THE GOVERNMENT MINUTE

IN RESPONSE TO

THE ANNUAL REPORT OF
THE OMBUDSMAN 2024/25

Government Secretariat
15 October 2025

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THE GOVERNMENT MINUTE IN RESPONSE TO THE ANNUAL REPORT OF THE OMBUDSMAN 2024

Introduction

The Chief Secretary for Administration presented the Annual Report of The Ombudsman 2024/25 (the Annual Report) to the Legislative Council at its sitting on 2 July 2025. This Government Minute sets out the Government's response to the Annual Report. It comprises three parts – Part I responds generally to issues presented in the section The Ombudsman's Introduction of the Annual Report; Parts II and III respond specifically to the recommendations made by The Ombudsman in respect of the full investigation and direct investigation cases in the Annual Report.

Part I
– Responses to Issues presented in the section

The Ombudsman's Review of the Annual Report

The Government notes that The Ombudsman summarised eight direct investigation and 40 full investigation cases in the Annual Report. This Government Minute responds to the eight direct investigation and 30 full investigation cases for which recommendations were made by The Ombudsman. All of the 254 recommendations made by The Ombudsman were accepted and have been or are being implemented by the government departments and public bodies concerned.

2. The Government will continue supporting the Office's work and collaborate with the Ombudsman to deliver efficient and high-quality public services.

Part II
– Responses to recommendations in full investigation cases

Architectural Services Department, Drainage Services Department, Home Affairs Department and Lands Department

Case No. 2023/2865A (Drainage Services Department) – Buck-passing among government departments and lack of coordination to properly resolve a clogged catchpit; failing to give a substantive reply to the complainant on the part of the Drainage Services Department

Case No. 2023/2865C (Architectural Services Department) – Buck-passing among government departments and lack of coordination to properly resolve a clogged catchpit

Case No. 2023/2865D and 2023/2865E (Home Affairs Department and Lands Department) – Buck-passing among Government departments and lack of coordination to properly resolve a clogged catchpit

Background

The complainant stated that on 7 September 2023, he complained to 1823 about sewage overflow from a clogged catchpit in a village (the Village) and piling up of miscellaneous articles, which caused poor environmental hygiene. On 11 September, 1823 replied that the matter had been referred to the relevant section of the Drainage Services Department (DSD) for follow up. The complainant subsequently lodged several complaints through 1823, but the problem of the clogged catchpit remained unresolved. DSD told the complainant that the matter would be referred to the Architectural Services Department (ArchSD) and the Lands Department (LandsD) for handling. However, DSD subsequently advised the complainant to contact the local District Office (DO) under the Home Affairs Department (HAD), noting that the matter had been referred to LandsD. The DO later replied to the complainant that drainage matter of the Village was outside its purview, and it was aware that DSD has been

assisting and following up on the matter. In light of the above, the complainant was dissatisfied with DSD for not giving a substantive reply and various government departments for shirking responsibilities and lack of coordination to resolve the problem of the clogged catchpit properly.

The Ombudsman's observations

Complaint against DSD

2. Regarding the complainant's dissatisfaction with DSD for not giving a substantive reply to his complaint, the Office of The Ombudsman (the Office) noted from the case information that DSD had notified him through 1823 after completing each one-off drainage clean-up, and had notified him through 1823 of its findings and further actions after site inspections. As such, the Office considered DSD to have properly followed up on the complainant's case and given him timely replies.

3. Based on the above analysis, The Ombudsman considered the complaint against DSD unsubstantiated.

Complaint against ArchSD, HAD and LandsD

4. Regarding the complainant's allegation against the government departments of shirking responsibilities and lack of coordination to properly resolve the problem of the clogged catchpit, the Office, after examining the information obtained from the investigation, considered the departments to have followed up on the complainant's case upon receiving complaints, including deploying staff to conduct inspections and clearance operations time and again, referring the case to the telecommunications company and other relevant departments for follow-up, and notifying the complainant of the case progress. The Office noted that his drainage blockage complaint to 1823 involved not only the clogged catchpit but also a cable drawpit of the telecommunications company and other public drainage or sewage systems, as well as such issues as environmental hygiene, unlawful occupation of government land, etc. The Office

considered the departments to have handled each complaint received according to their respective purview, referred any matters falling within the scope of other departments, and conducted joint operations as necessary. There was no impropriety.

5. Based on the above analysis, The Ombudsman considered the complaint against ArchSD, HAD and LandsD unsubstantiated.

Maintenance and Repair Responsibilities for Public Facilities in the Villages

6. On 6 and 7 April 2024, the complainant provided the Office with supplementary information about the recurrent problem caused by the clogged catchpit after rain. After further enquiries with DSD and the DO, the Office learnt that in March 2024, the DO had also received a report of drainage blockage from the Village's rural representatives. After the case was referred to DSD by the DO, DSD carried out a one-off clean-up on 26 March. The Office's observations on the recurrent problem of drainage blockage are given below.

7. The departments had indeed handled this complaint about the clogged catchpit according to their respective purview, and even carried out one-off drainage clean-ups based on circumstances and available resources. However, the complainant's supplementary information showed that the clogging problem recurred, and apparently could not be rooted out by repeated one-off clean-ups. After all, if no specific department would be responsible for regular management and maintenance of the catchpit, it would be unsustainable to simply rely on passive actions by departments in one-off clean-ups, referrals and joint operations upon receiving complaints.

8. The Office's investigation revealed that the management and maintenance responsibilities for public facilities in the Village have yet to be confirmed. The Office recognised the relatively complex development background of that location in the Village. The Development Bureau's

Circular has set out the maintenance responsibilities for village resite and village expansion areas, specifying the division of labour among various departments. The response from ArchSD also indicated that prior to 2018, it had handled complaints about public facilities in the Village pursuant to the Circular. However, since the Government decided not to proceed with the relevant Village Expansion Area Scheme and to "unfreeze" the development rights of the land within the original Village Extension Area (i.e. resuming the acceptance and processing of Small House Applications on private and government land within the original Village Extension Area in accordance with the applicable procedures), the relevant departments expressed different views on whether the Circular should still apply to the village in question. Having reviewed the information obtained from the investigation, the Office believed that the various departments have attempted to resolve the differences. In particular, LandsD explained the background of the original Village Extension Area project to the relevant departments in response to their request. Meanwhile, ArchSD explained its stance of inability to provide maintenance services for the Emergency Vehicular Access and drainage system not within a village expansion area, and urged relevant departments to clarify the management and maintenance responsibilities for public facilities in the Village as soon as possible. However, no consensus has been reached so far. In retrospect, following the full cancellation of the Village Expansion Area Schemes, relevant departments should have promptly clarified the management and maintenance responsibilities for public facilities in the Village.

9. The Office expected a cross-departmental meeting could clarify precisely the division of labour among departments, address the management, maintenance and repairs of public facilities at the root, thereby avoiding passive, one-off clean-up triggered each time by complaints. Furthermore, although the division of labour set out in the Circular might no longer be applicable, if the meeting still failed to resolve the responsibility issues, the Office believed that the arrangement under the Circular for resolving differences on division of labour, i.e. a final decision to be made at the level of Directors or even Permanent Secretaries, would worth serious consideration by relevant departments.

10. Moreover, including the Village, a total of 10 Village Expansion Area Schemes were either frozen or cancelled to date. As a result, other village expansion areas might have similar issues to those in this case. Through the report, the Office urged relevant departments to draw lessons from this case, review comprehensively the public facilities associated with these Village Expansion Area Schemes (where applicable), clarify management and maintenance responsibilities, and consider establishing a mechanism for handling these matters where necessary

11. Based on the above findings, the Office recommended ArchSD, DSD, HAD and LandsD to –

(a) promptly clarify the management and maintenance responsibilities for the catchpit through the cross-departmental meeting coordinated by HAD, and establish a proper mechanism for handling these matters where necessary;

(b) if a resolution cannot be reached in the cross-departmental meeting, consider referencing the arrangement under the Circular and escalating the matters to Directors and even Permanent Secretaries for a final decision; and

(c) draw lessons from this case, review comprehensively any unclear demarcation of management responsibilities for public facilities associated with other Village Expansion Area Schemes which have been frozen or cancelled, and clarify the responsibilities of departments as soon as possible.

Government's response

12. ArchSD, DSD, HAD and LandsD accepted The Ombudsman's recommendations and have taken the following follow-up actions.

Recommendation (a)

13. The DO under HAD held two cross-departmental meetings, one on 31 May and the other on 24 June 2024, to coordinate efforts among relevant departments to clarify the management and maintenance responsibilities of the facilities in question. However, no consensus has been reached.

Recommendation (b)

14. As the relevant departments cannot reach a consensus, the case has been escalated to the Deputy Chief Secretary for Administration for a steer. After considering the background and details of the case, it was decided that the DO would be responsible for handling public complaints and comments regarding the subject catchpit, and coordinating the necessary management and maintenance work by assigning DSD as the works agent.

Recommendation (c)

15. It is understood that there were no similar cases of unclear demarcation of management responsibilities for public facilities associated with the other nine Village Expansion Area Schemes mentioned above, which have been frozen or cancelled.

Buildings Department

Case No. 2023/2545 – (1) Delay in responding to the complainant's enquiries; and (2) Failing to properly follow up the complaint against an Authorized Person for alleged professional misconduct

Background

16. The complainant alleged that a registered architect, who was an Authorised Person (AP) registered under the Buildings Ordinance (the Ordinance) (AP A), was engaged in 2012 to provide professional advice and supervision in respect of the major repair works at a building (the subject building) commenced under "Operation Building Bright" of the Urban Renewal Authority (URA). The complainant further engaged a works contractor (Contractor B) to carry out the relevant works, which included removing unauthorised building works, repairing concrete elements in common areas and rendering on external walls, as well as carrying out fire safety improvement works in response to two Fire Safety Directions (FSDns) issued by Buildings Department (BD).

17. The complainant subsequently found that AP A had committed professional negligence in multiple instances in the supervision of the aforementioned works projects, resulting in some of the works projects not being completed on schedule or properly. The complainant lodged multiple complaints and enquiries with BD, but received no appropriate response and follow-up. Overall, the complainant had the following allegations against BD –

(a) On 17 September 2019, the complainant wrote to BD, pointing out that there was professional negligence on the part of AP A in the supervision of the aforementioned works, but had yet to receive a substantive reply from BD after a long time. Between January 2020 and July 2022, the complainant wrote to BD several times to follow up. On 30 August 2022, BD finally replied to the complainant in writing (Allegation(a));

(b) According to the complainant, BD stated in the reply that the works in question were classified as Class II and Class III minor works which did not require the appointment of an AP for supervision, and AP A's acts of misconduct alleged by the complainant, namely, serious delays in fire services works, unjustified approval for Contractor B's extension of time for the works, erroneous approval of the insurance premiums and wrong costs estimation of works, were matters concerning private contracts outside the ambit of the Ordinance (Allegation (b)).

18. The complainant was dissatisfied with BD's reply above and considered that AP A's acts of misconduct involved professional negligence and were not merely contractual matters. The complainant further pointed out that it was URA's requirement for the works to be supervised by an AP, and that regardless of whether the works required supervision by an AP, BD had the responsibility to regulate the performance of its registered APs and to follow up on their professional negligence.

The Ombudsman's observations

Allegation (a)

19. Although BD explained that its failure to respond to the complainant in a timely manner was due to the impact of the COVID-19 pandemic, the Office of The Ombudsman (the Office) considered that the incident revealed a series of delays and omissions on the part of BD. Firstly, the complainant wrote to BD for enquiry in September 2019 which was before the outbreak of the COVID-19 pandemic in Hong Kong, but BD only provided an interim written reply without any substantive written reply.

20. Subsequently, the complainant wrote to BD four times in January 2020, April 2021, May 2021 and July 2022 to follow up, but BD only provided interim written replies. Although BD claimed that its staff had

called the complainant in early 2020 to explain the relevant matters, the Office was unable to verify the conversation in the absence of corroborating evidence. On the other hand, the relevant documentary records indicated that BD had repeatedly failed to follow up on the aforementioned reminders from the complainant, resulting in multiple missed opportunities to make up for the long-outstanding reply. BD eventually provided a substantive written reply on 30 August 2022, i.e. three years after the complainant's initial enquiry, which was a severe delay.

21. Having considered the above circumstances, while the Office was aware that the delay in BD's reply was partly related to the impact of the pandemic, in any case, taking as long as three years to provide a written reply to the complainant's enquiry was unacceptable. Hence, Allegation (a) was substantiated.

Allegation (b)

22. BD's regulation of the performance of APs mainly includes that APs are required to fully discharge their statutory responsibilities prescribed under the Ordinance, and to comply with BD's requirements and conduct of registered building professionals, i.e. they should not commit negligence and misconduct as specified in BD's Practice Note for Authorised Persons, Registered Structural Engineers and Registered Geotechnical Engineers (PNAP) ADV-37.

23. As for the complainant's allegation regarding the misconduct of AP A, BD has explained the reasons for not taking further actions or imposing penalties. Firstly, the works involved in the case fell within Class II and III minor works or exempted building works under the approval system, which did not require supervision by an AP under the Ordinance. In other words, AP A's supervision of the aforementioned works did not involve any statutory responsibilities prescribed under the Ordinance. Secondly, some of AP A's acts alleged by the complainant (including delays in completion of works, and difference in costs and scope of works

from those stipulated in the contract) were contractual matters outside the ambit of the Ordinance. Furthermore, BD had examined the works alleged by the complainant to be faulty but found no contravention of the Ordinance.

24. Upon careful review and consideration of the relevant information, including AP A's acts of misconduct alleged by the complainant, as well as the roles and functions of BD, the Office accepted BD's explanations. As there was no information indicating that AP A had contravened the statutory responsibilities prescribed for APs under the Ordinance, or committed professional negligence or misconduct as set out in the PNAP, BD had no grounds to impose penalties or take further actions against AP A.

25. Nevertheless, the complainant might still consider seeking legal advice on their own to see whether the matters involved in the contract could be pursued by way of civil proceedings or the Architects Registration Board (ARB) might be contacted in respect of the acts they perceived as misconduct of AP A as a registered architect. The Office noted that the complainant had lodged a complaint with ARB for the matters concerned.

26. Moreover, the complainant queried that if BD considered that the matters concerned were not within its purview, BD should have informed them or referred the case to relevant departments or organisations for follow-up at an earlier stage. BD responded that this had already been stated in its pamphlets and other materials, and that it had informed the complainant over the phone in early 2020 as well as in the reply letter dated 30 August 2022 that the subject matters of the complaint were matters concerning private contracts outside the ambit of the Ordinance, and that the complainant might seek legal advice from professionals for consideration of taking appropriate actions. The Office was of the view that while BD's aforementioned practices were not deemed improper, from the perspective of good public administration, it would have been more desirable for BD to, at an early stage, clearly advise the complainant in the written reply to consider contacting ARB for follow-up on the matters

concerned. Having summarised the above points, the Office considers Allegation (b) unsubstantiated.

Other observations

27. The Office noted that one removal order and two FSDns issued by BD to the subject building had not yet been complied with for a long time. The Office was aware that BD would exercise discretion to grant a grace period for the completion of relevant works, having regard to individual circumstances and practical difficulties encountered by owners. However, the information indicated that BD had not been proactive in following up on the aforementioned order and FSDns, which appeared to be undue delay.

28. Firstly, regarding the removal order issued in July 2010, BD learnt from the certificate of completion of minor works submitted by Contractor B in May 2015 that part of the removal works had not yet been completed. BD stated that after the issuance of a warning letter in August 2015, a letter dated 29 August 2015 had been received from the Incorporated Owners of the subject building (IO), and enforcement action was thus suspended. Nevertheless, the Office noted that while the removal works of the metal gates had not been completed within a reasonable timeframe, BD had delayed resumption of enforcement action. It was not until May 2019 that BD issued another warning letter to the IO.

29. Regarding the two FSDns, AP A notified BD in April 2016 and August 2017 that the relevant fire safety improvement works and rectification works had been completed, but BD did not deploy its staff to inspect the site for confirmation until one year and half a year later respectively. Subsequently, in April 2018, AP A notified BD again of the completion of rectification of irregularities, but BD only deployed its staff for site inspection in October 2022, i.e. more than four years later. BD explained that the progress of the case was affected by the delay in arranging for timely inspection due to the transfer of the original staff and the subsequent COVID-19 pandemic. The Office found it difficult to fully

accept this explanation: BD's delay in handling the case was due to staff redeployment and the delay was not brief. The situation was indeed unsatisfactory. The COVID-19 pandemic had not yet broken out in Hong Kong before early 2020. Yet, between April 2018 and the outbreak of the pandemic, BD failed to take any concrete follow-up actions. Attributing the delay to the pandemic was unconvincing.

30. Ultimately, the above removal order was complied with almost a decade after its issuance, whereas the works required under the two FSDns have not yet been completed to date. From an administrative perspective, the situation was clearly unsatisfactory and posed potential building and fire safety hazards. The Office considered that BD has inadequacies that need to be addressed and improved.

31. On the whole, BD has fulfilled its regulatory duties over the AP concerned in this case in accordance with the Ordinance and its powers and functions. However, there were successive delays in BD's follow-up on the removal order and FSDns, as well as its replies to the complainant. Overall, The Ombudsman considered the complaint partially substantiated.

32. The Ombudsman recommended BD to –

(a) continue following up closely on the compliance status of the two outstanding FSDns;

(b) strengthen staff training and to remind the staff concerned of the need to follow up on cases and reply to public enquiries in a timely manner;

(c) consider reviewing the existing case management mechanism or procedures to enhance the monitoring of case progress, for example, by having supervisors regularly review and supervise their subordinates in following up on long-outstanding cases; and

(d) proactively consider reforming the mechanisms and procedures to prevent the recurrence of the above problems.

Government's response

33. BD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendation (a)

34. BD, in collaboration with the Fire Services Department (FSD), has been actively providing technical support to assist the IO and the consultant in expediting the completion of the works required under the two outstanding FSDns. As the IO has joined the "Fire Safety Improvement Works Subsidy Scheme" and received the Approval-in-Principle letter issued by URA, the fire safety improvement works required by BD and FSD would be carried out under this subsidy. Between August and October 2024, the consultant submitted the plans for fire service installations or equipment to FSD and enquired about the feasibility of adopting an improvised hose reel system. FSD approved the plans concerned and confirmed the feasibility of adopting an improvised hose reel system in November and December 2024 respectively. Additionally, the consultant submitted the plans for the building works corresponding to the above fire service installations to BD in September, which were approved in October. It is understood that the consultant is currently preparing the tender documents for the engagement of a contractor for the review by an independent consultant engaged by URA. It is expected that the engagement of a registered contractor would be completed in the first quarter of 2026 and the related works would then commence.

Recommendation (b)

35. BD has been providing appropriate training for the staff concerned on a regular basis, including experience sharing sessions,

seminars and workshops organised by the Civil Service Bureau, professional institutions and BD internally.

36. BD would regularly remind the staff concerned to study/review the relevant seminars and videos on practical tips available in "Seminars on Demand" of BD intranet. In addition, on 28 February 2025, BD held an experience sharing session in which experienced officers explained the Existing Buildings Division Manual (EBDM) and practical tips in case studies to strengthen staff training. The relevant videos have also been uploaded onto "Seminars on Demand" of BD intranet for staff learning and review.

37. BD would continue organising relevant experience sharing sessions and seminars.

Recommendations (c) and (d)

38. BD has reviewed the existing case management mechanism and procedures, and would implement the following measures to enhance the monitoring of case progress:

(a) BD would send regular e-mails on a half-yearly basis to remind staff of timely completion of inspections and updating of records in computer information systems, as well as compliance with the relevant guidelines of the Fire Safety Section;

(b) BD has completed a review of the procedures for handling replies to similar types of enquiries and revised EBDM to remind its staff to follow relevant guidelines on proper channels for acknowledgement of receipt, interim replies, and replies to enquiries; and

(c) BD enhanced its Building Condition Information System on 25 March 2025 by adding similar cases to the to-do list and sending emails periodically to the staff concerned and their supervisors as

reminders for regular case review, so as to prevent the recurrence of similar incidents.

Buildings Department

Case No. 2024/1283 – Failing to take timely enforcement or remedial action to address the unauthorised building works of a building

Background

39. The complainant was the owner of G/F of the building (the Premises). There were unauthorised building works (UBWs) on 2/F (UBW A and UBW B) of the building, which, according to the investigation conducted by an independent surveyor appointed by the complainant, was the highly probable source of the water seepage that has occurred at the Premises since around August 2022. Though several building orders and notices were issued by the Buildings Department (BD) to the relevant owners of the UBWs between December 2002 and November 2013, the UBWs remained intact. The complainant considered that the UBW have caused nuisance and damage, and jeopardised the structural integrity and safety of the building. Its legal representative requested BD to follow up, but BD merely replied that there was no imminent danger posed by the UBWs in question and that prosecution action would be taken against the owners concerned following the issuance of warning letters. Against this background, the complainant lodged a complaint against BD for failing to take timely enforcement actions and/or remedial measures to address the problem.

40. In December 2002, BD issued removal orders under section 24(1) of the Buildings Ordinance (the Ordinance) to the respective owners of the UBWs in question under a large scale operation (LSO). The orders were withdrawn in September 2006 upon completion of the modification works. Subsequently, warning notices under section 24C of the Ordinance were issued against the modified UBWs in November 2007 according to the established procedures at that time. Following the promulgation of the revised enforcement policy against UBWs in 2011, the building was selected for LSO again in 2012, and BD issued removal orders to the

relevant owners on 1 November 2013 requiring their removal of the UBWs in question.

