110
No. licensed (mid-year)	4,343	4,339	4,341	4,342	4,338	4,331	4,334	4,347	4,349	4,346	4,349
Annual veh-km (in millions)	341	373	365	366	350	356	364	378	387	380	377
Invol rate : per 1,000 vehicles	241.5	243.1	239.6	252.9	232.4	266.5	261.2	245.9	269.7	248.5	255.2
per million veh-km	3.08	2.83	2.85	3.00	2.88	3.25	3.11	2.83	3.03	2.84	2.94
<b>Medium &amp; heavy goods vehicles</b>											
No. involved in accident	1,235	1,217	1,185	1,249	1,108	1,197	1,180	1,155	1,081	1,045	907
No. licensed (mid-year)	39,245	41,390	42,036	41,725	41,761	42,106	42,549	42,261	41,659	40,857	39,079
Annual veh-km (in millions)	2,366	1,365	1,349	1,457	1,398	1,344	1,333	1,347	1,323	1,311	1,191
Invol rate : per 1,000 vehicles	31.5	29.4	28.2	29.9	26.5	28.4	27.7	27.3	25.9	25.6	23.2
per million veh-km	0.52	0.89	0.88	0.86	0.79	0.89	0.89	0.86	0.82	0.80	0.76
<b>Public bus*</b>											
No. involved in accident	2,265	2,288	2,445	2,380	2,219	2,407	2,379	2,393	2,649	2,463	2,322
No. licensed (mid-year)	11,533	11,836	12,322	12,724	12,875	12,867	12,812	12,796	12,803	12,803	12,757
Annual veh-km (in millions)	646	769	818	853	838	836	846	872	878	876	857
Invol rate : per 1,000 vehicles	196.4	193.3	198.4	187.0	172.3	187.1	185.7	187.0	206.9	192.4	182.0
per million veh-km	3.51	2.98	2.99	2.79	2.65	2.88	2.81	2.74	3.02	2.81	2.71
<b>Taxi</b>											
No. involved in accident	3,101	3,274	3,706	3,617	3,397	3,457	3,752	3,744	4,004	3,926	3,801
No. licensed (mid-year)	18,030	17,997	18,074	18,054	17,997	18,108	17,961	18,026	18,045	18,084	18,126
Annual veh-km (in millions)	1,757	1,843	1,822	1,793	1,719	1,797	1,880	1,991	2,102	2,135	2,130
Invol rate : per 1,000 vehicles	172	181.9	205	200.3	188.8	190.9	208.9	207.7	221.9	217.1	209.7
per million veh-km	1.76	1.78	2.03	2.02	1.98	1.92	2.00	1.88	1.91	1.84	1.78
<b>All motor vehicles<sup>#</sup></b>											
No. involved in accident	20,842	21,530	22,057	21,967	19,743	20,355	20,850	20,540	21,517	20,132	19,608
No. licensed (mid-year)	499,380	511,460	522,125	525,111	522,912	528,172	537,124	546,409	555,861	572,231	575,686
Annual veh-km (in millions)	11,040	11,639	11,509	11,576	11,190	11,109	11,193	11,521	11,973	11,969	11,785
Invol rate : per 1,000 vehicles	41.7	42.1	42.2	41.8	37.8	38.5	38.8	37.6	38.7	35.2	34.1
per million veh-km	1.89	1.85	1.92	1.90	1.76	1.83	1.86	1.78	1.80	1.68	1.66

Notes: \* Public buses include franchised public bus & non-franchised public bus.

# The figures for "All motor vehicles" include trailer, special purpose vehicle, private light bus, golf cart and illage vehicle which are not separately shown.

Source: Transport Department

**Table 3. Age Distribution of Existing PLBs registered before 1 August 2004  
(as at 30 September 2010)**

<i>Age</i>	<i>Number of PLBs</i>	<i>Percentage</i>
6 to < 7 years	674	29.6%
7 to < 8 years	446	19.6%
8 to < 9 years	239	10.5%
9 to < 10 years	188	8.3%
10 to < 11 years	132	5.8%
11 to < 12 years	177	7.8%
12 to < 13 years	130	5.7%
13 to < 14 years	133	5.8%
14 to < 15 years	72	3.2%
Over 15 years	85	3.7%
<b>Total</b>	<b>2,276</b>	<b>100%</b>

**Table 4. Age Distribution of PLBs Replaced  
from 1 August 2004 to 30 September 2010**

<i>Age</i>	<i>Number of PLBs</i>	<i>Percentage</i>
Under 10 years	291	13.9%
10 to < 11 years	216	10.3%
11 to < 12 years	349	16.7%
12 to < 13 years	339	16.2%
13 to < 14 years	350	16.7%
14 to < 15 years	252	12.0%
Over 15 years	296	14.2%
<b>Total</b>	<b>2,093</b>	<b>100%</b>