41. To follow up the non-compliance of the removal order issued in 2013, BD instigated prosecution against the owner of UBW B in September 2015. In May 2018, BD assigned its in-house Social Service Team to provide social assistance and to encourage the owner to comply with the removal order. The owner was fined upon conviction by the Court in December 2018. As non-compliance continued, BD instigated prosecution for the second time in May 2022. Nonetheless, the owner concerned failed to appear in the plea hearings scheduled for August 2023 and July 2024.

42. As for the UBW A, BD was informed in September 2015 that the owner concerned had appointed an authorized person to follow up on the removal order issued in 2013. Nonetheless, the UBWs were not removed afterwards. Subsequent to the warning letter issued by BD in June 2019, the owner concerned indicated that there was site constraint obstructing the removal works. A joint inspection was conducted by the owner's representative, the authorised person, the owner's contractor and BD's staff in July 2019 to discuss the required works for compliance with the removal order. In October 2022, November 2022 and January 2024, BD conducted further inspections to ascertain the progress of the removal works. Since the above inspections revealed no obvious obstruction to the removal works but the owner concerned did not comply with the order, BD issued further warning letters to the owner and instigated prosecution against the owner between January and July 2024.

The Ombudsman's observations

43. Regarding the UBW A, after being notified of the appointment of an authorised person by the owner concerned in September 2015, BD did not take further action for over three years before carrying out a compliance inspection in December 2018. Prior to June 2019, BD only issued one warning letter and allowed the removal order to remain

outstanding. Furthermore, after conducting a joint inspection with the authorised person and the owner's contractor in July 2019, BD had not followed up on the matter again until October 2022 when it merely conducted another inspection. Even if the inspection in 2022 revealed that the UBWs had not been removed almost nine years after the removal order was issued, no further action was taken by BD before the complainant raised the matter with BD in January 2024. It was not until the time of the investigation that BD stepped up its follow-up actions by instigating prosecution against the relevant owner and arranging default works.

44. As for the UBW B, although BD instigated prosecution action as early as 2015, resulting in a fine to the relevant owner in December 2018, the UBWs remained intact thereafter. Nonetheless, no further action had been taken by BD until it instigated prosecution against the owner concerned for the second time in May 2022. Furthermore, though prosecution did not seem to be effective in making the relevant owner to remove the UBWs, BD had not made a decision to take default action until the time of the investigation.

45. Despite BD's explanation on the COVID-19 pandemic's impact on its work between late 2019 and early 2022, the Office of The Ombudsman still considered BD''s delay undesirable. It was indeed imperative for BD to take rigorous and expeditious enforcement actions to ensure compliance of the removal orders issued, as the relevant UBWs were considered actionable and warrant immediate enforcement actions under the current regime. It was essential to achieve a stronger deterrent effect and maintain public confidence in BD's determination to tackle the problem of UBWs.

46. Overall, The Ombudsman considered this complaint substantiated and recommended BD to –

(a) remind its staff to closely monitor the progress of the compliance of removal orders and take follow-up actions where appropriate;

(b) consider taking more stringent enforcement actions regarding removal orders that have been outstanding for a long time;

(c) closely monitor the default works to be taken at the building to expedite the removal of the UBWs in question;

(d) take reference from this case for internal experience sharing or training purposes;

(e) take appropriate follow-up and enforcement actions if there are other outstanding removal orders at the building; and

(f) conduct a high-level review and explore measures to increase deterrence against non-compliance with removal orders.

Government's response

47. BD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendations (a) and (d)

48. An email was issued on 12 February 2025 to all Chief Professional Officers (CPOs) under Existing Buildings Divisions and Mandatory Building Inspection Division of BD to share the lesson learnt of this case and remind them to closely monitor the long outstanding orders in the Sectional Progress Monitoring Committee (PMC) Meetings. Also, the CPOs were requested to remind their team members to closely monitor the progress of compliance of removal orders and take more stringent enforcement actions such as default works if the owners still fail to comply with the orders to remove the UBWs after prosecution. BD would continue to closely monitor the progress of the compliance of removal orders during the regular Sectional PMC Meetings chaired by CPOs, Divisional PMC Meetings chaired by Assistant Directors and the PMC Meetings chaired by the Director of Buildings.

Recommendation (b)

49. In view of the large number of outstanding removal orders, BD has established the following measures for clearance of outstanding orders –

(a) BD has set annual targets for clearance of the outstanding orders through various means including prosecutions, order compliance and carrying out of default works. New key performance indicators have been implemented since 2023 for carrying out default works to enhance enforcement actions against long outstanding orders;

(b) BD has drawn up clearance programme for clearance of long outstanding orders and its progress is regularly monitored by PMCs and the senior directorate;

(c) BD has set up Squad Units and backlog clearance teams as dedicated teams to clear the long outstanding backlog orders; and

(d) See also the response to Recommendation (f).

Recommendation (c)

50. The removal works for both UBW A and UBW B were completed by the owner in January 2025.

Recommendation (e)

51. There is one outstanding removal order at 15/F of the building involving three UBWs of which two items were already removed by the owner. As the removal order has not been fully complied with, prosecution action has been instigated. Summons was issued in May 2025 and the plea hearing has been scheduled for December 2025. BD would continue to closely monitor the progress of compliance of this outstanding order.

Recommendation (f)

52. A review of the Ordinance has been conducted and the proposals of legislative amendments include, among others, increase in penalties against non-compliance with removal orders. In addition, to increase the deterrence against non-compliance with removal orders, it was recommended to introduce fixed penalty against minor UBWs and impose higher penalties against serious UBWs, etc. The Development Bureau and BD completed a two-month public consultation for the proposed amendments to the Ordinance. The Government is now formulating the legislative proposals, with a view to introducing the amendment bill into the Legislative Council in the first half of 2026.

Buildings Department and Food and Environmental Hygiene Department

Case No. 2024/0026A and 2024/0026B – Delay and mishandling the complainant's water seepage case

Background

53. In March 2023, the complainant lodged a complaint with the Joint Office for Investigation of Water Seepage Complaints (JO) on water seepage from the premises upstairs to his/her premises. In April 2023, JO indicated in its reply letter to the complainant that the case would be taken over by the consultant engaged by JO for follow-up action. In September, the complainant temporarily moved out of his/her premises due to the seriousness of water seepage. In November, the complainant called Ms A, a member of JO's staff, to enquire about the progress of the case. She replied that JO would inform the complainant of the investigation outcome in mid-November. However, JO had yet to inform the complainant of the investigation outcome when the complainant lodged the complaint with the Office of The Ombudsman (the Office). The complainant was of the view that JO was ineffective in its work and had procrastinated in handling the case, and therefore lodged the complaint with the Office.

The Ombudsman's observations

54. JO had explained the progress of the follow-up action on the water seepage complaint lodged by the complainant in March 2023. According to the sequence of events provided by JO, approximately seven months had lapsed from May 2023 when the consultant launched the investigation to December 2023 when the consultant submitted the report to JO. During this period of time, it took the consultant about three weeks (i.e. from mid-June to early July 2023) to successfully schedule the time for inspection with the occupants of the premises upstairs. Subsequently, as works were being carried out in the premises upstairs on the scheduled inspection day (i.e. 10 August 2023), JO had to further postpone the

investigation and testing to the end of September (i.e. more than a month later). As the above arrangements involved the co-operation of the occupants of the premises upstairs and the testing took time, they were not entirely within JO's control. However, the fact that the consultant took about seven months to submit the report to JO still fell short of public expectations. After reviewing the case, JO was also of the view that the progress was unsatisfactory and apologised to the complainant. The Office considered that JO should step up monitoring the progress of handling complaints by consultants.

55. In addition, the consultant engaged by JO had made a number of mistakes, including erroneously receiving the samples collected and submitted by the complainant on his/her own, failing to record the extended seepage area brought up by the complainant in the report dated 30 November 2023, as well as wrongly accusing the complainant of failing to arrange for re-checking. In this regard, the Office has the following observations:

56. On erroneously receiving the self-collected samples submitted by the complainant, the Office considered that the incident indicated a lack of comprehensive and correct understanding of the procedures for water seepage investigation and their roles by the consultant's staff. The investigation (including sampling) conducted by the consultant on behalf of the Buildings Department (BD) and the law enforcement and prosecution under the Public Health and Municipal Services Ordinance by Food and Environmental Hygiene Department were vital to dealing with water seepage cases in an effective manner. In addition, if the investigation outcome lost its evidentiary value due to incorrect sampling procedures, the entire period of time on investigation may have been spent in vain. The Office considered that JO should adopt measures to ensure that the consultants (including their staff) have a thorough understanding of the procedures for water seepage investigation, their roles and areas of responsibility, and that they would strictly comply with the relevant requirements. Furthermore, the Office noticed that it was not until April 2024 when the complainant provided his/her views on JO's response did

JO notice the mistakes in the sampling procedures. In this regard, the Office hoped that JO would consider ways to step up supervision on whether the consultant's follow-up actions were in compliance with the requirements, so that any problems could be detected in time for rectification.

57. Regarding the consultant's failure to record the extended water seepage area brought up by the complainant in the report dated 30 November 2023, while the Office could not comment on the reasons based on the information available, it considered that omission of such crucial information in the report may affect the follow-up action on handling the water seepage case in question, which was definitely undesirable from the administrative point of view. In addition, regarding the consultant wrongly accusing the complainant of failing to arrange for re-checking, JO had apologised. The Office considered that JO should consider strengthening the supervision of the consultants, requesting them to step up staff training to ensure accurate recording of important information, so as to facilitate appropriate follow-up actions based on the information available.

58. As regards the queries raised by the complainant on the clerical errors in the report, the Office, having reviewed the relevant records, opined that they match the relevant records and the complainant's queries are not grounded in fact.

59. At the same time, the Office noticed that JO's failure to complete the investigation within 90 working days indicated the complexity of the case. However, JO did not inform the complainant in writing of the case progress, which was unsatisfactory. The Office urged JO to ensure that its staff informs complainants of the case progress in a timely manner or they will mistakenly believe that their cases have been put on the back burner.

60. Regarding the complainant's claim of being told by Ms A that the investigation outcome would be available in mid-November 2023, the Office has no way of finding out the specifics of the conversation due to a

lack of independent corroborating evidence. Nonetheless, the Office has always encouraged government departments to maintain good communications with the public. JO may further improve the frontline officers' communication skills through in-house training on a continued basis.

61. With regard to the complainant's queries on the investigation methods employed by JO, the Office would not intervene as it is a matter of JO's professional judgement rather than an administrative matter. From an administrative point of view, JO's explanation was reasonable.

62. Having reviewed the case, JO had followed up with the consultant concerned on its inadequacies. The Office urged JO to draw on the experience from this case, step up monitoring of the consultants so as to improve their performance and work progress, give an honest reflection of the consultants' performance in their performance reports which will be used as reference for future tender exercises or contract renewal, and arrange for experience sharing and training sessions for JO's staff in light of the experience from this case. The Office also urged JO to closely monitor the re-opened water seepage investigations to ensure proper follow-up and to inform complainants of the investigation outcome as soon as possible.

63. Based on the above, the Office found inadequacies on the part of JO and thus considered the complaint substantiated.

64. The Ombudsman made the following recommendations to JO(BD) –

(a) step up monitoring of the progress of water seepage investigations handled by the consultants;

(b) adopt measures to ensure that the consultants (including their staff) have a thorough understanding of the procedures for water

seepage investigation, their roles and areas of responsibility, and that they will strictly comply with the relevant requirements;

(c) consider ways to step up supervision on whether the consultant's follow-up actions are in compliance with the requirements, so that any problems can be detected in time for rectification;

(d) request the consultants to strengthen staff training on accurately recording important information, so as to facilitate appropriate follow-up action based on the information available;

(e) ensure that its staff informs complainants of the case progress in a timely manner[1];

(f) JO may further improve the frontline officers' communication skills through in-house training on a continued basis[1];

(g) give an honest reflection of the consultants' performance in their performance monitoring and assessment reports, which will be used as reference for future tender exercises or contract renewal;

(h) arrange for experience sharing and training sessions for JO's staff in light of the experience from this case[1];

(i) with respect to re-opened water seepage investigations, JO is required to maintain close liaison with complainants, ensure proper follow-up action, and inform complainants of the investigation outcome as soon as possible[1]; and

(j) JO should closely follow up on the above recommendations and ensure their prompt implementation[1].

[1] Recommendations involving FEHD and requiring joint follow-up action with the BD.

Government's response

65. JO accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendations (a), (c) and (g)

66. To further enhance the monitoring of and to improve consultants' follow-up progress and performance in handling water seepage investigations, JO has formulated more stringent assessment standards for the quarterly performance reports of consultants in late 2023 (for instance, if consultants fail to conduct investigation or testing, or submit case reports within the time specified in the contract and the delay of which reaches a certain percentage, JO would immediately issue reminders, pre-warning letters or warning letters depending on the severity of the case). Moreover, the data on consultants' work progress generated from the Water Seepage Complaint Management System have been enhanced so that JO can more effectively and timely step up random audit checks on consultants with unsatisfactory performance, issue reminders, pre-warning letters and warning letters, and conduct interviews with the senior management of the consultants in a timely manner, as well as issue adverse performance reports to require rectification and improvement of performance. A consultant who has been issued with more than one consecutive adverse performance report under the same contract would be temporarily suspended from bidding for new contracts for a period of three months to one year depending on the severity of the case.

67. Moreover, on 28 February 2025, JO wrote to remind all consultants to comply with contractual requirements in conducting water seepage investigations. In March, new measures were implemented to further enhance the monitoring of consultants and improve their performance. For instance, if the content of any report submitted by a consultant is found to be inaccurate or unsatisfactory, or there is obvious erroneous information resulting in the failure to ascertain the source of water seepage, or important information is omitted from the report, or

testing procedures or sampling methods are not in compliance with JO's contractual requirements, JO would issue a pre-warning letter or warning letter to the consultant to ensure the accuracy of the water seepage investigation reports submitted by the consultant. In case of repeated violations, JO would issue an adverse performance report and consider prohibiting the consultant from bidding new contracts in accordance with the established mechanism.

68. As regards the subject case, JO issued two warning letters to the consultant on 20 May and 1 August 2024 respectively for its unsatisfactory performance, and conducted an interview with its senior management on 8 August requiring improvement of performance and compliance with contractual requirements in carrying out water seepage investigations, to which the consultant has committed to making improvements to prevent similar incidents from occurring again. JO has learnt that an internal investigation was conducted by the consultant, and that the staff in question found to have conduct issues was relieved of their duties in late August. Additionally, JO has increased the frequency of site audits on the subject consultant, closely monitoring its improvement measures, and would reflect its performance in the performance reports.

Recommendations (b) and (d)

69. In August 2024, JO requested the subject consultant to strengthen staff training to ensure that their staff can accurately record important information and conduct water seepage investigations in accordance with contractual requirements. The consultant stated in the same month that the case was an isolated incident and undertook to organise training for its staff, as well as to step up its efforts in urging all staff to conduct water seepage investigations in strict accordance with contractual requirements, including accurately recording important information and taking appropriate follow-up actions based on the information obtained.

70. JO has clearly specified in the tender documents the proper water seepage investigation procedures, as well as the roles and purview of

consultants' staff at various ranks (including professionals and technicians) involved in water seepage investigations. JO conducts briefings during the tendering process to explain the relevant requirements.

71. When awarding consultancy contracts, JO arranged a kick-off meeting with the management and frontline staff of consultants (including professionals and technicians). One of the agenda items of the meeting was to remind consultants of the requirements for water seepage investigations, including investigation and sampling procedures, the roles and purview of their staff in the investigation, etc., to ensure both the management and frontline staff of consultants have a thorough understanding of the requirements for the services to be provided, water seepage investigation procedures and their roles and purview, and they would strictly comply with the relevant requirements.

72. During the contract period, JO staff also conducted bi-weekly work meetings with consultants to follow up on the progress of individual cases with their staff directly, which was initiated after the previous direct investigation of The Ombudsman in 2020, and depending on the circumstances, supervise and contribute to the resolution of the difficulties and problems encountered in the cases to expedite the handling of the cases.

73. In February 2025, JO issued a written reminder to all consultants requiring them to conduct water seepage investigations in compliance with contractual requirements. JO would also enhance the terms of new consultancy contracts to be awarded after 2026 to ensure further strengthening of staff training on requirements such as accurate recording of important information, and to require regular submission of staff training records.

Recommendations (e), (f), (h) and (i)

74. For simple and straightforward cases with the co-operation of the owners/occupants concerned, JO would normally complete the

investigation and tests within 90 working days and inform the informant of the outcome. If the investigation could not be completed within 90 working days, JO would inform the informant of the investigation progress in writing.

75. JO has reviewed the aforementioned arrangements and implemented enhancement measures in October 2024, including the addition of a reminder system to remind case officers of the expiry of the 90 working days so that informants are informed of the investigation progress in writing in a timely manner. JO staff are also reminded via email that an interim reply must be given to inform the informant of the case progress if a case cannot be completed within 90 working days.

76. JO has provided appropriate training to relevant staff on a regular basis, including seminars and experience sharing sessions organised by the Civil Service College, professional institutions, and JO internally. Additionally, workshops especially designed for JO frontline staff are also held to enhance their communication skills.

77. JO has reminded its staff that both new investigations and re-opened investigations must be properly followed up, and that the complainants must be informed of the case progress and the investigation outcome in a timely manner. In this connection, JO has implemented improvement measures in October 2024, including the introduction of an alert system to remind case officers of the day the 90th working day falls due, so as to inform the informant in writing of the investigation outcome or progress.

78. JO has also covered the relevant content in its current in-house training courses to remind JO's staff of the proper attitude while handling complaints for better understanding of complainant's needs.

79. JO would continue to arrange for multiple training workshops every year, including case experience sharing, to further improve the communication skills of the relevant staff. In March 2025, JO arranged an

experience sharing session on this case for the staff of the four Regional Joint Offices to take reference from this case, with a view to enhancing service quality.

80. The informant provided further information to JO on 27 May 2024. JO re-initiated the water seepage investigation, and found that the water seepage problem had persisted when conducting investigation at the informant's flat on 3 June 2024. Due to the ongoing repair works at the upper flat at the time, the informant agreed to have the investigation resumed after the completion of the relevant works. On 26 September and 4 October 2024, JO staff conducted colour water tests on the drainage pipes in four sub-divided rooms at the upper flat. On 4 October 2024, JO informed the informant in writing of the latest investigation progress of the case.

81. As it could not be confirmed that the source of water seepage was related to the drainage pipes while water seepage persisted, JO informed the informant in writing on 15 October and 17 October 2024 that a contract consultant had been engaged to conduct the Stage III professional investigation. On 8 November 2024, the consultant's staff, by appointment, conducted investigation and tests in two of the sub-divided rooms, and collected samples for testing at the Government Laboratory (GL) afterwards. Subsequently, the test report issued by GL on 30 December 2024 indicated that the samples did not contain the colour dyes used in the tests carried out at the upper flat, and it could not be confirmed that the source of water seepage was in the two sub-divided rooms at the upper flat.

82. As water seepage might involve multiple sources including the water supply pipes, the consultant carried out a water meter flow test for the upper flat on 17 December 2024, and the test result indicated that there was leakage from the water supply pipes of the flat. On 27 December 2024, JO referred the test result to the Water Supplies Department (WSD) for follow-up in parallel and informed the informant in writing the latest progress of the case.

83. WSD issued a repair notice to the owner of the upper flat on 9 January 2025. After the owner of the upper flat arranged for the improvement works to be carried out, WSD conducted a water meter flow test again on 3 February 2025 and notified JO on 18 February 2025 that the test results did not provide sufficient evidence to indicate that the building was involved in waste of water.

84. As investigation and tests could not be successfully arranged for the remaining two sub-divided rooms despite multiple attempts to contact the owner of the upper flat, JO initiated the procedures pertaining to the "Notice of Intended Entry" on 24 January 2025. Finally, the owner voluntarily replied to JO that they were able to arrange for the investigation and tests to be carried out on 28 February 2025. However, no test colour water was found at the seepage areas. Subsequently, JO notified the informant of the latest investigation progress of the case by phone in January, February, March and April 2025 respectively.

85. Due to the persistent water seepage and high moisture content at the seepage areas, the consultant suspected that water seepage might still have originated from the water supply pipes, and therefore further conducted a reversible pressure test on the water supply pipes at the upper flat. However, the source of water seepage still could not be ascertained. The consultant further conducted a static pressure test on the water supply pipes at the upper flat on 22 April 2025 and the results indicated suspected leakage from the water supply pipes. JO notified WSD of the results for follow-up and informed the informant in writing on 30 April 2025. JO was informed that WSD had issued an advisory letter to the upper flat on 12 May 2025 requesting the registered user to maintain and service the internal water supply system of the upper flat, including identifying leaking pipes or facilities, immediately hire a licensed plumber or qualified professional to conduct a detailed inspection of the internal water supply system. If leaking pipes or facilities are discovered, necessary repair work should be carried out promptly, as WSD considered the test result carried out by the consultant does not warrant issuance of repair notice under Waterworks Ordinance.

Recommendation (j)

86. JO has closely followed up on and fully implemented the recommendations above.

Food and Environmental Hygiene Department, Home Affairs Department, Lands Department and Marine Department

Case No. 2023/1742A, 2023/1742B, 2023/1742C, 2023/1742D – The unauthorised operation of fresh food stalls, illegal occupation of government land, unauthorised erection of structures, pollution of inshore water quality, etc. by moorings and an extended on-shore bazaar outside a certain harbourfront, with no improvement made after repeated complaints

Background

87. In June 2023, the complainant lodged complaints with the Office of The Ombudsman (the Office) against the Food and Environmental Hygiene Department (FEHD), alleging that seven to eight residential boats were illegally rented out for unlicensed seafood, meat, fruit and dried seafood stalls and "private kitchen" operations in Tin Kwong Hui, Aberdeen, and that structures were built on the shore to occupy government land, as well as dumping a large amount of seafood residues, foam boxes and garbage into the sea, affecting environmental hygiene. The complainant was also of the view that these vendors used nearby seawater to raise seafood, which might contain cholera bacteria, and citizens might suffer from food poisoning after consuming the seafood. The complainant had called FEHD since 2021 for lodging the complaints, but the department had never responded or explained the results of the investigation to her, and she noted that the boats involved continued to operate illegally.

88. After reviewing FEHD's responses and considering all the matters involved in the complaint, the Office included the Lands Department (LandsD), the Home Affairs Department (HAD) and the Marine Department (MD) as the departments complained against upon consulting the complainant in October 2023. In accordance with The Ombudsman Ordinance, the Office launched a comprehensive investigation on FEHD, LandsD, HAD and MD, and requested the Civil

Engineering and Development Department (CEDD) and the Leisure and Cultural Services Department (LCSD) to provide relevant information.

The Ombudsman's observations

Complaint against FEHD

89. Upon reviewing its records, FEHD stated that it only received, by referral from 1823, a complaint from a complainant with the same surname in relation to Tin Kwong Hui on 25 October 2022. From FEHD's response, it could be seen that the Department had taken follow-up actions on the issues of unlicensed sale of seafood and obstruction by goods as mentioned in the complaint, and had replied to the complainant on the investigation results. Having examined the records provided by FEHD, the Office was of the view that FEHD had followed up on the complaint of the complainant in accordance with the established procedures.

90. However, the complainant told the Office that there was no reply received from FEHD staff on 30 October 2022. In this connection, FEHD provided the Office with a written statement of the staff member concerned and the relevant records. (FEHD did not keep any audio record of the conversation between the staff member and the complainant.) Since the complainant and FEHD had their own versions of the story as to whether the staff member had given the complainant an account of the investigation results by phone on 30 October 2022, the Office could not ascertain the facts given the lack of objective corroborative evidence.

91. Regarding the suspected unauthorised sale of restricted food (such as fresh fish and live marine fish) on decks of vessels, in illegal structures on shore and on vessels at sea at Tin Kwong Hui, no enforcement or prosecution actions were taken between January 2022 and July 2023. Although the Department explained that whether prosecution could be instituted was subject to the observations of law enforcement officers and the evidence collected at the time, the data and documentary information obtained from the Office's investigation showed that FEHD had

considerably strengthened its enforcement actions in respect of the above non-compliance issues since the intervention of the Office on 28 July 2023. Similarly, as regards whether the five vessels in question had strictly complied with the permit conditions of the Restricted Food Permit, including whether the quality of the seawater in fish tanks used for keeping live marine fish on board was up to standard, and whether the fish was sold in whole on board, FEHD had not found any non-compliance in its previous inspections; however, after the Office's intervention, irregularities were detected.

92. At the Southern District Management Committee (SDMC), FEHD appealed to other departments to actively involve in addressing the issue of Tin Kwong Hui. It also proactively proposed joint operations with the Marine Department and the Police to crack down on unlicensed food businesses. The Office acknowledged the follow-up actions taken by FEHD. Nevertheless, prior to the intervention of the Office, FEHD had failed to perform its function in taking enforcement actions against the selling of restricted food without permission, nor had it adequately checked the compliance with the permit conditions by the holders of the Restricted Food Permit of the five vessels covering the water quality of fish tanks. This was actually a shortfall on their part.

93. Besides, the unauthorised sale of seafood at Tin Kwong Hui would inevitably affect the business of seafood stalls operating in the nearby markets under the purview of FEHD. To avoid causing unfairness to the affected stall operators, FEHD should squarely address such irregularity and continue to take enforcement actions until the outcome of the regularisation application by the Aberdeen Promenade Fishery's Association would be made available. Furthermore, the problem of unauthorised sale of seafood was not only limited to the early morning period. During an on-site inspection by the Office, it was found that similar irregularity existed even at noon, though with lower pedestrian flow.

94. Therefore, The Ombudsman found the complaint against FEHD partially substantiated.

Complaint against LandsD

95. In 2010, the concerned District Lands Office (DLO) of LandsD did participate in an inter-departmental operations targeting to purge the illegal structures that occupy government land at the marketplace, including clearance of eight onshore stalls and three bridge decks that were supported by piles extending down to the seabed. Nevertheless, no enforcement action was taken by DLO between December 2021 and October 2023 despite multiple site inspections by staffs of DLO of the illegal structures at the marketplace were arranged. LandsD explained that illegal hawking and the occupation of government land by illegal structures was a kind of street management issues, which ought to be dealt with through joint operations co-ordinated by the DMC.

96. In effect, the non-compliance of the marketplace fell under the purview of several departments. The DMC, after repeated discussions, agreed to address the issue through a joint operation but held the view that a holistic approach should be taken in dealing with the problem since the hawking of seafood and marine products by fishermen or hawkers had existed a long time and members of the local community still had divergent views on whether enforcement action should be taken to eradicate the problem at that moment. While the DMC's stance was understandable, The Ombudsman found it unacceptable that in recent years, the DLO only adopted a wait-and-see attitude, but without taking any enforcement action against the occupation of government land by illegal structures at the marketplace.

97. According to LandsD's explanation, the DLO had to prioritise enforcement actions following a risk-based criteria, carefully take into account the opinion of other departments and the local community, as well as to thoughtfully thrash out the details of any joint operation. While the Ombudsman had no dispute against LandsD's explanation, it considered

that LandsD failed to explain why the existence of the illegal structures at the marketplace had no immediate risk concern and no action was ever taken by the DLO to address the potential safety hazards that might be caused by the illegal structures. Furthermore, LandsD did not explain why the DLO had not executed the required measures as unanimously agreed by the DMC before September 2023, i.e. the concerned departments should continue dealing with the non-compliance of the marketplace according to their respective roles even if a resolution for handling the problem was still unavailable.

98. In light of the above, The Ombudsman considered the complaint against LandsD substantiated.

Complaint against MD

Matters relating to vessel licences

99. The Office made enquiries with MD regarding five of the vessels at the subject location (the five vessels). MD clarified that the five vessels were not dwelling vessels, but stationary vessels classified as Class II and of a specified type under the Merchant Shipping (Local Vessels) (Certification and Licensing) Regulation. It was also noted that the gangways of the five vessels were objects affixed to the shore rather than part of the vessels' structure. As such, the gangways were not relevant to the vessel licences. Regarding issues involving vessels operating catering services or restaurants, illegal hawking, unlicensed sale of food and violation of marine legislation, MD conducted 35 inspections, including 13 joint operations with FEHD, at the subject location between January 2022 and December 2023. No illegal activities were detected during these inspections. As for the suspected illegal modification of a vessel uncovered during an inspection conducted by MD in August 2023, prosecution has been initiated against the vessel owner in accordance with the established procedures and a day has been fixed for hearing.

Floating refuse at sea

100. Regarding the suspected dumping of refuse into the sea by hawkers at the subject location, MD stated that it had followed up on the matter upon receipt of the complaint. The contractor of MD would also clear floating refuse at sea on a daily basis. However, during one of the Office's site inspections, a significant amount of refuse was observed on the sea surface near the vessels concerned. In light of this, the Office urged MD to continue closely monitoring the issue of marine refuse. If cases of indiscriminate dumping of refuse are identified, decisive enforcement actions should be taken to serve as a deterrent.

MD's lack of proactive attitude

101. The Office also noted that FEHD had repeatedly sought the assistance of MD in intercepting dinghies suspected of selling seafood illegally. Although MD denied stating that it would only participate in inter-departmental operations coordinated by HAD, the information provided by MD to the Office revealed that it had, on three occasions, namely 14 August, 24 August and 7 September 2023, responded to FEHD by asserting that the matter did not fall within its jurisdiction and that it would not deploy staff to assist with FEHD's operations. This reflected a lack of proactive attitude. Although MD subsequently deployed staff to join FEHD's operations on a few occasions, the Office considered that the issue of illegal sale of seafood by hawkers on dinghies could not be tackled by FEHD alone. Given that the vessels in question might also have breached the terms of their licenses, MD should have initiated prompt investigation and enforcement actions, working in collaboration with FEHD to combat the illegal activities. Therefore, The Ombudsman found the complaint against MD partially substantiated.

Complaint against HAD

102. HAD has explained that the Southern District Office (SDO) was not a law-enforcement agency and did not have any law-enforcement

power over the issues at Tin Kwong Hui. However, as the secretariat of the DMC, SDO provided a platform through DMC for various departments to discuss and to collaborate in solving the problems in the district. As DMC has taken into account the long history of Tin Kwong Hui and the tourism characteristics of the district, there should have been a comprehensive plan formed for the site. Nonetheless, the Office noted that SDO continued to follow up the issue with relevant departments, including considering more joint inter-departmental actions and examining the request of the Aberdeen Promenade Fishery's Association for the Government's assistance in regularising Tin Kwong Hui.

103. Since DMC's issuance of advisory letters to the licensees of the vessels in question in July 2022, the relevant departments did not take further actions to remove the illegal structures on the shore, and failed to effectively combat the unlicensed sale of seafood in these structures. This inevitably gave the impression that the government departments were not enforcing the law. The situation was undesirable as it might cause the offenders to escalate their actions. The Office was of the view that even if DMC intended to adopt a holistic approach to tackle the problem at Tin Kwong Hui, the relevant departments should not turn a blind eye to the long history of non-compliance at the site. After issuing the draft investigation report, HAD provided further explanation on the reasons why SDO did not take lead in coordinating large-scale inter-departmental enforcement actions in recent years. The Office noted that the minutes of the DMC meetings support HAD's claim and that SDO has already coordinated small-scale joint operations between FEHD and MD. However, given that the relevant departments have failed to reach a consensus on the large-scale inter-departmental operation for a long period of time, SDO was inadequate in reporting and seeking instructions timely from the senior management of the Government, resulting in the continuation and worsening of illegal situations at Tin Kwong Hui. The Ombudsman therefore considered the complaint against HAD unsubstantiated but other inadequacies found.

104. In addition, while conducting on-site inspections, the Office noted that some of the illegal structures at Tin Kwong Hui had large shelves and were connected to power, and some of the boat bridges also had stalls and a lot of goods. The Office was concerned about the safety hazards caused by the loadings on these structures. While the Office was aware that the compliance requirements of the relevant structures would be discussed in detail at the DMC meetings, the licences currently issued by MD do not impose any restriction on the structural integrity or load-bearing capacity of the bridges.

105. The Office was of the view that the Government should set a timetable for discussing the long-term positioning of Tin Kwong Hui; and at the same time formulate clear short-term and medium-term measures to address the safety and environmental hygiene hazards associated with the site's illegal situations, including reviewing the compliance with conditions of the Composite Restricted Foods Permit, and how to appropriately regulate the safety of the bridges leading to the vessels. The Office also considered that there was no conflict between the safety and environmental hygiene hazards and the regularisation or otherwise of Tin Kwong Hui for the Administration. If necessary, the departments concerned should seek steer from the Task Force on District Governance (TFDG).

106. Overall, the Office considered this complaint unsubstantiated but other inadequacies found and recommended that FEHD, LandsD, MD, and HAD set a timetable for the discussion on the long-term positioning of Tin Kwong Hui at DMC; formulate clear short-term and medium-term measures against illegal situations at the site, including reviewing compliance with the licensing conditions of Composite Restricted Foods Permit; develop approaches to properly regulate the safety of the vessel bridges; and consider seeking steer from the TFDG when necessary.

Government's response

107. FEHD, LandsD, MD and HAD accepted The Ombudsman's recommendation and have taken the following follow-up actions.

FEHD

108. In response to the Office's recommendations, the issue of illegal hawking activities at Tin Kwong Hui has been put on the agenda of the SDMC for discussion. Meanwhile, FEHD was taking stringent enforcement actions to combat the irregularities at Tin Kwong Hui. Among others, the Department has strengthened inspections of the five permit-holding vessels at the said location to monitor their compliance with the permit conditions. If any non-compliance was found, verbal or written warning would be issued to the permit holder concerned for failure to comply with the permit conditions.

LandsD

109. In connection with the non-compliance issues at the marketplace, LandsD and other concerned departments have adhered to the recommendations outlined in the Ombudsman's investigation report to take follow-up actions, including thrashing out all round measures at the DMC's meeting to tackle the non-compliance at the target area. After taking the views of the concerned departments comprehensively, the DMC has submitted several proposed schemes to The Task Force on District Governance for consideration and directives.

110. LandsD would closely monitor the latest situation. Upon receiving DMC's notification of the endorsed scheme, LandsD would fully co-operate and take such appropriate action under its purview.

MD

Inspections and enforcement actions

111. In 2024 and 2025 (between January and June), MD conducted 39 inspections and 14 enforcement actions at the subject location, including 27 and eight joint operations with FEHD respectively.

Floating refuse at sea

112. Apart from arranging daily collection of floating refuse by the contractor from the waters around the subject location, MD has also deployed the contractor to carry out large-scale cleansing operations in the waters concerned. In 2024 and 2025 (between January and June), MD conducted two and one large-scale cleansing operations respectively in the waters concerned. In addition, to promote and enhance public awareness of keeping the harbour clean, MD conducted 62 and 30 leaflet distribution campaigns respectively in the waters concerned during the above period.

Meetings of DMC

113. MD would continue to participate in the meetings of DMC to proactively discuss the comprehensive proposal of the subject location with the departments concerned and actively work with them to implement the proposal.

HAD

114. SDO and relevant departments have diligently followed up the hawking, unlicensed sales, and catering services, etc. by conducting joint enforcement and prosecution actions on a regular basis. Relevant departments have also discussed different enforcement measures at the DMC Meetings.

115. DMC would continue to closely monitor the operation of Tin Kwong Hui to ensure public safety, health, and to prevent the situation from deteriorating.

Government Secretariat - Education Bureau

Case No. 2023/1512 – Failure to proactively follow up on the case of the complainant's son who had been required by the school to stay home due to alleged misbehaviours and could not resume class attendance for a prolonged period

Background

116. The complainant stated that her son, who has Autism Spectrum Disorder, was studying Primary 3 at an aided primary school in the 2022/23 school year. On 23 February, 6 March, and 17 March 2023, her son was involved in three incidents at school. The school accused him of misbehaviour, which the complainant considered slanderous. On 19 March, the school requested that her son stay home from 20 to 31 March, and arranged for him to begin online classes from 28 March. From late April onwards, her son did not attend any classes, nor was he included in the class photo taking or the graduation ceremony.

117. From March 2023, the complainant repeatedly called the District School Development Section of the Education Bureau (EDB), seeking assistance to understand the incidents of 6 and 17 March, address her son's difficulties with online classes, obtain the full name of the teacher involved in the incident of 17 March to enable her son to write an apology letter, and communicate with the school to allow her son to resume face-to-face classes as soon as possible. EDB responded by stating that it would relay her concerns to the school and advised her to communicate with the school. In addition, EDB declined to follow up on the two incidents, citing ongoing police investigations. However, the police told the complainant that no investigation was underway. In May 2023, the complainant approached EDB's Non-attendance Cases Team (NACT) to enquire about the reasons for her son's absences as reported by the school and sought NACT's assistance in facilitating her son's return to school. Likewise, NACT only recommended that she discuss the matter with the school and refused to meet with her. Subsequently, the complainant submitted a withdrawal

application for her son after the 2023/24 school year commenced. In mid-September, NACT called the complainant, indicating that a home visit would be arranged, but this never materialised. Upon discovering that the complainant's son was struggling to adapt to the new school and wished to return to the original school, NACT simply stated that it was beyond their purview.

118. The complainant alleged that EDB had responded in a perfunctory and detached manner. Despite being aware of the disagreement over the arrangements for her son's return to school, EDB failed to actively intervene or assist in her communication with the school. In addition, it overlooked the impact of his non-attendance, allowing the school to suspend him from school for one week in March 2023 and to devise an inappropriate plan for resuming schooling. Consequently, her son ceased attending school since late March, extending his absence through late April and beyond the start of the 2023/24 school year. Furthermore, the complainant alleged that EDB unreasonably refused to investigate the incidents of 6 and 17 March, did not provide appropriate assistance in obtaining the full name of the teacher involved, and unreasonably declined to disclose the reasons the school reported for her son's absences.

The Ombudsman's observations

119. According to the Government's education policy, school-age children are required to receive primary and secondary education in schools. EDB, as the lead department overseeing education affairs, is charged with ensuring that this policy is implemented, while schools and parents share the responsibility of facilitating the prompt return of non-attendance students to school.

120. In this specific case, after reviewing the circumstances surrounding the complainant's son and considering the perspectives of various stakeholders, the school decided that the boy should return to school gradually. This gradual return would enable the school to observe the situation and determine the most appropriate time for the boy's full

reintegration into the classroom. EDB supported the school's rationale, agreeing that the training activities the Red Cross provided during the boy's absence were no substitute for formal classroom learning. However, the complainant disagreed with this plan, insisting that her son should immediately resume classroom learning and stated that she would not allow him to attend any classes otherwise. Given the professional judgement by both the school and EDB that a gradual return would be in the boy's best interests, the Office of The Ombudsman (the Office) deemed it necessary for both parties to employ all feasible measures to facilitate this approach, thus mitigating the adverse impacts of his absence.

121. The information available indicates that the school fulfilled its responsibilities by adhering to EDB's recommendations, employing various approaches, and consulting with professionals to repeatedly revise the resumption plan in an effort to accommodate the complainant's wishes. Despite these efforts, a consensus with the complainant was never reached. Numerous attempts were made by both the complainant and the school to contact EDB, expressing difficulties in communication and requesting mediation or a tripartite meeting. Nevertheless, EDB declined to engage, justifying its refusal by stating that it does not offer mediation services and expressing doubts about the effectiveness of such meetings. Furthermore, due to the complainant's reluctance to share details about her son's situation, EDB did not engage directly with her and reached out again only after being informed of his withdrawal from school. However, no further follow-up occurred due to the complainant's continued unwillingness to communicate.

122. The Office acknowledges that direct communication between schools and parents is generally more effective and usually fosters better relationships. However, the discrepancies in the accounts provided by the school and the complainant to EDB indicated significant communication challenges. Despite the prolonged non-attendance of the complainant's son and both parties repeatedly seeking assistance, EDB, being fully aware that direct communication was failing, continued to act merely as a "messenger". It provided only general advice without offering assistance

tailored to the unique circumstances of the case, which rendered its efforts routine and perfunctory. Additionally, although EDB has the authority to act against parents who unreasonably prevent their children from returning to school, it refrained from issuing any verbal or written advice or warning, despite recommendations from the boy's psychiatrist and educational psychologist for a gradual resumption of schooling. It chose not to intervene, citing ongoing support from these professionals as the reasons. The criteria and timing for intervening in non-attendance cases should be made clearer.

123. The Office reiterated that EDB, as the lead department overseeing education affairs, should prioritise students' educational interests and provide timely support to stakeholders. This case involved a student's prolonged absence, which violated education policies and impinged on his right to schooling. EDB should proactively facilitate communication between the complainant and the school to ensure an effective resolution of the issues. This lack of concrete action conveyed an impression of indifference to the boy's prolonged absence.

124. Regarding other allegations made by the complainant, after reviewing the information provided by EDB (including records of communications with the police, the school, and the complainant), the Office accepted EDB's explanations.

125. The non-attendance issue stemmed from three separate incidents at school involving the complainant's son, with divergent narratives from the complainant and the school, leading to police involvement. There were clear difficulties in communication and a lack of trust from the complainant towards the school.

126. While it is crucial for EDB to work with the school to formulate a resumption plan that addresses the concerns of both the complainant and the school, helping both parties overcome barriers, rebuild trust, and communicate openly is also key to resolving the case. In fact, both the school and the complainant have requested such assistance from EDB.

EDB added that it had attempted to follow up by arranging a tripartite mediation meeting. However, the Office noted that despite EDB being aware since early May 2023 of the lack of agreement between the school and the complainant regarding the boy's absence from school since late April 2023, it did not initiate mediation until mid-September 2023. Moreover, EDB made only one request for the school to remind the parent of her legal responsibility to ensure her son's attendance, without directly contacting the parent or issuing any form of advice (not even a verbal one, which would be less severe than a warning letter). The Office believes that the timing of EDB's mediation efforts and its criteria for deciding when to issue formal advice should be reconsidered. Earlier mediation could have created a perception of more active support, potentially improving communication and addressing the non-attendance issue sooner. Even if mediation were ultimately not arranged or unsuccessful, EDB could have made earlier decisions on further steps to take (such as advising or warning the parent or facilitating a school transfer), thus avoiding the undesirable outcome of the boy's continued absence until he withdrew and was transferred to another school at the start of the new school year.

127. To ensure the implementation of the policy requiring school-age children to receive primary and secondary education in schools and to safeguard their right to schooling, the Office believes that EDB should learn from this case. There is a need to enhance staff sensitivity and flexibility in handling non-attendance cases and to strengthen staff training in mediation, providing more specific instructions on when and how to offer support or intervene. The Office also urged EDB to continue monitoring the situation of the complainant's son and provide timely support to mitigate the impact of his prolonged absence from school.

128. Overall, The Ombudsman considered this complaint partially substantiated and recommended EDB to –

(a) learn from this case, enhance staff sensitivity and flexibility in handling non-attendance cases, strengthen staff training in

mediation, and provide more specific instructions on when and how to offer support or intervene; and

(b) continue to monitor the situation of the complainant's son and provide timely support to mitigate the impact of his prolonged absence from school.

Government's response

129. EDB accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendation (a)

130. To further enhance the sensitivity and flexibility of caseworkers in handling various types of cases, EDB has introduced professional exchange sessions on complicated cases to its regular team meetings, which included the discussions on the handling of the complainant's case. Moreover, EDB has stepped up individual supervision of caseworkers, including increasing the number of discussions on complicated cases, ensuring that caseworkers provide appropriate and timely support and intervention.

131. According to current practices, heads of relevant teams at EDB hold monthly meetings to discuss complicated cases, exchanging strategies and insights on handling cases. Starting from September 2024, staff at the rank of Assistant Inspector also participate in these meetings to further enhance their professional knowledge and abilities in handling non-attendance cases, and to provide more appropriate supervision for caseworkers.

132. EDB has consistently encouraged caseworkers and supervisors to actively participate in training related to handling non-attendance cases. Following the recommendations of the investigation report, EDB has systematically arranged for staff to participate in relevant courses. In

addition, experienced accredited mediators will be invited to conduct internal training in the 2024/25 school year so as to equip staff with the skills to assist stakeholders in reaching mutually acceptable solutions that help non-attendance students resume schooling as soon as possible.

133. EDB has further refined the procedures for handling non-attendance cases and reinforced the specific instructions on when and how to offer support or intervene. EDB will continue to take student non-attendance seriously, reviewing and enhancing the relevant mechanisms in a timely manner to ensure that non-attendance students receive timely and appropriate intervention and support, enabling them to resume schooling as soon as possible.

Recommendation (b)

134. EDB has been concerned about the schooling situation of the complainant's son, providing appropriate assistance. In September 2023, the complainant withdrew her son from his original school. Subsequently, she arranged her son to enrol at a primary school in Wong Tai Sin District and then at a primary school in Sai Kung District. Following this, EDB received a referral from the Social Welfare Department concerning placement assistance services for the boy. Between April and June 2024, EDB suggested three different schools in Wong Tai Sin District to the complainant. However, the complainant did not accept these options for various reasons. Under the arrangement of EDB, the boy was officially admitted by a school in Wong Tai Sin District in July 2024 and began attending Primary 5 there in September 2024. However, on 30 September 2024, the complainant notified EDB that she had arranged for her son to withdraw from that school and requested placement assistance services. EDB attempted to arrange for the boy to enrol in two other primary schools within Wong Tai Sin District. Eventually, the boy was registered at one of them. Since the commencement of her son's schooling on 18 November 2024, the school has maintained regular communication with the complainant, offering support tailored to her son's learning needs and fostering home-school co-operation. EDB will

continue to liaise with the school and the complainant to monitor her son's situation at school and provide appropriate assistance.

135. In summary, EDB has fully implemented and remains committed to executing the recommendations made by the Office.

Housing Department

Case No. 2024/1390 – Failing to properly follow up on the problem of illegal parking in a public housing estate

Background

136. The complainant lodged a complaint to the Office of The Ombudsman (the Office) on 12 May 2024, expressing dissatisfaction with the Housing Department (HD)'s lack of proper enforcement against illegal parking at the roundabout of a road (the concerned location) in a public housing estate, where illegally parked vehicles routinely obstructed vehicle owners who rented parking spaces in the open car park.

137. The complainant is a licensee of an open parking space on a road in a public housing estate. In April 2024, the complainant lodged a complaint with HD via 1823 about the severity of the illegal parking problem at the concerned location, which had persisted since March of the same year. Many vehicles had been illegally parked at the concerned location routinely and overnight, obstructing licensees of nearby parking spaces from parking. The complainant pointed out that there had been no improvement after HD's follow-up actions, and that the problem involved repeated illegal parking of certain vehicles. Therefore, the complainant believed that HD was suspected of breach of duty and failing to manage the estate facilities properly.

The Ombudsman's observations

138. The Office has reviewed the information provided by HD. HD has been making every effort to tackle illegal parking in the estate with a multi-pronged approach, flexibly deploying limited resources and manpower to conduct more enforcement actions during non-office hours, to increase the non-compliance costs of vehicle owners parking illegally and to curb misbehaviour. Given resource and manpower constraints, it would be difficult for HD to arrange for patrol and enforcement round the

clock in the estate. According to HD's explanation, owing to geographical constraints and road conditions, barrier gates cannot be set up in most of the roads in that estate (including that road) to control traffic flow, which undoubtedly pose a challenge to road management by frontline officers.

139. The Office noticed that upon strengthened enforcement by HD, night-time illegal parking had tapered, even though some vehicles were still parked illegally. The Estate Office has strengthened road management and the combat against illegal parking. The Office opines that HD's follow-up actions were appropriate, and even if illegal parking is still going on, it is not a result of maladministration on the part of HD.

140. The Office believes that HD's enforcement actions have adequately addressed the requests of the complainant. Lasting solutions to illegal parking require more than HD continuing its rigorous enforcement actions – drivers also have to be self-disciplined and law-abiding – only then can the problem be resolved completely.

141. Overall, The Ombudsman considered this complaint unsubstantiated. The Office recommended HD to –

(a) continue to closely monitor the illegal parking situation in the public housing estate;

(b) step up enforcement actions as necessary to reduce the safety risks to members of the public arising from illegal parking;

(c) continue to arrange joint operations with the Hong Kong Police Force from time to time to enhance deterrence and increase the non-compliance costs of drivers;

(d) conduct timely reviews of the effectiveness and results of the pilot use of closed-circuit television (CCTV) surveillance systems and Internet of Things (IoT) sensors to help frontline officers effectively detect illegal parking;

(e) consider compiling records of the figures on the written warnings against illegal parking issued by the Estate Office to facilitate its frontline staff in monitoring the problem, to supervise staff and to allocate resources where necessary;

(f) organise sharing sessions and trainings on enforcement against illegal parking for Estate Offices and security service contractors from time to time;

(g) continue to maintain effective communication with the complainant to let her know the enforcement actions taken by HD, to minimize misunderstandings; and

(h) draw up an implementation timetable for the above recommendations and conduct regular reviews.

Government's response

142. HD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendations (a) and (b)

143. The Estate Office has been proactively carrying out estate road management duties, bolstering enforcement in a timely manner and deploying additional public officers to the estate to take part in enforcement actions. In cracking down on widespread night-time illegal parking, the staff of the Estate Office and the officers of the Mobile Operations Unit from the Headquarters not only carried out enforcement actions more frequently, but also ramped up the combat against illegal parking during non-office hours (such as late at night and in the early hours). The relevant measures have proven effective on that road and various service roads in that estate, significantly improving illegal parking.

Recommendation (c)

144. The Estate Office will, depending on the situation, seek the Police's assistance in enhancing deterrence against illegal parking through joint enforcement actions. In the past year, the Office and the Police have conducted two joint operations. In addition, the Police has strengthened enforcement against illegal parking on that road section, resulting in marked improvement.

Recommendation (d)

145. The Estate Office has installed CCTV systems for the monitoring and video-recording of road conditions to help its staff monitor the traffic remotely. IoT sensors are being trialed on selected road sections to send real-time illegal parking alerts to the staff's mobile phones, so they can get the latest updates and take appropriate actions. Such devices are helpful for combating illegal parking.

Recommendation (e)

146. The Estate Office has compiled records of the figures on written warnings. The staff of the office will review the records from time to time for staff supervision and manpower deployment, to combat illegal parking strategically and more effectively.

Recommendation (f)

147. HD will regularly organise training courses and invite frontline staff and outsourced contractors to participate, so as to enhance their knowledge of enforcement actions against illegal parking. Meanwhile, Housing Managers will conduct meetings with security service contractors from time to time to explain the latest revised legislation and share the points to note in enforcement against illegal parking. In addition, contractors will arrange on-site trainings for frontline security guards to improve the effectiveness of enforcement.

Recommendation (g)

148. The staff of the Estate Office have been actively communicating with the complainant, explaining to her the measures and enforcement actions taken by HD.

Recommendation (h)

149. The above recommendations have been implemented and are being carried out.

Post Office

Case No. 2023/3121 – Wrongly informing the complainant that a packet could not be delivered successfully because no one answered the door

Background

150. The complainant lodged a complaint with the Office of The Ombudsman (the Office) against the Post Office on 6 October 2023.

151. The complainant claimed that he was the recipient of an inward packet. On 6 October 2023, he received an SMS message from the Post Office, indicating that the packet was expected to be delivered before 1:00 p.m. on that day. As he had yet to receive the packet at around 1:40 p.m., he made an enquiry by calling the Wan Chai Post Office[2]. The staff handling the enquiry (Staff A) stated that the delivery postman (the postman in question) had arrived at his unit at 1:30 p.m. that day for delivery, but no one answered the door. Another staff from the Wan Chai Post Office (Staff B) later called the complainant and advised that the delivery would be made again. He received the packet at around 3:00 p.m. that day. He alleged that Staff A had lied and maintained that the Post Office should have arranged for the postman to deliver the packet to his door.

The Ombudsman's observations

152. The Post Office has always been adhering to the principle of "delivery by address", i.e. a mail can be received by anyone within the unit of the recipient's address. If the address on a mail pertains to a subdivided flat without an individual door or doorbell, the postman will not be able to identify the room specified in the mailing address and therefore in general door delivery to such an address cannot be arranged. However, postmen

[2] The Post Office clarified that the complainant had called the general enquiry hotline instead of the "Wan Chai Post Office." The call was transferred to its Mail Tracing Office, and the staff there replied to the complainant based on system records.

are required to record delivery results in their electronic devices and immediately issue mail collection notification cards to recipients, allowing the latter to collect mails from the post office by presenting the notification cards and their identity documents.

153. The Post Office stated that the complainant's mailing address was a subdivided flat without an individual door or doorbell, and thus was not "door-deliverable". The postman in question in fact was not required to deliver to the door that day, but he failed to follow the established procedures to record the result in the electronic device and issue the mail collection notification card immediately as he did not bring a card. He recorded the delivery result in the electronic device and logged "mail collection notification card issued" in the computer system only when the postman in question returned to the Wan Chai Delivery Office at 1:30 p.m. that day. Staff A responded to the complainant based on the above system record.

154. For the complainant's allegation that Staff A had lied, the Office accepted the Post Office's explanation that Staff A answered the complainant's enquiry based on the system record and thus had not lied. However, the Office considered that Staff A mistakenly replied to the complainant that a delivery attempt had been made, due to the failure of the postman in question to follow the established procedures to record the delivery result in his electronic device upon arriving at the recipient's building and issue a mail collection notification card, as well as the lack of an appropriate option in the computer system, leading to the postman in question to only select the option of "unsuccessful delivery" as the result on the system. The Office therefore concluded that the complaint was unsubstantiated, but other inadequacies were found on the part of the Post Office.

155. As regards the delivery arrangement for subdivided flats, the Office agreed with the Post Office that if a recipient's address is a subdivided flat without an individual door or doorbell, the Post Office

should accord priority to the mail security, and hence door delivery will not be arranged in general.

156. The Office recommended the Post Office to –

(a) inform in the SMS message sent to recipients prior to delivery that their addresses are not "door-deliverable addresses" and the postmen will not deliver to their doors under normal circumstances, as well as provide a hotline for recipients to contact the post office concerned to arrange for door delivery if needed;

(b) include an appropriate option in the computer system as soon as possible to indicate mail items that do not fall under the category of "door-deliverable addresses"; and

(c) enhance the mail tracking function on the website as soon as possible to enable the public to know that a certain address is not a "door-deliverable address".

Government's response

157. The Post Office accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendation (a)

158. In order to inform the recipients earlier that their addresses are not "door-deliverable addresses", the Post Office included a new option in its system in October 2024 for postmen's selection. In delivering a mail item where signature for the receipt is required, if a postman finds that the address does not fall under the category of "deliverable address", he/she can select this option and the system will automatically send an SMS message (only applicable to Express Mail Service items and parcels, with a mobile number capable of receiving SMS messages provided) to notify

the recipient that the mail item will be despatched to the post office for collection as the address is not door-deliverable, with a hotline provided for the recipient to contact the Post Office if necessary.

Recommendations (b) and (c)

159. To accurately reflect the situation where addresses of subdivided flats are not "door-deliverable addresses" and postmen could not deliver to the door, the Post Office introduced in the system in April 2024 a new delivery result option of "not yet delivered - address is not door-deliverable and the recipient has been notified to collect the item at post office" for postmen's selection. When delivering an item where signature for the receipt is required to a subdivided flat that is not door-deliverable, the postman must select this option to reflect the actual situation. When responding to such enquiries according to system records, the staff manning the Post Office hotline can reply more accurately to recipients based on the relevant information. In addition, the Post Office has enhanced the mail tracking function on its website to enable the public to know that a certain address is not door-deliverable and thus the postman would not make door delivery.

Lands Department

Case No. 2024/0996 – (1) Failing to properly follow up a complaint about unlawful occupation of government land; and (2) Failing to give a timely reply to the complainant

Background

160. On 16 October 2023, the complainant lodged a complaint with the Lands Department (LandsD) via 1823 against a licensed hut for occupation of government land and illegal alteration works, but LandsD did not respond. On 9 March 2024, the complainant lodged the same complaint with 1823 again. By late April of the same year, the complainant received a reply from the relevant District Lands Office (DLO) under LandsD, which claimed that it would deploy staff to inspect the site. The complainant criticised LandsD for not handling the complaint properly as the complainant had not seen any action taken by it.

The Ombudsman's observations

161. The investigation of the Office of The Ombudsman (the Office) focused on two aspects: LandsD's specific follow-up actions against occupation of government land and whether their way of handling the complaint was appropriate.

162. The Office believed that the complainant might perceive DLO's inaction was due to the persistent occupation of land at the time. The Office's investigation revealed that the DLO had been following up on the case. Nevertheless, due to the complex land status involved in the vicinity of the hut, the DLO needed time to identify and clarify the boundaries, which were essential steps prior to enforcement, and took time to exercise land control. After reviewing the DLO's handling process, the Office found the time taken not brief, but no delay in the specific actions. The Office considered the DLO has followed up on the case properly.

163. Regarding the DLO's complaint handling, the Office found inadequacy in the DLO's mistaken assumption that its email sent on the morning of 2 January 2024 could serve as a reply to the complainant's afternoon email. Given the sequence of events, the DLO's explanation was also unreasonable. In retrospect, even if the content of its morning email could already address the complainant's afternoon email, the DLO should have issued a simple reply or acknowledgment to avoid misunderstanding.

164. Moreover, after reviewing the email records between January and April 2024, the Office noted that the complainant repeatedly and clearly requested the DLO to update him on the progress of complaint handling. However, the DLO only responded in late April 2024. While the Office recognised that departments might need flexibility in responding to complainants depending on specific circumstances (including the latest information referred by 1823), in this case, the DLO did not respond promptly despite the complainant's repeated and clear requests for updates. The Office found negligence on the part of the DLO in failing to reply based on the latest information provided by the complainant. Furthermore, the delay in reply that lasted for several months highlighted that the DLO must step up monitoring cases that require longer time to handle.

165. Based on the abovementioned, the Office considered this complaint partially substantiated and recommended LandsD to –

(a) remind relevant staff to handle public emails carefully to ensure a proper handling of and response to complaints or latest information from complainants;

(b) consider updating the procedures or guidelines for handling public complaints or enquiries: even if the content of an earlier email from the department could already address a subsequent email from the complainant, a simple reply or acknowledgment should still be provided to avoid misunderstandings;

(c) review with the staff members involved to ensure that they would promptly respond to latest information from complainants in the future;

(d) the DLO should consider stepping up monitoring cases that require longer time to handle with enhanced mechanism, such as escalating cases for stringent review of progress by senior management; and

(e) use the case as a reference for staff training, illustrating the lessons learned from this case to improve the DLO's standard of public service.

Government's response

166. LandsD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendations (a) and (b)

167. LandsD has incorporated the recommendations into the updated internal guidelines on handling public complaints;

Recommendation (c)

168. DLO had reviewed with the staff member involved, instructing him that he should promptly respond to the latest information from complainants in the future;

Recommendation (d)

169. DLO issued Internal Standing Instruction No. 2/2024 with enhanced measures to strengthen the monitoring mechanism for cases that require a lengthier handling process. Internal follow-up meetings were

held to review the implementation and effectiveness of the measures set out in the said Standing Instruction; and

Recommendation (e)

170. LandsD invited the Office to brief staff members on the handling of complaints by The Ombudsman in July 2025. LandsD had taken this opportunity to use this case as teaching material to remind staff members that they should strictly adhere to the internal procedures and guidelines when handling public enquiries or complaints, so as to provide appropriate public services.

Leisure and Cultural Services Department

Case No. 2024/0084 – Failing to resolve the obstruction of passageways caused by a bicycle rental operator with many bicycles persistently placed outside its business area

Background

171. the Office of The Ombudsman (the Office) received a complaint concerning an operator of bicycle rental services at the bicycle kiosks near Shing Mun River at Sha Tin Park (the Operator), which was under the management of the Leisure and Cultural Services Department (LCSD), for placing a large number of bicycles outside the designated business area for a protracted period, causing obstruction to the pathway. Since March 2022, the complainant had lodged several complaints to LCSD, but the situation continued to deteriorate. The complainant criticised that LCSD had not properly followed up on the issue and had failed to effectively monitor the Operator. As a result, the complainant could not have safe and unobstructed access to the nearby jogging path (the Passageway) and bicycle lane.

The Ombudsman's observations

172. The Office understood that as a department promoting cycling and recreational activities, LCSD had to consider the sustainability and stability of bicycle rental services as well as the difficulties faced by the Operator, including the constraints of the Permit Area which was narrow. However, these constraints were clearly known to the Operator at the time of bidding, and the contract terms clearly stated that occupying areas outside the Permit Area was not allowed. It was the Operator's responsibility to properly store unrented bicycles. While the Operator had occupied government land and violated the contract terms, it appeared that such irregularities bore no consequence.

173. After reviewing the relevant contract terms, the Office found that the contract explicitly forbids placing bicycles and articles relating to the bicycle rental business outside the Permit Area, and also clearly set out the consequences of violating these terms. The Department of Justice (DoJ) already advised LCSD of the above as early as June 2022. However, LCSD only issued verbal and written reminders to the Operator without any formal warnings, and did not seek further legal advice on contract enforcement until February 2024, indicating a delayed response to address the issue through proper contract management. The Office considered this undesirable. During this period, LCSD continued to issue multiple reminders to the Operator and the inter-departmental task force on handling illegal bicycling parking (Task Force) carried out two joint operations to clear illegally parked bicycles. There was, however, no significant improvement in the obstruction of the Passageway, inevitably gave the public the perception that LCSD had been negligent in its management and shirked responsibilities.

174. The Office understood that the area outside the Permit Area of the bicycle kiosks was not under LCSD's jurisdiction. However, the bicycles were obstructing a public pedestrian pathway on unleased land. LCSD's verbal and written reminders were ineffective and failed to bring lasting impact, which amounted to tacit approval of storing bicycles outside the Permit Area by the Operator. The Task Force has limited resources, and the joint operations it coordinated are intended to address illegal parking of bicycles across the entire Sha Tin District, including those abandoned by the general public. Since the Operator was subject to the terms in the permit contract, which already had clear provisions regarding bicycle storage, LCSD should have addressed the issue through contract management rather than reporting it to the Task Force as if it was an ordinary member of the public.

175. Overall, the Office considered that LCSD had been following up on the issue and exploring long-term solutions since August 2023, including taking a proactive step to relocate the bicycle kiosks. LCSD's responsibility to oversee the Operator was unshirkable. It had placed

undue reliance on the Task Force's clearance actions and failed to act decisively in accordance with the contract terms. The Office considered that LCSD should have acted earlier with more stringent and deterrent actions under the contract terms to prevent the worsening obstruction of the Passageway.

176. In view of the above, the Ombudsman considered this complaint partially substantiated and recommended that LCSD should step up its contract management efforts and take other appropriate measures to completely resolve the Operator's irregularities such as violations of contract terms, occupying unleased land outside the Permit Area and the obstruction of the Passageway etc.

Government's response

177. LCSD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

178. Further to LCSD's warning letter to the Operator on 29 April 2024, sternly pointing out that the violations could lead to serious consequences, including contract termination, the Department was also actively seeking DoJ's advice on how to address the challenges in adducing evidence having regard to the unique geographical location of the bicycle kiosks that fell outside LCSD's jurisdiction, rendering it difficult for LCSD to enforce the relevant contract terms.

179. LCSD kept close contact with the Task Force and participated in joint enforcement operations against violations on 19 June and 12 September 2024. Since August 2024, LCSD had conducted monthly reviews of the relevant permit and reiterated to the Operator that any recurrence of violations would result in immediate termination of the permit. Until the relevant contract expired on 31 March 2025, the Operator did not commit any further significant violations related to bicycle parking.

180. LCSD has been in close communication with the works departments to relocate the bicycle kiosks, and the works project is currently in the construction phase. The new bicycle kiosks will be relocated within the Park under LCSD, where sufficient space has been allocated to accommodate the business area of the permit for future operators to display bicycles or offer trial rides to members of the public.

Leisure and Cultural Services Department

Case No. 2024/1834 – Confusing tender procedures for the permit to conduct light refreshment business in a park

Background

181. On 25 June 2024, the complainants lodged two complainants against Leisure and Cultural Services Department (LCSD) to the Office of The Ombudsman (the Office).

182. According to the complainants, they were the service providers which respectively held a permit (Permit A) to operate light refreshment business at a kiosk in a park (Park A) and a permit (Permit B) to operate general restaurant business at a swimming pool (Pool B), both of which were under the management of LCSD. Regarding the complaint on Permit B, please see Case No. 2024/2261.

183. As regards Permit A, the complainants alleged that LCSD's tender procedures for Permit A was confusing. In particular, LCSD staff called one of the complainants before the close of tender and suggested that they should raise the monthly permit fee offered in their tender (Allegation (a)). In addition, shortly after the complainant had restored the business premises to original status for LCSD's repossession after the telephone notification from a LCSD staff that the complainant's tender was unsuccessful, LCSD then issued a letter of acceptance regarding their tender offer of February 2024 (Allegation (b)).

The Ombudsman's observations

184. LCSD provided details about the two tender exercises for Permit A. In handling the second tender exercise, LCSD took into account of the fact that the tender price was below the valuation, the tender for Permit A had already failed once, and the advice from the Rating and Valuation Department (RVD). Hence, it decided to attempt negotiation with the

complainants in accordance with the Terms of Quotation, and enquired if they would be willing to raise the monthly fee for Permit A for re-assessment. The Office considered this approach not inappropriate. Despite the complainants' verbal refusal to accept the new contract on several occasions, LCSD still issued the Notice to the complainants as no written notification had been received from the complainants regarding cancellation of the price proposal or withdrawal of the tender. As such, LCSD continued to issue the Notice to the complainants based on the Terms of Quotation and procedures, and requested their formal refusal to accept the offer in writing. The Office was of the view that the practices were in line with the relevant procedures.

185. However, between March and mid-May 2024, while LCSD was in ongoing liaison with RVD regarding the monthly fee for Permit A, a staff member from LCSD (staff X) contacted one of the complainants on 19 April 2024, informing that their tender was unsuccessful and requesting a clear-out of the business premises. Regardless of whether the words "tender failed" were used at that time, staff X confirmed that the complainant was told that their tender was unsuccessful. From the complainants' perspective, this signified the end of the tender process. Furthermore, in the morning of 17 May, staff X and staff of the Architectural Services Department inspected the light refreshment kiosk at Park A jointly with one of the complainants, specifically requesting him/her to follow up on the demolition arrangements for the premises. As commonly understood, this confirmed that the business operations would certainly discontinue after the expiry of Permit A's contract. Nevertheless, in the afternoon of same day, staff X enquired if the complainant would consider accepting LCSD's new contract, which would inevitably be perceived by the complainants that LCSD's handling of tender for Permit A was confusing, and LCSD's actions and decisions were also self-contradictory.

186. After reviewing the relevant information and records, the Office considered that the crux of the matter was inadequate communication between staff X and the colleagues within the department responsible for

liaising with RVD, resulting in the failure to keep abreast of LCSD's latest position in handling the tender. Shortly after staff X, on behalf of LCSD, notified the complainants that their tender was unsuccessful and instructed them to restore the business premises to original status, staff X then indicated acceptance of their tender offer, leaving the complainants at a loss. The Office found the handling process not satisfactory. On the other hand, misunderstanding was caused by inadequate explanation given by LCSD in negotiating with the complainants on the monthly fee for Permit A and the execution of new contract. As admitted by LCSD, the misunderstanding could have been avoided if staff X had kept proper written records and confirmation on the tender monthly price of Permit A during the negotiation with the complainants, and had explained to them the rationale of citing the relevant terms in the process. Moreover, although LCSD stated that it had formulated departmental guidelines on tender procedures based on the Government's Stores and Procurement Regulations (SPR), and had reminded its staff to follow the procedures stipulated in the SPR in handling work relating to "Negotiation", it appeared that staff X, in the present case, did not have a clear grasp of the relevant requirements and procedures in the SPR.

187. In light of the above, The Ombudsman considered the complaint partially substantiated and recommended LCSD to –

(a) learn from this case and strengthen training for relevant staff;

(b) enhance internal communication among staff to ensure that all staff responsible for the same tender project (including those who communicate with tenderers) are kept abreast of the latest progress of the tender;

(c) consider introducing measures to remind staff of the proper procedures and points to note (including issuing written confirmation) when conducting tender negotiation in future;

(d) consider introducing measures to make tenderers aware of the "Negotiation" clause in the tender documents and LCSD's execution arrangement; and

(e) share this case with relevant staff (especially those responsible for handling permits and tender exercises) to avoid recurrence of similar situation.

Government's response

188. LCSD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendations (a) and (b)

189. The concerned office of LCSD held a briefing on 25 February 2025 to share this case with all staff members responsible for handling tender exercises. Staff were reminded to comply with the procedures and guidelines for inviting tenders, including tender procedures for government procurement as well as the points to note and protocols to follow during negotiations, to prevent recurrence of similar incidents. In addition, LCSD has enhanced the content of the Contract Management Training Course to improve staff's understanding of procurement procedures, ensuring that procurement matters are handled in strict accordance with the relevant procedures.

Recommendations (c) and (e)

190. LCSD shared this case and The Ombudsman's recommendations with districts offices/sections responsible for handling tendering matters related to revenue contracts via email on 7 March 2025. They were further reminded to follow the departmental guidelines in future tender-related negotiations, including obtaining prior approval and keeping proper written records of all discussions. Meanwhile, LCSD has also updated the requirements for tender negotiation in its procurement guidelines,

incorporating the aforementioned requirements on seeking prior approval and keeping written records.

Recommendation (d)

191. LCSD reminded all relevant staff via email on 7 March 2025 to explain to tenderers the "Negotiation" clause in the tender documents during future quotation/tender briefings and its execution arrangement.

Leisure and Cultural Services Department

Case No. 2024/2261 – Delay in commencing open tender procedures for the permit to conduct general restaurant business at a swimming pool, and failure to properly arrange the maintenance works of the food business premises

Background

192. On 25 June 2024, the complainants lodged two complaints against Leisure and Cultural Services Department (LCSD) to the Office of The Ombudsman (the Office).

193. According to the complainants, they were the service providers which respectively held a permit (Permit A) to operate light refreshment business at a kiosk in a park (Park A) and a permit (Permit B) to operate general restaurant business at a swimming pool (Pool B), both of which were under the management of LCSD. Regarding the complaint on Permit A, please see Case No. 2024/1834.

194. The complainants alleged that LCSD had not followed the established procedures of inviting tenders four to six months before the expiry of Permit B (i.e. 31 July 2024) (Allegation (a)) and had not properly arranged and planned for the maintenance works involving the business premises, causing a delay in the commencement of the open tender procedures for Permit B (Allegation (b)).

The Ombudsman's observations

195. LCSD explained its handling regarding the tender for the new contract of Permit B and why tenders were not invited four to six months before the expiry of existing contract. The Office understood that the complainants, as the incumbent holder of Permit B, wished that LCSD would promptly initiate the tender for the new contract so that the complainants could ascertain at an early stage whether they could continue

to operate the restaurant business at Pool B. However, as explained by LCSD, the new contract could not start immediately upon the expiry of existing contract due to the large-scale maintenance works required for the restaurant premises. LCSD further pointed out that inviting tenders too early might affect the bidding decisions of potential tenderers as market situation changed rapidly. The Office considered these explanations reasonable.

196. In fact, LCSD initiated the tender in July 2024 once confirming that the new contract of Permit B could start in February 2025. This complied with the time frame stipulated by departmental guidelines. Meanwhile, LCSD also reached out to the complainants and provided assistance. The Office considered that LCSD had handled the tender exercise for Permit B according to actual circumstances with no delay.

197. Regarding the maintenance works and installation of solar energy system in the restaurant premises at Pool B, LCSD provided details on its necessity and planning details. LCSD commenced discussions with the works department about the maintenance works and installation of solar energy system as early as April and November 2023. While LCSD stated that the complainants were verbally notified of the above matters between December 2023 and May 2024, the Office considered it advisable for LCSD to promptly and formally notify the complainants in writing once the details of maintenance works were finalised, which would enable the complainants to fully grasp and understand LCSD's decision and make corresponding planning for their business.

198. Moreover, to enhance transparency for potential tenderers and incumbent permit holders regarding LCSD's tender procedures and time frame for granting new permit contracts, the Office recommended that LCSD to consider providing them with information about tender schedule to avoid misunderstanding or false expectations.

199. In light of the above, The Ombudsman considered this complaint unsubstantiated, but there was room for improvement on disseminating

information to the complainants about the maintenance works of its restaurant premises and tender schedule.

200. The Ombudsman recommended LCSD to –

(a) learn from this case and share it with relevant staff (especially those responsible for tender exercises) to improve the department's handling of similar cases in the future;

(b) strengthen training for relevant staff;

(c) consider promptly and clearly notifying the incumbent permit holders of the arrangements if large-scale maintenance works resulting in suspension of business operation of its restaurant premises are required; and

(d) consider introducing measures to notify tenderers of the latest information on tender schedule to avoid misunderstanding.

Government's response

201. LCSD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendations (a) and (b)

202. The concerned office of LCSD held a briefing on 25 February 2025 to share this case with all staff members responsible for handling tender exercises. Staff were reminded to comply with the procedures and guidelines for inviting tenders, including tender procedures for government procurement, as well as the points to note and protocols to follow during negotiations, to prevent recurrence of similar incidents. In addition, LCSD has enhanced the content of the Contract Management Training Course to improve staff's understanding of procurement

procedures, ensuring that procurement matters are handled in strict accordance with the relevant procedures.

Recommendations (c) and (d)

203. LCSD has reminded all venue staff to evaluate the potential impact on contracted services when handling maintenance projects for its facilities. For large-scale maintenance works at their premises, venue staff should promptly notify relevant stakeholders, including incumbent food business operators, so that they could make necessary arrangements for their businesses in advance.

204. In addition, LCSD has reminded staff to alert tenderers the tendering timelines as stipulated in the tender documents, such as the tender closing date, tender validity period, and date of commencement of the contract during quotation/tender briefings.

205. LCSD has also updated the "Forecast of Major Purchases" section on its website, advising tenderers to regularly visit its website or contact the relevant district offices/sections for the latest tender updates. To avoid unnecessary misunderstanding, tenderers are reminded that there is no commitment on the part of the LCSD to initiate tendering procedures prior to the expiry of existing contracts.

Registration and Electoral Office

Case No. 2023/3685(I) – (1) Refusing to provide the breakdown figures of voter registration rates and number of voter deregistration; and (2) Inconsistent reply on reason for refusal

Background

206. The complainant lodged a complaint with the Office of The Ombudsman (the Office) against the Registration and Electoral Office (REO) on 4 and 11 December 2023.

207. The complainant requested the following information from REO vide email on 27 July 2023 –

(a) the overall voter registration (VR) rates and breakdown by age groups in respect of geographical constituencies since 2015 (Information (a)); and

(b) the figures of self-request deregistration (SRD) breakdown by age groups in respect of geographical constituencies since 2015 (Information (b)).

208. REO replied to the complainant on 4 August 2023, providing the overall estimated VR rates and total number of SRD for the years from 2018 to 2022, and expressing that REO did not have further breakdown on statistics and estimation by age groups.

209. The complainant wrote to REO on 6 August 2023, indicating that REO had provided the breakdown of VR rates by age groups in respect of geographical constituencies for some years when replying to a question raised by Legislative Council Members in the Special Finance Committee Meetings (Finance Committee). The complainant made a request for the above information again under the Code on Access to Information (the Code).

210. REO replied to the complainant on 25 September 2023 with the following information –

(a) a hyperlink to REO's written reply to the Finance Committee in examining the Estimates of Expenditure 2021-22 (LegCo Paper), which contained the overall estimated VR rates and the breakdown by age groups in respect of geographical constituencies for 2015, 2016 and 2019;

(b) the overall estimated VR rates for the remaining years (i.e. 2017, 2018, and from 2020 to 2023) that were not covered in the above-mentioned LegCo Paper;

(c) explaining to the complainant that the VR rate was an estimated figure mainly for internal reference. It was not an accurate statistical information;

(d) further explaining that REO was unable to provide the breakdown by age groups for 2017, 2018, and from 2020 to 2023, and indicating that REO was reviewing the estimation method for VR rate. The estimation method and the estimated VR rates might be revised after completion of the review, and thus REO was unable to provide the breakdown concerned at that moment; and

(e) the overall figures of SRD in respect of geographical constituencies for the years from 2015 to 2023, and explaining that REO did not maintain the breakdown figures by age groups. The figures concerned thus could not be provided to the complainant.

211. The complainant requested REO vide email to provide the breakdown figures for VR rates again on 26 September 2023. REO replied to the complainant on 25 October 2023, reiterating its stance and further explaining that REO was assessing the impact of the increasing population mobility in recent years on the estimation of VR rates. REO was exploring

how to improve the estimation method so as to make a more accurate estimation. Since the review was in progress, REO considered it inappropriate to provide the relevant breakdown at that moment of time.

212. In view of the foregoing, the complainant complained against REO for –

(a) the reasons of not providing the information are inconsistent. The complainant was discontent that REO in the first place refused to provide information on grounds that it did not have further breakdown on the statistics and the estimation by age groups, while subsequently it advised that the refusal to provide information was due to the fact that the estimation method of VR rate was under review (Allegation (a)); and

(b) the reason of not providing the information was due to the fact that the estimation method of VR rate was being reviewed was unjustifiable as the review and provision of information were not contradictory (Allegation (b)).

The Ombudsman's observations

Information (a) and Allegation (b)

213. REO had explained to the complainant about the reason for not providing the VR rate breakdown by age groups for some of the years. Considering that REO was still reviewing the estimation method of VR rates, and the methodology and the estimated VR rates might be revised after completion of the review, the Office accepted REO not to provide the information pursuant to paragraph 2.13(a) (information relating to incomplete analysis, research or statistics, where disclosure could be misleading) of the Code.

Information (b)

214. REO reiterated that it did not compile the breakdown figures by age groups for SRD cases in the past. In response to the investigation by the Office, REO explained that there was no record in the database of the departmental system that whether or not an application for SRD was eventually accepted. It therefore could not compile the statistics on the SRD cases received through retrieving the records in the database of the departmental system.

215. The Office considered that REO's refusal to provide the complainant with the breakdown by age groups was in line with paragraph 1.14 (i.e. the Code does not oblige departments to create a record which does not exist) of the Code, and paragraph 1.14.2 of the Guidelines on Interpretation and Application (the Guidelines) was not applicable.

Allegation (a)

216. As for the complainant's allegation of inconsistent reply on the reasons of refusal, REO had explained the factors of consideration for the two replies to the complainant. That said, after reviewing the case, REO recognised that there was room for improvement in its first reply to the complainant and would pay attention to such matters in the future.

217. In hindsight, the Office considered that misunderstanding could be avoided should REO provide more details in its first reply. The Office was delighted to note that REO could learn from the experience when reviewing this case. The Office took this opportunity to remind REO to be more mindful on the words used in future correspondence with members of the public so as to explain in more detail to avoid misunderstanding.

Other Observations

218. The Office noted that, REO, when partially refusing to provide information to the complainant, did not comply with the requirement under

paragraph 2.1.2 of the Guideline to cite the relevant paragraph in Part 2 of the Code as refusal reasons. In response to the Office's investigation, REO had explained with elaboration that paragraph 2.13(a) of the Code was invoked for the partial refusal. The Office urged REO to remind relevant staff to comply with the requirements of the Code and the Guidelines in handling requests for information from members of the public.

219. Besides, the Office noted that, in response to the complainant's request for information since 2015, REO in its first reply only provided the information from 2018 to 2022 (with information from 2015 to 2017 omitted) without explanation. Upon the complainant's further query, REO supplemented the information in its second reply. The Office considered it more appropriate for REO to provide all the information as per the complainant's request in its first reply.

220. The Ombudsman considered that it was not unreasonable for REO to partially refuse the provision of information to the complainant, but there were inadequacies in REO's replies. Therefore, the complaint was unsubstantiated but other inadequacies were found.

221. The Ombudsman recommended REO to –

(a) strengthen staff training, ensuring that when processing the requests for information from members of the public, the staff would provide clear replies and strictly comply with the requirements of the Code and Guidelines, including quoting relevant provision under Part 2 of the Code with specific elaboration if the request for information would be refused; and

(b) process the complainant's request for breakdown of statistical figures again pursuant to the Code after completion of the review on estimation of VR rate.

Government's response

222. REO accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendation (a)

223. REO has strengthened staff training, ensuring that when processing the requests for information from members of the public, the staff would provide clear replies and strictly comply with the requirements of the Code and Guidelines.

Recommendation (b)

224. The review on voter registration rate is still in progress. Upon completion of the review, REO will process the complainant's request for breakdown of statistical figures pursuant to the Code again.

Registration and Electoral Office

Case No. 2024/0692A(I) – (1) Refusing to provide the breakdown figures of persons eligible for voter registration; and (2) Delay in replying to the review request and failure to explain the reason for a deferred response

Background

225. The complainant lodged a complaint with the Office of The Ombudsman (the Office) against the Registration and Electoral Office (REO) on 7 March 2024.

226. According to the information provided by the complainant, the complainant requested the following information vide two emails to the Constitutional and Mainland Affairs Bureau (CMAB) under media enquiry and the Code on Access to Information (the Code) respectively on 27 November 2023 –

(a) The estimated figures of potential electorate from 2020 to 2023 (Information (a)); and

(b) The breakdown by age groups of the estimated figures of potential electorate from 2020 to 2023 (Information (b)).

227. The CMAB subsequently referred the complainant's media enquiry to REO for follow-up. REO replied to the complainant on 30 November 2023 with the following information –

(a) the estimated voter registration (VR) rates from 2020 to 2023;

(b) explaining that the VR rate was an estimated figure mainly for internal reference. It was not an accurate statistical information. REO, when estimating the figures, had made reference to other similar estimation-based information, such as the estimated

population figures of 18 years of age or above published by the Census and Statistics Department; and

(c) REO was assessing the impact of the increasing population mobility in recent years on the estimation of VR rates. In addition to the fact that the current estimation method has been adopted for more than 25 years, there were substantial changes in circumstances. REO thus considered it is necessary to conduct a full review and improve the estimation method of the VR rate so as to make a more accurate estimation. Since the review was in progress, REO considered it was inappropriate to provide the further breakdown of the estimated VR rates, including age groups.

228. The complainant requested REO to review its decision on 5 January 2024. The complainant indicated that, through search of information, the CMAB had provided the estimated figures of potential electorate in the past, such as provision of the breakdown of potential electorate by age groups to the Finance Committee of the Legislative Council when examining the Estimates of Expenditure 2021-22. Besides, the complainant opined that as REO had already provided the overall estimated VR rate, theoretically it should have the breakdown of potential electorate by age groups. As such, the complainant requested REO to explain the reason for not providing the information which had already been made to the public, and to explain whether such information was the "Information which may be refused" under the Code and why the information was not categorised as "Information which may be refused" in the past.

229. REO provided interim replies to the complainant on 12 and 25 January 2024. The complainant wrote to REO vide email on 6 February 2024, enquiring the progress of the review, and requesting for a substantive reply as soon as possible and an explanation for a deferred response. After the review, REO replied to the complainant on

16 February, reiterating the stance and upholding its original decision on refusal of releasing the relevant information.

230. In view of the foregoing, the complainant complained against REO for –

(a) refusal of provision of information which was maintained by REO and had been made public (Allegation (a));

(b) refusal to provide information on the ground that the estimation method of VR rate was under review was unjustifiable. Besides, REO did not explain why the breakdown could not be provided when the overall VR rate could be published (Allegation (b)); and

(c) not replying to the review request according to the deadline as stipulated under the Code and failure to explain the reason for a deferred response (Allegation (c)).

The Ombudsman's observations

Information (a), (b) and Allegations (a), (b)

231. REO had explained to the complainant about the reason for not providing the Information (a) and (b). Considering that REO was still reviewing the estimation method of VR rate, and the methodology and the VR rates might be revised after completion of the review, the Office accepted REO not to provide the information pursuant to paragraph 2.13(a) (information relating to incomplete analysis, research or statistics, where disclosure could be misleading) of the Code. On replying to the complainant, the Office considered it would be more appropriate if REO could further explain to the complainant the reason for not providing the breakdown while it provided the overall estimated VR rate.

Allegation (c)

232. Based on the information provided by the complainant, REO, upon receipt of the request for review on 5 January 2024, issued interim replies on the 7th day (12 January) and the 20th day (25 January) as well as the substantive reply on the 42nd day (16 February). The Code and the Guidelines on Interpretation and Application (the Guidelines) allow that responses may be deferred beyond 21 days in exceptional circumstances.

233. Given REO gave no response to Allegation (c), the Ombudsman considered that there was no evidence suggesting that there was an existence of exceptional circumstance warranting a deferred response beyond 21 days.

234. On the other hand, the Ombudsman noted that REO did not comply with the requirement under paragraph 1.18 of the Code to explain to the complainant the reason for a deferred response to the review request, not even when the complainant requested so in his reminder dated 6 February 2024. The Office thus reminded REO to adhere to the response timeline as stipulated in the Code and explain to the applicant if there were exceptional circumstances warranting a deferred response while handling review requests from the members of the public in the future.

Other Observations

235. The Office noted that, REO, when partially refusing to provide information to the complainant, did not comply with the requirement under paragraph 2.1.2 of the Guidelines to cite the relevant paragraph in Part 2 of the Code as refusal reasons. REO did not respond even though the complainant had demanded for an explanation on whether the requested information was the "Information which may be refused" under the Code in his application for review. Nevertheless, upon the Office's investigation, REO explained with elaboration that paragraph 2.13(a) of the Code was invoked for the partial refusal which could be considered as a remedial action. The Office urged REO to remind relevant staff to

comply with the requirements of the Code and the Guidelines in handling requests for information from members of the public.

Conclusion

236. The Ombudsman considered that it was not unreasonable for REO to partially refuse the provision of information to the complainant. However, there was no evidence to suggest that there was an existence of exceptional circumstance warranting a deferred response when reviewing the request. REO also did not explain to the complainant the reason for the deferred response according to the requirement under the Code. Hence, the complaint was unsubstantiated but other inadequacies were found.

237. The Ombudsman recommended REO to –

(a) strengthen the staff training, ensuring that the requests for information and requests for review under the Code would be handled in strict compliance with the requirements of the Code and the Guidelines, including explaining in detail the reason for a deferred response to the applicant. Also, relevant provision under Part 2 of the Code should be cited with specific elaboration if the request for information would be refused; and

(b) process the complainant's request for the relevant figures again pursuant to the Code after completion of the review on estimation of VR rate.

Government's response

238. REO accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendation (a)

239. REO has strengthened staff training, ensuring that when processing the requests for information from members of the public, the staff would provide clear replies and strictly comply with the requirements of the Code and Guidelines.

Recommendation (b)

240. The review on voter registration rate is still in progress. Upon completion of the review, REO will process the complainant's request for breakdown of statistical figures pursuant to the Code again.

Social Welfare Department

Case No. 2023/2641 – (1) Failing to properly monitor a residential care home for the elderly; and (2) Failing to probe the anomalies in the explanation given by the care home's staff

Background

241. The complainant claimed that on the night of 15 January 2022, his mother fell and was injured at a residential care home for the elderly (RCHE) operated by a subvented non-governmental organisation (NGO). She had to be sent to the hospital for head stitch surgery (the fall incident). The complainant suspected that the RCHE had not activated his mother's bed exit alarm (the alarm), which led to her fall and subsequent injury. He thus lodged a complaint with the RCHE and the NGO respectively. Representatives of the RCHE met with the complainant on 7 April of the same year, and stated that, at the time of the fall incident, the care worker heard the alarm, immediately went to check on the complainant's mother in her room, and saw her getting out of bed. She then fell to the ground near the foot of the bed, but the care worker could not catch her in time. The complainant did not accept the RCHE's explanation for the fall incident and lodged a complaint with the Social Welfare Department (SWD) on the same day. With the consent of the complainant, the Licensing Office of Residential Care Homes for the Elderly (LORCHE) of SWD referred the case to the Lump Sum Grant Independent Complaints Handling Committee (ICHC) for follow-up. LORCHE also conducted an investigation into the matters of complaint within its licensing and regulatory purview.

242. In May 2022, an LORCHE staff member informed the complainant by phone that LORCHE had not found any non-compliance at the RCHE during its inspection. However, between July and September, the superintendent and deputy superintendent of the RCHE told the complainant that they would hold themselves accountable for the fall incident and apologise (Matter 1). In addition, a staff member of the

RCHE (Staff A) told the complainant that the alarm's power plug was not connected to the power socket at the time of the incident (Matter 2). The complainant relayed Matter 1 and Matter 2 to SWD, which stated that it would contact the RCHE and request a response to the complainant.

243. On 28 September 2022, the ICHC replied to the complainant, stating that, after reviewing the relevant information, no objective evidence was found to indicate that the NGO/RCHE had failed to meet the requirements of the Funding and Service Agreements, or the requirements of Service Quality Standards, or the relevant guidelines. As a result, the ICHC decided not to pursue further action regarding the complaint.

244. The complainant believed that SWD had not properly followed up on his complaint, so he lodged a complaint with the Office of The Ombudsman (the Office).

245. In response to the Office's inquiry, SWD replied to the complainant on 3 October 2023. On the 25th of the same month, the complainant expressed his views and provided information regarding SWD's reply. The complainant's dissatisfaction with SWD is summarised as follows –

(a) failure to properly monitor the RCHE, including the lack of follow-up on Matter 1 and Matter 2 (Allegation (a));

(b) failure to follow up on the following queries raised by the complainant –

i. The medical report provided by the Hospital Authority regarding his mother's admission showed that she had sustained injuries on one side of her body and an eye injury on the other, which was inconsistent with the fall position witnessed by the RCHE staff (Allegation (b)); and

ii. during an interview with the complainant on 7 April 2022, the RCHE presented written statements from four of its staff members regarding the fall incident. These statements contained inconsistencies and unreasonable elements (Allegation (c)); and

(c) failure to provide a written reply to the complainant (Allegation (d)).

The Ombudsman's observations

Allegation (a)

246. As evidenced by the records and information provided by SWD, LORCHE handled the complainant's complaint in accordance with the existing mechanism. This included conducting surprise inspections of the RCHE, reviewing the personal health and care records of the complainant's mother, examining relevant incident reports, interviewing the staff and residents of the RCHE, and observing the services provided by the RCHE staff to its residents on-site. SWD also issued an advisory letter recommending improvements based on the deficiencies identified by LORCHE during its investigation of the RCHE.

247. However, with respect to Matter 1, it involved not only the governance of the RCHE and the NGO, as well as the integrity of the staff, as pointed out by SWD, but also whether the RCHE had failed to properly use the alarm system and promptly respond to the call bell, which might have directly or indirectly contributed to the fall of the complainant's mother. SWD also conducted an investigation into these matters. In this regard, the Office believed that SWD initially treated Matter 1 merely as an issue of the NGO's day-to-day governance and thus simply relayed the complainant's demands to both the RCHE and the NGO. It did not question the RCHE staff about the claims made by the complainant, including inquiring with the superintendent and deputy superintendent as to whether they had indicated any intention to apologise to the complainant

and the reasons for such an apology. This approach was deemed inadequate.

248. SWD had explained why LORCHE initially did not follow up on Matter 2. Regarding the complainant's assertion that he had informed SWD that, according to Staff A, the alarm was not connected to its power source at the time of the fall incident, the Office, in the absence of independent corroboration, was unable to ascertain the content of the complainant's phone conversation with the staff of SWD. As such, the Office refrained from commenting on this matter. However, the Office conveyed the complainant's concerns to SWD in a letter dated 27 October 2023. SWD did not contact the complainant to gather the facts for follow-up until December of the same year (i.e., after the commencement of a full investigation by the Office). The Office considered this a delay in follow-up. As to SWD's response to the complainant on 1 March 2024 regarding its investigative findings, which included an analysis of the collected data to determine whether the RCHE had violated any regulations and whether to accept the RCHE's explanation, the Office found no grounds to dispute the conclusions made by SWD based on the data obtained during its investigation, the relevant legislation, and the Code of Practice for Residential Care Homes (Elderly Persons).

249. The Ombudsman considered Allegation (a) partially substantiated.

Allegation (b)

250. The complainant had provided SWD with his mother's medical report through the Office, stating that the report was intended to question the account of the fall incident provided by the RCHE staff regarding his mother's fall, rather than to suggest suspicion about the cause of her injuries. The Office noted that long-term residents of RCHEs must rely on others for their care. As such, SWD should adopt a more proactive and cautious approach when handling complaints against RCHEs involving allegations of improper care and/or the improper use of safety facilities.

While the Office did not assert that the medical report alone could settle the matter, its contents could assist in understanding the incident and/or in corroborating the accounts provided by the RCHE and the staff concerned, thereby enabling SWD to determine whether further investigation was warranted. Therefore, SWD's drawing of the conclusion that it was inappropriate to use the medical report to make inferences or question the RCHE, without first reviewing the report, demonstrated a lack of rigour in its handling process.

251. The Office noted that, according to SWD's investigation report on the fall incident, Staff B claimed to have witnessed the complainant's mother getting out of bed and falling. However, Staff B was not among those questioned by SWD. In response to the Office's inquiry as to why Staff B was not questioned, SWD indicated that inspectors of LORCHE decided whom to interview on a case-by-case basis, and the inspector responsible for this case had taken statements from relevant staff (but the care worker who witnessed the complainant's mother fall to the ground (Staff B) was not among them). The Office believed that since Staff B claimed to be an eyewitness to the fall incident, his/her statement was particularly crucial for SWD to understand the sequence of events. Therefore, the Office did not agree with SWD's omission of interviewing Staff B during its investigation.

252. The Office considered SWD's failure to review the complainant's mother's medical report, and its initial omission to question Staff B about the incident, to be imprudent, as it raised doubts about whether SWD had fulfilled its duty to diligently handle the complaint.

253. The Ombudsman considered Allegation (b) substantiated.

254. In its response to the draft investigation report, SWD clarified that LORCHE had, in fact, reviewed the complainant's mother's medical report and had decided not to further question the RCHE staff after reviewing the report. Therefore, the comments in the preceding paragraphs suggesting that SWD did not review the relevant report, and the Office's

recommendation that SWD should first review the report before deciding whether further inquiries with the RCHE were necessary, were not applicable.

255. The Office was pleased to learn that, following the Office's investigation, LORCHE considered Staff B's account of the incident and replied to the complainant accordingly. The Office found no grounds to object to LORCHE's conclusions as drawn from its analysis/follow-up work on Staff B's statement.

256. Based on the above analysis, The Ombudsman amended the finding for Allegation (b) to be partially substantiated.

Allegation (c)

257. SWD indicated that it only became aware of the complainant's doubts about the written statements of the RCHE staff in October 2023. The complainant stated that he had raised this issue with SWD before filing his complaint with the Office but had forgotten the date or the specific staff member to whom he had spoken. As there was no objective information to verify whether the complainant did, in fact, relay his concerns to LORCHE, the Office refrained from commenting on this matter.

258. In response to the information provided by the Office and the complainant's amended complaint details, LORCHE made further inquiries with the RCHE regarding the meeting with the complainant and the presentation of the written statements, and reviewed the staff statements kept by the RCHE. The Office considered that LORCHE had followed up on the matter appropriately and had responded to the complainant's views in its reply letter dated 1 March 2023. As for the results/analysis from LORCHE's follow-up on these statements, the Office found no grounds to call them into question. If the complainant had further questions or information to provide, he was advised to contact LORCHE directly.

259. The Ombudsman considered Allegation (c) unsubstantiated.

Allegation (d)

260. The complainant confirmed to the Office that he had lodged his complaint with SWD verbally. He did not subsequently request a written reply from SWD, nor had SWD indicated that it would provide one. As a result, the Office considered that it was not unreasonable for SWD to reply to the complainant verbally.

261. The Ombudsman considered Allegation (d) unsubstantiated.

262. Overall, The Ombudsman considered this complaint partially substantiated. The Office recommended that SWD remind its staff that when handling complaints involving RCHEs, they should first thoroughly review the information provided by the complainants before determining which matters require follow-up under SWD's existing monitoring mechanism, and how to follow up on those matters.

Government's response

263. SWD accepted the Office's recommendation and has taken the following follow-up actions.

264. SWD's LORCHE has used various channels, such as emails, staff meetings and training programmes, to remind its inspectors to handle complaints with rigour. SWD held a "Workshop on Handling Complaints against Residential Care Homes" and a "Sharing Session on Inspections and Complaint Handling for Inspectors" in July and November 2024 respectively. During the orientation briefing for inspectors newly posted to LORCHE, they were also reminded to first thoroughly review the information provided by complainants when handling complaints, in order to determine the matters requiring follow-up and the specific approaches to adopt under the existing monitoring mechanism.

265. In addition, SWD organised a "Sharing Session on the Investigation and Handling of Complaint Cases from the Office of the Ombudsman" on 20 January 2025 to enhance the complaint-handling skills of its staff (including LORCHE inspectors). LORCHE will continue to remind its inspectors of the relevant matters concerning the handling of complaints through various channels.

Social Welfare Department

Case No. 2024/2139 – Erroneous information about the services and fees of a residential care home for the elderly on the webpage of the Residential Care Services Scheme in Guangdong

Background

266. The complainant's father was admitted to a residential care home for the elderly (RCHE) in the Mainland (RCHE A) under the Social Welfare Department's (SWD) GDRCS Scheme. According to the SWD's website, participating RCHEs will provide escort services for medical follow-ups and arrange persons staying with residents during their hospital stays at no additional charge to residents. However, the complainant discovered that RCHE A not only failed to arrange persons staying with residents during their hospital stays but also charged for medical escort services exceeding three hours. In addition, the complainant alleged that RCHE A charged his/her father for a prescription drug. These practices contradict the information provided on the SWD's website and the promotional materials of RCHE A. As a result, the complainant believes that the SWD's website and RCHE A's promotional materials may be misleading.

The Ombudsman's observations

267. the Office of The Ombudsman (the Office) acknowledged the achievements of SWD in implementing GDRCS Scheme, which provides elderly persons waitlisted for subsidised residential care services places in Hong Kong with the additional option of considering admission to RCHEs in nearby Mainland cities under the Scheme. The Office recognised that elderly persons typically require long-term and frequent follow-up medical consultations. Therefore, the availability of escort services for medical follow-ups in Hong Kong and persons staying with them during hospitalisation in the Mainland was likely to be one of the key considerations for them and their families when deciding whether to join.

268. In July 2024, upon receiving the complaint, the Office reviewed the May 2024 version of the SWD's website regarding GDRCS Scheme. The website contained general information about the services provided under GDRCS Scheme, including "providing transport and escort for the residents to attend medical follow-ups and receive treatment at designated hospitals and clinics, including arranging for persons to stay with the residents during his/her hospitalisation… The service fees paid by the Government to the recognised service providers include... the aforementioned… services." The Office considered that this description indeed might have given the impression that all RCHEs were providing such services, thus directly leading to this complaint. Furthermore, the above description was inconsistent with the service details outlined in the introduction and scope of services for individual RCHEs, which could easily cause confusion. The Office was pleased to note that, following its intervention and investigation, the SWD has taken proactive steps to make improvements, and RCHE A has revised the relevant sections of its service agreement to provide clearer service information.

269. Regarding the issue of RCHE A charging the complainant's father for a prescription drug, the SWD clarified that the drug in question was not included in the designated prescription drug list. The Office found no deficiencies on the SWD's part in this matter. However, the current SWD website did not provide a prescription drug list or fixed drug costs for RCHEs joining GDRCS Scheme prior to 2024. While the information concerned had been posted inside the RCHE, the Office considered this arrangement inconvenient for families of residents living in Hong Kong. Requesting a copy of the information from RCHEs was also time-consuming and inefficient for these families. The Office recommended that a better approach would be for the SWD to consider including the relevant information of each participating RCHE on its website to enhance transparency. This would not only help prevent similar complaints in the future but also make it more convenient for elderly persons and their families to choose the suitable RCHE.

270. Overall, The Ombudsman considered this complaint partially substantiated. The Office recommended SWD to –

(a) promptly rectify or supplement incomplete information (the SWD has implemented this measure during the full investigation of the Office);

(b) expedite the review of other existing information on the website to ensure its clarity and accuracy;

(c) establish a mechanism for reviewing website content to ensure the accuracy of the information provided;

(d) require the responsible department to review related information on the website for any inconsistencies when launching new services or terminating existing ones;

(e) provide a prescription drug list or fixed drug costs for RCHEs joining GDRCS Scheme prior to 2024 in the service brief of respective RCHEs to enhance transparency;

(f) learn from the experience of this case, and, upon receiving a complaint or feedback that is substantiated or necessitates further clarifications, promptly issue a correction or provide supplementary information to prevent further complaints; and

(g) cite this case as an example in internal training to continuously strengthen reforms in public administration, improve service quality and enhance the sense of satisfaction and well-being among service users and their families.

Government's response

271. SWD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendations (a) and (b)

272. During The Ombudsman's full investigation, SWD had simultaneously reviewed and revised all the content on its website regarding the GDRCS Scheme to ensure clarity and accuracy.

Recommendations (c) and (d)

273. Apart from regularly reviewing the content of its website, SWD has further strengthened the mechanism for vetting the information on the website of the GDRCS Scheme. This includes reviewing such information every six months (i.e. in April and October each year) and providing timely updates to reflect the latest progress of the Scheme. All updates are subject to review by team heads to ensure accuracy of the content. In the light of the increasing number of Mainland RCHEs joining the GDRCS Scheme and the launch of the Social and Care Support Service, SWD had, in accordance with the above arrangements, conducted comprehensive review of the information on its website and made corresponding updates in March and May 2025 respectively.

Recommendation (e)

274. SWD has included the fixed drug costs covered by the subsidised services of individual RCHEs in the service briefs. SWD has also incorporated the prescription drug lists of RCHEs joining GDRCS Scheme prior to 2024 into the relevant briefs. The above arrangements help enhance the transparency of RCHE service content, and provide useful reference for elderly persons and their families when considering the Scheme and choosing a suitable RCHE.

Recommendations (f) and (g)

275. With lessons drawn from this case, SWD has reminded the frontline staff to carefully review relevant details when handling complaints or feedback from the public, and to follow up and respond

promptly. SWD will continue to strengthen staff training and supervision to enhance service quality.

Transport Department

Case No. 2024/0827 – Unreasonably restricting the transference of JoyYou Card to smartphones or smartwatches

Background

276. On 19 March 2024, the complainant complained to the Office of The Ombudsman (the Office) against the Transport Department (TD).

277. The complainant complained against TD for unreasonably restricting the transference of the new JoyYou Card to smartphones or smartwatches. He considered such restriction inconvenient to the elderly who must carry and show their JoyYou Card on entry and exit of all public transport, unlike other Octopus users whose Octopus cards can be stored in their mobile devices. Moreover, Octopus Cards Limited (OCL) had already allowed users to select different images to display on their smartphone or smartwatches when using the Octopus App. He also considered that there are other ways to handle the issue of enforcement, as claimed by TD, that would be equally effective, for instance, requiring the JoyYou Card with photo be shown whenever required for enforcement. The complainant also queried if TD had adequately informed or consulted the elderly regarding the impact of this restriction before imposition.

278. The Office conducted preliminary inquiry with TD on 16 April 2024. On 21 May 2024, TD replied to the complainant and the Office. Between 21 May and 2 September 2024, the complainant and TD had further email exchanges regarding this case. On 15 October 2024, the Office decided to conduct a full investigation into this complaint. Having examined all relevant information, the Office completed the investigation on 26 November 2024.

The Ombudsman's observations

279. The Government had conducted a comprehensive review of the Government Public Transport Fare Concession Scheme for the Elderly and Eligible Persons with Disabilities ($2 Scheme), during which views from stakeholder groups such as the concerned groups for the elderly were gathered, before implementing the mandatory use of JoyYou Card. TD has explained why Octopus cards installed in mobile or other electronic devices are currently not readily adapted for use under the $2 Scheme and its concern on the enforcement issue. From the administrative perspective, the Office considered that there was no maladministration on the part of TD. The complaint was unsubstantiated.

280. Having said that, it has been the Government's policy in recent years to actively promote the city's digital development. For instance, the Digital Policy Office was established for promoting various digital inclusion measures to help those in need (especially the elderly) to understand and use digital technology products and services so that they can use digital technologies effectively and safely, thereby fully integrate into the digital society. The Office considers that TD should, in line with the Government policy on digital development, endeavour to overcome the technical and enforcement issues mentioned above so as to provide more convenience to the $2 Scheme beneficiaries (including JoyYou Card holders).

281. The Ombudsman recommended TD –

(a) to periodically follow up with OCL on the development of the mobile versions of JoyYou Card and PwD Octopus that could support the display of user's photo in order to enhance user convenience, but on the premise that the overriding policy objective of combatting abuse of the $2 Scheme and ensuring the proper use of public funds will not be compromised; and

(b) as an interim measure and in accordance with the overriding policy objective mentioned above, to explore the feasibility of allowing the $2 Scheme beneficiaries aged 60 or above using the mobile version of JoyYou Card and to show the Card or other valid identification document for verification whenever required for anti-abuse enforcement.

Government's response

282. TD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendation (a)

283. TD undertook to keep in view OCL's development of the mobile versions of JoyYou Card and PwD Octopus that could support the display of user's identity (i.e. photo and full name) and carefully consider any proposals from OCL that can provide users with greater convenience without compromising the overriding policy objective of combatting abuse of the $2 Scheme by ineligible users, with a view to ensuring proper use of public funds.

Recommendation (b)

284. Having re-considered the matter, TD took the view that it was not practicable to allow beneficiaries under the $2 Scheme to use mobile version of JoyYou Card which did not display the user's identity. It considered that allowing a beneficiary to show valid identification document(s), other than JoyYou Card, for verification upon inspection, as an interim measure, would undermine the very purpose of mandating all beneficiaries to use JoyYou Card in order to benefit from the $2 Scheme starting from August 2024. While TD was supportive of innovative ways to provide more convenience to passengers, it would need to carefully evaluate the flip sides that any interim measure may bring, such as whether it would add difficulties to the frontline staff of the public transport

operators (PTOs) in conducting identity verification and or give rise to disputes between passengers and frontline staff, and; if so whether the above would hamper the overall efficiency of transport operation and compromise the Government's efforts in combatting abuse of the $2 Scheme.

285. TD has been following-up with OCL to explore the feasibility of developing a mobile version of JoyYou Card that can display cardholders' photo, name and card number, and with appropriate anti-forgery features, to facilitate instant passenger identification by frontline staff of PTOs and ensure that the policy objective of combatting abuse of the $2 Scheme by ineligible users is not compromised.

Transport Department

Case No. 2024/1477 – (1) Shirking of responsibility and poor communication with Star Ferry, resulting in different reasons given for the temporary suspension of ferry services; and (2) Failing to notify the Information Services Department of the temporary suspension of ferry services, resulting in the Government not making any relevant announcement

Background

286. On 20 May 2024, the complainant lodged a complaint with the Office of The Ombudsman (the Office) against the Transport Department (TD).

287. The complainant alleged that on the morning of 2 April 2024, she went to the Central Pier with a view to taking Star Ferry to Tsim Sha Tsui. A notice was put up at the pier stating that ferry services were temporarily suspended due to a fireworks preview. However, the complainant could not find such notice on the websites of Star Ferry and TD. After calling the Star Ferry to enquire about the resumption arrangements for ferry services, she was also unsuccessful. On the same day, she lodged a complaint with 1823 about TD's failure to notify the public of the suspension of Star Ferry services and the resumption arrangements in advance. TD replied to her by phone and via SMS message on 3 and 6 May respectively, indicating that it had followed up on the issue with Star Ferry; the temporary suspension of ferry services on that day was due to the rehearsal of a fleet of vessels at sea, not because of the fireworks preview; and that a notice had been put up at the pier by Star Ferry to notify the passengers.

288. In light of the above, the complainant was dissatisfied that TD had shirked its responsibility to Star Ferry and communicated poorly with them, resulting in different reasons given for the temporary suspension of ferry services (Allegation (a)); and it had failed to notify the Information

Services Department of the temporary suspension of ferry services, resulting in the Government not making any relevant announcement (Allegation (b)).

The Ombudsman's observations

Allegation (a)

289. TD already explained its responsibility to monitor the operation of Star Ferry and the follow-up actions taken in respect of the complaint lodged by the complainant. The Office was of the view that TD had been communicating with Star Ferry to make corresponding and necessary service adjustments upon learning about the rehearsal on 2 April and that the reasons given by TD and Star Ferry for the temporary suspension of ferry services on that day were not contradictory. The Office considered Allegation (a) unsubstantiated.

Allegation (b)

290. TD already explained the general arrangements for disseminating information on ferry service adjustments and the reasons for not making announcement on ferry service adjustments in advance. The relevant records showed that, upon being notified of the details of the event concerned by the Marine Department, TD, in accordance with its duties, reminded the operator in a timely manner to pay attention to sea activities and inform passengers of the service adjustments. In accordance with the requirements of TD, the operator put up notices on site to inform the affected passengers of the temporary suspension of ferry services. The Office understood that the complainant did not consider the impact minor from the perspective of those affected. However, from an administrative perspective, the Office was of the view that TD did not violate the Government's general arrangements for disseminating information on ferry service adjustments in the handling of this case, and there was no maladministration involved. The Office considered Allegation (b) unsubstantiated.

291. Overall, the Office considered this complaint unsubstantiated and recommended TD to –

(a) explore with the operator the feasibility of notifying the public of frequency adjustments to ferry services (including service suspension and resumption arrangements) on its website and social media as early as possible;

(b) consider formulating an implementation plan if Recommendation (a) is proved to be feasible;

(c) explore the feasibility of issuing notification of frequency adjustments to ferry services (including service suspension and resumption arrangements) using the all-in-one mobile application "HKeMobility" launched by TD;

(d) consider formulating an implementation plan if Recommendation (c) is proved to be feasible; and

(e) review the current arrangements for disseminating information on temporary service adjustments of other public transport operators (PTOs) in order to explore room for improvement.

Government's response

292. TD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendations (a) to (d)

293. TD has thoroughly reviewed the notification and arrangements for disseminating information on temporary ferry service adjustments, and has discussed with various franchised and licensed ferry operators on the implementation of the following enhancement measures –

(a) Ferry operators will disseminate information on temporary service adjustments to the public through their websites or social media as soon as practicable in terms of resource management and actual operation; and

(b) TD will make the announcement as soon as possible via its mobile application "HKeMobility" after notification of temporary ferry service adjustments is received from ferry operators.

294. TD had implemented the above notification and information dissemination arrangements on a trial basis for six months from 17 February 2025 to 16 August 2025. TD and ferry operators are reviewing such arrangements in the light of operational experience obtained during the trial period to make appropriate adjustments and enhancements. The above notification and information dissemination arrangements are expected to be implemented by Q4 2025.

Recommendation (e)

295. TD stated that the major PTOs currently have in place effective incident reporting and information dissemination mechanisms. The Emergency Transport Co-ordination Centre (ETCC) of TD also operates 24 hours daily, monitoring the traffic conditions in all districts across Hong Kong. In case of traffic incidents, ETCC will closely monitor the traffic and transport situation in collaboration with the relevant PTOs, other related departments and organisations, and timely disseminate the latest traffic news to the public through media, TD's website and mobile application "HKeMobility". All along, the major PTOs will timely notify the public of temporary service adjustments through established channels, such as their websites and mobile applications, as well as by putting up passenger notices inside vehicle compartments and at stations. Besides, TD will, through regular meetings and daily communications, remind the relevant PTOs to timely disseminate information on temporary service adjustments to the public in accordance with the existing incident reporting mechanism, enabling the affected passengers to plan their trips in advance.

After reviewing the arrangements, TD considered that the current arrangements for disseminating information on temporary service adjustments by the above mentioned PTOs is generally smooth. TD will continue to closely monitor the arrangements.

Transport Department

Case No. 2024/1655 – Failing to explain the Department's follow-up actions when responding to the complainant's enquiry about his defective vehicle report

Background

296. The complainant has earlier lodged a complaint with the Office of The Ombudsman (the Office) concerning the Transport Department (TD)'s failure to properly handle the complainant's report of defective vehicles. Regarding the case, the Office gave a written reply on 19 April 2024 to inform the complainant of his investigation results, including how TD had handled the reports that the complainant made between December 2023 and January 2024. In particular, TD indicated that if the informant takes the initiative to request the Vehicle Inspection Office (VIO) of the department to explain the follow-up actions on the reported cases, VIO will entertain his request subject to no information about the vehicle owners being revealed.

The Ombudsman's observations

297. The complainant complained that regarding his report of defective vehicles, VIO's reply in May 2024 that "follow-up actions have been completed" was inconsistent with TD's indication that "if the informant takes the initiative to make a request, VIO will explain its follow-up actions subject to no information about the vehicle owners being revealed".

298. TD has given an account on the guidelines on the handling of defective vehicle reports as updated by VIO in April 2024 and the contents of the relevant reply to the informant, the contents of reply as subsequently enhanced in the light of this case and the handling of the reports made by the complainant between March and April 2024. TD further acknowledged that it is undesirable that in handling the reports concerned, it might have

confused this case with other reported cases of similar nature and thus failed to assign the case to a vehicle examiner upon the complainant's second enquiry for individual follow-up in accordance with the prevailing guidelines.

299. While VIO did follow the then standard format of reply in responding to the complainant's first enquiry, indicating that "follow-up actions have been completed", the reply did not "explain VIO's follow-up actions to the informant" as claimed by TD. Nor did it achieve TD's purpose of addressing the informant's concern about road safety. As such, the Office finds the complaint substantiated.

300. Since the Office's commencement of investigation, TD has promptly responded to its suggestions by reviewing and improving the contents of VIO's replies, incorporating the indication that upon a request initiated by the informant for VIO to explain the follow-up actions on the reported cases, VIO will, having regard to the progress of individual cases, provide a more specific reply to the informant. Hence, the Office recognises TD's efforts in enhancing the contents of its replies.

301. The Office recommended TD to –

(a) continue to monitor the performance of VIO and the number of cases of defective vehicle reports;

(c) depending on the monitoring results of (a) above, consider reviewing the staffing arrangements as necessary, including the need for staff redeployment having regard to actual circumstances so as to maintain VIO's effective operation; and

(d) learn from the experience of this case and remind the VIO staff to provide precise responses to individual enquiries from complainants of defective vehicle report to avoid confusion with other cases.

Government's response

302. TD accepted the Office's recommendations and has taken the following follow-up actions.

Recommendation (a)

303. VIO will record monthly numbers of defective vehicle reports, update the progress of follow-up actions on the reported defective vehicles in the current month (including the number of replies given to the informant), and submit the relevant information to the head office of the Vehicle Safety and Standards Division (VSSD) for perusal by the supervisors there on a monthly basis.

Recommendation (b)

304. Having reviewed the manpower deployment of VSSD, TD considers that given the already acute shortage in civil service establishment of the division, it is rather challenging to cope with the increasing cases of defective vehicle reports. Therefore, TD has recruited contract staff members to assist in the administrative and clerical work in handling such cases in order to expedite their progress and minimise the chance of compromising efficiency or errors resulting from the excessive workload.

Recommendation (c)

305. TD has reminded the VIO staff to provide precise responses to individual enquiries from the complainants to avoid confusion with other cases when handling defective vehicle reports in future. Also, supervisors in VIO will conduct regular random checks on the records of replies given and provide appropriate guidance to the staff of the office.

Urban Renewal Authority

Case No. 2023/1879 – (1) Mishandling an application under the Building Maintenance Grant Scheme for Needy Owners; (2) Unreasonable conduct of means test; and (3) Unreasonably refusing to disclose the amount of grants for different works items

Background

306. The complainant reported that the "Tenants Purchase Scheme" (TPS) unit jointly purchased by the complainant and her husband was in need of repair. On 16 April 2023, the complainant applied the "Building Maintenance Grant Scheme for Needy Owners" (Grant Scheme) through the Urban Renewal Authority (the Authority)'s website ("Application of 16 April"). On the same day, the Authority acknowledged receipt of the complainant's online application by email, providing the file number. On the 21st of the same month, the complainant's son submitted the physical proof documents to the Authority, providing the aforementioned file number. Subsequently, the complainant's son contacted the Authority's hotline to inquire about the progress of the application and the staff member advised the complainant's son to wait for a return call from the case officer.

307. The Authority sent two acknowledgment letters to the complainant on 28 April and 9 May respectively, quoting two distinct sets of application numbers. On 22 May, a staff member from the Authority, referred as Staff Member A, contacted the complainant's son requesting the complainant to submit physical proof documents. The complainant's son stated that he had already submitted these documents to the Authority on 21 April. On 23 May, the complainant's son emailed the Authority seeking updates on the application progress and inquired about the existence of multiple application numbers. On the same day, Staff Member A called the complainant's son identifying himself as the case officer, and reassured the complainant's son that having two application files was not a problem.

308. On 29 May 2023, the Authority sent a letter requesting the complainant to submit the Income and Asset Declaration Form and the signature page of the Form by 7 June, or otherwise, the Authority would terminate processing the application. On 31 May, the Authority notified the complainant that the application submitted on 21 April ("Application of 21 April") would be cancelled due to the duplicate submission of applications. On 2 June, the complainant's son sent the signed documents by the complainant and her husband to the Authority. On 8 June, the complainant's son called Staff Member A to inquire which application was cancelled. Staff Member A stated that only one file was cancelled and promised to notify the complainant's son after receiving the signed documents. Moreover, Staff Member A noted that the business registration certificate of the repair contractor appointed by the complainant would expire in September 2023, advising the complainant to consider cancelling the application in advance. On 9 June, Staff Member A updated the complainant's son that the documents had been received, but stated that asset assessment of the applicant was required and the approval process would take about two months to complete.

309. During an inspection of the complainant's unit on 20 June 2023, the Authority identified multiple safety hazards, such as cracked kitchen wall tiles, concrete spalling on the ceiling near the kitchen window, and a rotten toilet doorframe. They suggested that the complainant "make an adjustment to the application to increase repair items and costs". Following the Authority's recommendation, the complainant added repair items, increasing the total subsidy application to $43,500. However, the Authority's "Approval-in-Principle" (AIP) issued on 13 July of the same year granted a subsidy of only $9,400. This decision was considered unreasonable, especially as the AIP did not explain the subsidy amounts allocated for the various repair works.

310. As complainant had not previously obtained the Housing Department's approval to remove a door between the unit's kitchen and balcony, the Authority rejected the subsidy application for the repair items involved (Involved Items). The complainant believed the Authority

overlooked the fact that her unit was a TPS unit, which the Housing Department's approval was not required for such alternations. Furthermore, the changes did not involve load-bearing walls and did not require approval from the Buildings Department. The complainant considered this approach by the Authority unreasonable.

311. The complainant has declared the completion of the repair items to the Authority. However, as of 18 October 2023, the Authority had neither disbursed the subsidy nor communicated with any update progress, indicating a delay in the process.

312. The complainant's complaints against the Authority were as follows –

(a) mishandling complainant's application under the Grant Scheme (Allegation (a)), which included –

i. incorrectly creating two application files;

ii. acknowledgment letters providing only hotline numbers;

iii. letters lacking Staff Member A's full name, appearing bureaucratic;

iv. the letter dated 29 May 2023, demanding supplementary document within seven working days or risking application cancellation, perceived as threatening;

v. insufficient explanation in the letter dated 31 May 2023, regarding the cancellation of only the "Application of 21 April", not the "Application of 16 April", causing unease; and

vi. Staff Member A attempted persuasion to cancel the application in a phone call on 8 June 2023.

(b) unreasonable conduct of income and asset test (Allegation (b));

(c) suggested increase in repair items without granting the corresponding subsidy amount and failure to explain subsidy amounts for each works item (Allegation (c));

(d) denial of subsidy based on unapproved unit alterations by the Housing Department (Allegation (d)); and

(e) delay in disbursing the subsidy (Allegation (e)).

The Ombudsman's observations

Allegation (a)

313. Regarding item (7)(a)(i), the Authority has explained why the complainant's physical application form received (i.e. Application of 21 April) was treated as a new application. The complainant did not adhere to the hotline staff's instructions to submit only the signature page of the application form as supplemental documents. However, the complainant's son marked the system file number on a blank page, indicating the prior online application submission. In retrospect, if the Authority staff had noticed this system file number, they could have located the record for the "Application of 16 April" or clarify with the complainant whether a new application was necessary, thereby avoiding the subsequent need to cancel the "Application of 21 April". The Ombudsman considered the handling by the staff of the Authority was imperfect, but there was no evidence that the progress of the "Application of 16 April" was affected.

314. Regarding items (7)(a)(ii) to (v), the Office found the Authority's explanations reasonable. The Office welcomed the Authority's implementation of optimisation measures to address the issues raised in items 7(a)(iii) and (v).

315. Regarding item (7)(a)(vi) and the Authority's explanation, the Office did not consider it unreasonable for the Authority's staff to provide different suggestions for the applicant's consideration based on the their situation. However, the complainant's son denied having told Staff Member A during the 1 June phone call that it might take two to three months to submit supplementary documents. Without independent evidence, the Office could not determine the details of the conversation between Staff Member A and the complainant's son or whether there was an attempt to persuade the complainant to cancel the application. Therefore, no further comments would be provided.

316. Based on the above analysis, Allegation (a) was not substantiated, but there were deficiencies in the handling process of the "Application of 21 April" by the Authority.

Allegation (b)

317. The Authority has admitted that Staff Member A mistakenly requested the complainant to complete the Income and Asset Declaration Form. Although this mistake did not negatively affect the progress of the complainant's application, it did waste the time of the complainant or those assisting the complainant in completing the forms. Thus, Allegation (b) was substantiated.

Allegation (c)

318. Regarding the suggestions made by the building surveying consultant (BSC) during the inspection, there were discrepancies between the complainant's son and the Authority's statements. In the absence of independent evidence (e.g. recordings), the Office was unable to ascertain the facts and thus refrained from commenting. As for the complainant's views that the approved grant amount being unreasonable, the Authority determined the grant amount based on professional inspection and evaluation, which was their professional judgment. After a detailed review of the information and explanations provided by the Authority, the Office

found no breach of established principles in their assessment process. Since there was no evidence suggesting improper procedures or irrationality in the Authority's decision, the Office would not intervene.

319. After careful consideration of the Authority's explanation and the Competition Commission's opinion on potential consequences of disclosing information, the Office accepted the Authority's decision not to disclose the grant amount for each repair item.

320. Based on the above analysis, Allegation (c) was not substantiated.

321. Although this complaint was unsubstantiated, the Office was concerned that the Grant Scheme was meant to provide financial support for repairs of owner-occupied properties for those in need. Applicants who required grant might need to decide whether to undertake certain projects based on the grant amount, especially in cases where there was a large gap between the grant and the quoted amount. The Office understood that the Authority must consider the impact of disclosing information on market operations to prevent anti-competitive behaviour but believed that the current practice allowed applicants to consider only the overall grant amount, lacking additional useful information, which may affect optimal decision-making when selecting repair items.

Allegation (d)

322. The Office agreed that the Authority must ensure that subsidised projects did not violate the Buildings Ordinance (the Ordinance) when approving subsidy applications. However, alterations categorised as exempted works or minor works under the Minor Works Control System did not require written approval from the review committee. Hence, alterations (i.e. discrepancies with original building plans) in the complainant's unit might not necessarily violate the Ordinance. While the Office agreed in principle that the applicant should prove compliance with the Ordinance for alterations within TPS units, the "In-flat Notes" and its revised version from the Authority did not clearly state that subsidies

would not be approved due to alterations potentially violating the Ordinance. The AIP only mentions discrepancies between the location involved and the original plans without explaining potential violations of the Ordinance, which was unsatisfactory. Consequently, the complainant may not comprehend from the In-flat Notes or AIP that the non-granting of the subsidy was due to potential non-compliance with the Ordinance.

323. More importantly, if the alterations were minor works under the Minor Works Control System, the complainant could provide relevant documentation submitted by the contractor to the Independent Checking Unit (ICU) to demonstrate compliance with the Ordinance. However, if the changes were designated exempted works, since they did not require formal approval from the ICU, the complainant would not be able to provide documents issued or archived by the ICU to prove no violation of the Ordinance. The Office believed that the scope of the BSC's on-site inspection should include determining whether alterations at the repair location deviate from the original plans, and the BSC should provide professional opinion on whether the changes are exempt works, minor works, or require review committee approval, in order to facilitate the Authority requesting necessary documentation from the applicant. In reality, as the age of TPS properties increases, more units would require repairs and the Authority may need to handle a growing number of subsidy applications from owners. The Authority should consider formulating guidelines for handling applications involving alterations that do not require ICU approval.

324. Furthermore, as the Authority has already put in place a review and appeal mechanisms related to the subsidy scheme, the Office advised the Authority to inform the public of the same. Further, according to the Office's investigation, despite the Authority's cancellation letter allowed objection before a specified deadline, it did not request the applicant to set out written arguments, nor explained the appeal process. Moreover, there was a lack of information in application documents, the AIP, website, or other informational channels on the review and appeal channels for the

subsidy scheme, which was inadequate. Based on the above analysis, Allegation (d) was partially substantiated.

Allegation (e)

325. The timeline from the submission of completion documents to the disbursement of the subsidy was approximately six weeks, with two weeks spent organising a visit for the BSC with the complainant. Additionally, during the 4-week period from the BSC's inspection on 29 September 2023, to the disbursement by the Authority on 27 October, the BSC prepared a report, which was reviewed by the Authority. They then confirmed the final subsidy amount and arranged for disbursement. The Office considered this timeframe reasonable. Overall, there was no evidence to prove that the Authority delayed disbursing the subsidy. Therefore, Allegation (e) was unsubstantiated.

326. Overall, The Ombudsman considered this complaint partially substantiated. The Office recommended the Authority to –

(a) remind staff to be careful when handling applications. In cases of uncertainty regarding submission documents, promptly seek clarification from the applicant to avoid unnecessary requests for information;

(b) ensure that information on review and appeal channels related to the subsidy program was appropriately communicated and accessible to applicants; and

(c) consider updating the content of the In-flat Notes and the AIP to inform applicants (including the complainant) that the reason of rejection was relevant to whether their unit alteration complies with the Ordinance. This would enable applicants to submit necessary documents proving that alterations in their units do not violate the Ordinance.

Government's response

327. The Authority accepted the Office's recommendations and has taken the following follow-up actions.

Recommendations (a)

328. The Authority accepted this recommendation and emphasises its ongoing commitment to staff training. Staff has been reminded to handle applications carefully according to established guidelines and to avoid requesting unnecessary information from applicants when assessing application eligibility.

Recommendations (b)

329. The Authority accepted this recommendation and has already made updates to the application notes for the Building Maintenance Grant Scheme for Needy Owners (Grant Scheme) on the Building Rehabilitation Platform website. The revised application notes, which were published by the end of July 2024, now included sections that provide detailed information on review and appeal channels.

Recommendations (c)

330. The Authority has completed revisions to the content of the AIP by July 2024, clearly indicating the reasons for non-subsidised repair projects in the completion declaration form for residential unit repairs. Additionally, the first paragraph on page 4 of the In-flat Notes has been revised to address the requirement to submit documents proving that alterations conform to the Buildings Ordinance, thereby improving applicants' understanding. In June 2024, the Authority also launched a new "Smart Guide" leaflet for the Grant Scheme, which featured key considerations for potential applicants. This leaflet explicitly stated that if unit alterations were involved, and if the applicant could not provide

documents proving compliance with the Buildings Ordinance, the subsidy would be reduced.

Vocational Training Council

Case No. 2024/0696(R) – Refusing without sufficient grounds to disclose the documentation of an architectural competition

Background

331. The complainant requested for access to documents related to an architectural design competition (the requested documents) from the Vocational Training Council (VTC). VTC responded that the acquired information was not in its possession at the time of the request.

332. Since a report from a government department (Department A) had mentioned the contents of the requested documents, the complainant then approached Department A to obtain them. Department A replied that the document held by Department A was third-party information managed by VTC. After consulting VTC, Department A was informed that the contents were internal discussion materials and, with reference to Paragraph 27.5 of VTC's Code on Access to Information (the Code), the disclosure of such information would inhibit the frankness and candour of the discussions within VTC in future planning for similar projects. VTC therefore did not agree to the disclosure of the document held by Department A to the complainant.

333. The complainant argued that the primary audience of the requested documents was the participants in the competition, which did not fall under the category described in Paragraph 27.5 of the Code. Furthermore, VTC did not explain how the disclosure might hinder the frankness and candour of the discussions in future projects in a similar nature. The complainant believed that the reasons given by VTC for refusing disclosure were insufficient.

The Ombudsman's observations

334. VTC explained the reason for the absence of the requested documents in its institutional archives. When handling the complainant's request and subsequent review, VTC had informed the complainant that the documents were not in its possession. According to Paragraph 16 of the Code, VTC is not obligated to provide information not in its possession. the Office of The Ombudsman (the Office) considered that VTC responded based on the actual circumstances known at the time and was therefore did not constitute to maladministration nor violation of the Code.

335. However, the Office found that when VTC cited Paragraph 27.5 of the Code to refuse disclosure of several pages of the requested documents held by Department A, it failed to provide specific and reasonable explanations as to how disclosure of the information that had already been made public during the competition stage would affect candid internal discussions in future planning projects. As for the handwritten notes on those pages, since they were added by Department A, VTC could have considered discussing with Department A whether disclosure was possible, or even considered redacting the notes before releasing the document.

336. The Office concluded that VTC did not provide sufficient justification when refusing to disclose the requested documents under Paragraph 27.5 of the Code. Therefore, the complaint against VTC was substantiated.

337. Nevertheless, the Office noted that VTC made its best efforts to locate the requested documents during the handling of the case. It was appreciated that VTC eventually obtained the documents through means outside of its institutional archives and provided them to the complainant.

338. The Office recommended VTC to enhance staff training to strengthen their understanding of the Code.

Government's response

339. VTC has accepted the Office's recommendation and enhanced its staff training, including the implementation of the following regular measures –

(a) Briefing Sessions on the Code

i. Arranging for staff quarterly briefing sessions to explain the Code's provisions and key points and the established procedures for handling requests in accordance with the Code, and providing practical guidelines, emphasising the principle of handling such requests based on valid justifications.

(b) Case Studies/Experience Sharing

ii. Arranging quarterly sharing sessions (blending precedent cases with the Office's recommendations), and having regard to the prevailing mechanisms and application guidelines of the Government and other institutions on handling requests under the existing Code, exploring with staff for continuous improvement the good practices and common challenges in handling information requests.

(c) Individual Support and Feedback Mechanism

iii. Providing individual coaching sessions for staff on an on-going basis to deepen their understanding and implementation of the Code; and

iv. Soliciting staff feedback on an on-going basis and exchanging insights and improvement suggestions regarding the implementation of the provisions.

Water Supplies Department

Case No. 2023/3517 – (1) Delay in notifying the complainant of the mix-up of water meters between another flat and hers, and in issuing a demand note for adjusted water charge; and (2) Unreasonable refusal to extend the due date for the complainant to settle the adjusted water charges

Background

340. The complainant stated that after she had moved out of her former address (Flat 4G) in June 2022 and applied to Water Supplies Department (WSD) for closure of account, WSD confirmed the termination of her consumer registration, issued a final bill and refunded the deposit balance. Nevertheless, in September 2023, WSD notified the complainant that because the water meters of her flat and a neighbouring flat (Flat 4H) had been mixed up back in 2019, she was required to pay $6,064.4 after water charge adjustment. In connection with the above, the complainant made the following allegations against WSD –

(a) After the meter mix-up had occurred in November 2019, WSD already discovered the incorrect meter records in June 2021, but did not notify her immediately. Moreover, she had moved out of flat concerned and successfully closed the account in June 2022, but it was not until more than a year later that WSD recovered the charges from her. The situation resulted in her being unable to make a timely request for a review of the meter readings, data or charges, and deprived her of the opportunity and right to verify the matter. She considered that WSD had mishandled the case and was unfair to her (Allegation (a)); and

(b) It was unreasonable that WSD had delayed for so long in calculating the adjustment but only gave her one month to pay the bill after it was issued. As she was working out of town at the time of complaint, she requested WSD to suspend the case until she

returned to Hong Kong in late December 2023, so she could contact WSD personally to resolve the matter. However, WSD did not respond to her request and only asked her to settle the water charge adjustment according to the bill (Allegation (b)).

The Ombudsman's observations

Allegation (a)

341. Overall, the Office of The Ombudsman (the Office) considered WSD to have inadequacies in handling this case. With the benefit of hindsight, even if WSD needed a longer time to handle the case due to the special circumstances during the epidemic, it would have been more desirable to first give the affected consumers an account of the meter mix-up, and let them know that they would be notified later (e.g. after the epidemic subsided) in a gradual and orderly manner of the adjusted amounts after rectification of the meters. This would have prevented them from being caught by surprise and aggrieved when receiving the adjustment bills a long time subsequently.

342. The Office is pleased to note that WSD has taken follow-up and remedial measures about the inadequacies of the responsible staff, and has improved the monitoring mechanism for handling complaints. Regarding meter mix-up, WSD has issued departmental guidelines requiring staff to step up checking relevant documents after meter replacement, thereby further enhancing the effectiveness of monitoring. Meanwhile, while the Office does not deny that WSD's current practice of handling meter mix-up cases (i.e. notifying the affected consumers after completion of case investigation and calculation of the adjustment) can ensure the provision of accurate information to consumers, the Office also considered WSD to have the responsibility to notify the affected consumers of meter mix-up as soon as possible, especially when it was indeed an error made by WSD. The Office therefore recommended that WSD review the existing procedures and guidelines to consider whether a maximum time limit

should be set for notifying the affected consumers after a meter mix-up is confirmed, thereby preventing the recurrence of similar incidents.

343. Based on the analysis above, the Office considered Allegation (a) partially substantiated.

Allegation (b)

344. Having examined the findings, including the chronology of events and WSD's work records, the Office considered WSD, after learning of the complainant's queries and dissatisfaction with the adjustment bill, to have explained the issue to her repeatedly, including the provision of such data as the meter readings, water consumption and water and sewage charges before and after the meter replacement works; it also froze her bill temporarily and extended the payment due date in response to her being out of town when lodging the complaint. However, in replying to her enquiries or complaints, the Office noted that WSD only stressed that she should pay the bill issued on 4 October 2023 (Note: the payment due date was 27 October 2023). The Office believes that this might have given the complainant a misperception that WSD had not considered her request for suspension of payment and processing of the case. It was only after she had lodged a complaint with the Office that WSD explicitly indicated that the payment due dates would be extended to 24 January and 27 February 2024 respectively.

345. Based on the analysis above, the Office considered Allegation (b) unsubstantiated but with other inadequacies found on the part of WSD.

346. Overall, The Ombudsman considered this complaint partially substantiated. The Office recommended WSD to –

(a) consider revising the departmental guidelines to specify a time frame for notifying the affected consumers in writing of a water mix-up case after it is confirmed, including that WSD will suspend the issuance of water bills, and will issue notices of

billing adjustment to the consumers after completing calculation of the adjusted water and sewage charges; and

(c) remind staff of the need for handling carefully the account enquiries or complaints from registered consumers and to provide clear replies as soon as possible.

Government's response

347. WSD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendation (a)

348. WSD revised the departmental guidelines on handling cases of meter mix-up resulting in adjustment to water and sewage charges on 1 August 2024, as summarised below –

(a) The responsible staff must notify the affected consumers in writing of the meter mix-up case within seven working days after it is confirmed, including suspending the issuance of water bills and notifying consumers that the adjusted bills will be issued after completing calculation of the adjusted water and sewage charges;

(b) The adjusted bills for water and sewage charges should be issued to the affected consumers if possible within 30 days after giving notice in writing. If the case is more complicated and cannot be completed within 30 days after giving notice in writing, the responsible staff must report the situation to Senior Accounting Officers and Senior Treasury Accountant; and

(c) An Accounting Officer will be assigned to compile a record book for meter mix-up cases. The record book should be submitted to the Senior Clerical Officers, Senior Accounting Officers and Senior Treasury Accountant of the Customer Accounts Section on

a weekly basis so that relevant colleagues can follow up the cases in a timely manner.

Recommendation (b)

349. WSD has reminded staff of the need for handling carefully the account enquiries or complaints from registered consumers and to provide clear replies as soon as possible.

Water Supplies Department

Case No. 2024/0033 – (1) Allowing no consumer to take up the water consumership of a flat for a long time without disconnecting the water supply, but disconnecting it immediately upon the complainant's repossession of the flat and application for taking up the consumership, and unreasonably charging for reconnection; and (2) Failing to update the complainant's contact details in a timely manner

Background

350. According to the complainant, she was the owner of a private residential flat (the flat). She purchased the flat in May 2022 and rented it out until the tenant (former tenant) moved out in October 2023. In November 2023, the complainant emailed Water Supplies Department (WSD) to apply for taking up the consumership of the flat. Subsequently, she was informed that WSD had removed the water meter of the flat in late November 2023 to disconnect the water supply. Therefore, she had to pay an additional fee to WSD for reconnection of water supply.

351. In late November 2023, WSD staff called the complainant to arrange for reconnection of water supply. During the call, the staff mentioned that WSD did not update her phone number, resulting in the call being made to her old number and failing to contact her in time.

352. The complainant later repeatedly expressed her dissatisfaction with WSD's handling of the case and requested a refund of the reconnection fee. WSD replied to her three times, stating that the consumership of the former consumer of the flat had been terminated in late April 2022, and that WSD had disconnected the water supply as it did not receive an application for taking up the consumership after the deadline specified in the disconnection notice. WSD reiterated that it had handled the case in accordance with relevant regulations and procedures and therefore refused to waive the reconnection fee.

353. The complainant was dissatisfied with WSD's response and made the following allegations against WSD –

(a) During the tenancy period from May 2022 to September 2023, the former tenant neither took up the consumership nor paid the water bills. However, WSD allowed the tenant to consume fresh water without disconnecting the water supply, which was unfair and a waste of public funds. When the complainant applied for taking up the consumership of the flat in November 2023, WSD disconnected the water supply in just a few days and unreasonably charged her for reconnection; and

(b) WSD failed to update the complainant's phone number in its record in a timely manner, resulting in delays in contacting her and arranging for reconnection of water supply.

The Ombudsman's observations

354. In summary, the Office of The Ombudsman considered that WSD had disconnected the water supply for the flat without consumers taking up the consumership in accordance with established procedures and actual circumstances. WSD later handled the complainant's application for taking up the consumership and restored the water supply in a timely manner. But on the other hand, the investigation also revealed that WSD currently lacks an active monitoring mechanism, leading to delays in investigating suspected cases of unlawful taking of water. Overall, The Ombudsman considered this complaint partially substantiated.

355. The Ombudsman recommended WSD to –

(a) continue to follow up with the complainant on the report of suspected unlawful taking of water at the flat;

(b) if sufficient evidence is found after implementing Recommendation (a), consider whether to take further actions such as instituting prosecutions or issuing warning letters;

(c) consider adding reminders or warnings to the "Invitation to Taking up Consumership and Notice of Disconnection" and the "Final Notice of Disconnection" to inform the occupants that consuming water without taking up the consumership may involve illegal acts, and explain to them the relevant responsibilities and consequences;

(d) regularly review the implementation of new measures to monitor the water consumption after closure of registered accounts to ensure their effectiveness;

(e) periodically circulate relevant notices or guidelines to ensure staff are aware of and implement the above new measures and monitoring mechanisms;

(f) remind staff to take this case as a lesson and strengthen communication with the informant when handling reported cases, and provide detailed explanations of WSD's decisions when necessary;

(g) strengthen staff training to improve communication and skills in handling complaints and reports;

(h) in addition to the above, consider adopting other measures to prevent recurrence of similar problem; and

(i) continue to optimise and reform existing procedures and mechanisms to enhance service quality.

Government's response

356. WSD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

357. On Recommendations (a) and (b), WSD contacted the complainant via email in early and late June 2024, requesting further information to facilitate the investigation of the suspected unlawful taking of water at the flat. However, no reply was received from the complainant. Subsequently, WSD sent another email to the complainant in late December 2024, requesting information on the suspected unlawful taking of water for further follow-up. WSD also stated that if the complainant failed to provide information about the case by late January 2025, WSD would not be able to proceed with the case. In mid-January 2025, WSD sent another email requesting the complainant to provide the information before the aforementioned deadline. The complainant replied to WSD on the same day, stating that the information had already been provided in the previous emails for WSD's investigation. However, WSD found that the information provided did not include the particulars of the occupant of the flat from April 2022 to November 2023, which were necessary for WSD to arrange for interviews and statement taking. Consequently, on the following day, WSD emailed the complainant again, requesting the particulars of the occupant during that period for follow-up. WSD also stated that if the complainant failed to provide the particulars by late January 2025, WSD would not be able to proceed with the case. As no reply was received from the complainant by late January 2025, WSD was unable to follow up on the suspected case of unlawful taking of water at the flat. During the handling of the complaint, the WSD has been maintaining fresh water supply to the resident (i.e. the complainant). Besides, in an email in mid-January 2025, the complainant suggested WSD to inspect the water meter and water mains at the back alley of the building to check for any unlawful taking of water. WSD completed the inspection of the back alley in late January 2025 and did not identify any unlawful taking of water.

358. On Recommendation (c), WSD revised the departmental guidelines in March 2025. In addition to inviting new consumers to notify WSD of taking up of consumership before the deadline, WSD also added reminders or warnings to the "Invitation to Taking up Consumership and Notice of Disconnection" and the "Final Notice of Disconnection" to inform the occupants that consuming water without taking up the consumership may involve illegal acts, and explain to them the relevant responsibilities and consequences.

359. On Recommendation (d), WSD established a mechanism in September 2024 to monitor the water consumption upon closure of registered accounts, and will conduct timely review of the new measures to ensure their effectiveness. WSD will conduct monthly checking on the water meter readings of the premises without consumers taking up the consumership and monitor the changes in water consumption. When there is a significant increase in meter reading, WSD will disconnect the water supply promptly. If there is any suspected unlawful taking of water and a reasonable possibility of obtaining sufficient evidence, WSD will initiate prosecution.

360. On Recommendation (e), WSD revised the departmental guidelines in March 2025 for periodic circulation to ensure staff are aware of and implement the new measures and monitoring mechanisms.

361. On Recommendations (f) and (g), WSD provided training for staff in December 2024 on improving communication and skills in handling complaints and reports. WSD will also enhance communication with the public when responding to public reports in the future so that the public will have a better understanding of WSD's response.

362. Recommendation (h) has been implemented.

363. On Recommendation (i), WSD will review the above new measures and monitoring mechanisms in a timely manner, with a view to

continuously optimising and reforming existing procedures and mechanisms to enhance service quality.

Part III
– Responses to recommendations in direct investigation cases

Department of Health, Food and Environmental Hygiene Department, Hospital Authority and Immigration Department

Case No. DI/472 – Government's Provision of Public Services Relating to the After-death Arrangements

Background

364. In Hong Kong, public services relating to after-death arrangements including death registration, mortuary services, cremation and coffin burial services are provided by different government departments. Taking care of after-death arrangements requires time and effort and dealing with the loss of a loved one at the same time is not an easy process.

365. While grieving for the loss of a beloved family member, the bereaved still have to deal with various formalities for after-death arrangements. If the dissemination of information on related public services could be improved, relevant application procedures could be simplified, and the workflows of death registration and related applications could be digitalised or personalised, these would significantly reduce the pressure and emotional stress on the bereaved in dealing with the formalities for after-death arrangements, as well as enhancing the work efficiency of relevant government departments.

366. Moreover, government statistics show that with an ageing trend in Hong Kong's population, the demand for public services relating to after-death arrangements, including death registration, mortuary services and burial arrangements, continues to rise. Members of the public are increasingly concerned about the arrangements for such services and dissemination of related information. Hence, the Office of The Ombudsman (the Office) has examined the Government's provision of

public services relating to the after-death arrangements and dissemination of related information.

The Ombudsman's observations

Creating A One-stop Thematic Website

367. Currently, information about the formalities for after-death arrangements can be found on the webpage, "Services and Support for the Bereaved" of the government website, Gov.HK. Nevertheless, it is difficult for the bereaved to find the information they need because they have to click on the links, one by one, to look for the information from the website of different government departments. Take death registration as an example, clicking on "Forms related to deaths registration" will lead to the webpage of "Births and Deaths Registration" on Immigration Department (ImmD)'s website. On that page, nine application forms relating to births and deaths registration and other services are available, including the forms for "Application for Search of Record of Birth in Hong Kong", "Application for a Certified Copy of an Entry in the Deaths Register" and "Application for Search of Record of Death in Hong Kong". Members of the public will have to spend time browsing the websites of different departments and checking one webpage or another before they can find the forms or information they need.

368. The Office considered that, for better support and assistance to the bereaved in dealing with after-death arrangements for the deceased, relevant departments should explore developing a one-stop thematic website on after-death public services offered by all the relevant departments so as to provide standard and consistent information to the public. The contents of the website may include information on the application procedures for related services provided by the Department of Health (DH), Food and Environmental Hygiene Department (FEHD), Hospital Authority (HA) and ImmD, clear guidelines, relevant legal procedures and required documents as well as answers to frequently asked questions.

369. The Office noticed that in the past, the bereaved had to approach the offices of individual departments to complete the various formalities for after-death arrangements in person due to the lack of digitalised services. Some therefore chose to engage a funeral agent to deal with the formalities for related public services. The Office has from time to time received complaints about inadequacy in the digitalisation of public services relating to the after-death arrangements. For example, even if the bereaved have submitted an online application for allocation of a renewable new niche via FEHD's online system, the Platform for Cemeteries and Crematoria Services, they still have to complete the verification of death documents and pay the fee at FEHD offices because the online system does not support verification of cremation cases on the same day. Subsequent to the Office's intervention, FEHD launched the "After-death Arrangements" thematic website in November 2024 to provide an integrated platform for the public to handle cemeteries and crematoria services. Upon launching of the online platform, the same situation in the aforesaid example can be handled, that is, verification of cremation cases on the same day could be handled and the bereaved need not complete the verification formality and settle the payment at FEHD offices in person.

370. In recent years, the Government has stepped up the pace of building a digital government and promoting digitalisation of government services. The Office considered the relevant departments should provide online application for more public services-death on the one-stop thematic website. They should also make good use of the "iAM Smart+" mobile app to promote digitalised after-death public services so that the bereaved could complete relevant procedures more quickly. That could save the bereaved the trouble of having to make the relevant applications in person. The Office has noticed that FEHD has launched the "After-death Arrangements" thematic website to facilitate the bereaved to apply for green burials online and to search for information about licensed undertakers of burials in November 2024. The Office recommended in light of the success of online platform launched by FEHD, the Government should further explore the development of a one-stop thematic website,

offering inter-departmental and relevant e-service applications relating to after-death public services provided by all relevant departments.

371. In the long run, as people have become more open-minded about after-death arrangements, the relevant departments may study the feasibility of expanding the functions in the one-stop thematic website to provide personalised services and collect data for sharing among the departments so as to assist the public to plan ahead for their after-death arrangements. For example, the website may allow the public to pre-set their personal medical directive and indicate their choices of end-of-life care service and burial. Besides, the Government may develop a central database to document these types of information so that the relevant departments and HA can use the data collected to follow up on the decisions of members of the public on after-death arrangements. The one-stop thematic website should also include the function to allow the bereaved to learn about the deceased's decision on their after-death arrangements. For example, members of the public can give consent to sending a timely notification to their family of their option for after-death arrangements by activating the function of an email reminder. That would make it easier for the bereaved to take care of the after-death arrangements according to the wish of the deceased. It can also save the bereaved the trouble of having to provide information of the deceased to different departments separately, thus lessening the impact on their lives at the time they are still mourning the death of their beloved ones.

372. While the Office acknowledged the importance of safeguarding personal data, the Office considered that relevant departments should promote digitalisation of public services relating to the after-death arrangements and at the same time examine how the information including the after-death arrangements that involve the deceased's privacy should be managed and maintained in the central database. In devising the information system, the departments should also draw up guidelines and formulate measures to ensure data protection for workflows including collection, storage, use and transfer of data.

Thematic Website Should Cater for Needs of Ethnic Minorities and Different Cultures

373. Hong Kong is a multicultural society and home to over 300 000 ethnic minorities. The Government of HKSAR is determined to build a caring and inclusive community and has been providing comprehensive support to ethnic minorities. Handling after-death formalities for the deceased involves legal and administrative procedures, which would prove to be even more complicated for non-Chinese speakers, not to mention that different cultures have different customs and taboos surrounding the topic of death. The Office considered that the one-stop thematic website, in addition to providing information in more languages, should be culture-sensitive and careful in the choice of wording and graphics, as well as provide answers to frequently asked questions among ethnic minorities. Better still, the content of the one-stop thematic website can be categorised by religion and ethnicity.

Stepping up Promotion through Seminars And Publicity

374. The Government is vigorously promoting green burials in the society so that cremains of the deceased can be handled in a more environmentally-friendly and sustainable manner. Green burials are gaining popularity, and latest statistics show that this option was adopted in after-death arrangements of 18.2% of the total number of deaths in a year. The Office agreed with FEHD that changing customs and traditions takes time. FEHD should collaborate with other government departments so that green burial can gradually become the preferred option of the public when they handle cremated ashes.

375. In this light, the Office considered that the Government should strengthen publicity and public education such as coordinating relevant departments or public organisations to hold seminars or forums periodically (e.g. every quarter) for the public, inviting staff of the relevant government departments and professionals (such as legal consultants and funeral service providers) to explain the services relating to after-death

formalities and answer public queries so that members of the public can better understand after-death arrangements and relevant issues. Such seminars or forums can also serve as a platform for the public to reflect their views on the procedural arrangements for after-death formalities to the Administration.

376. Furthermore, the Government has amended relevant legislation to facilitate the choice of dying in place for terminally ill patients in prescribed residential care homes in accordance with the wish and needs of the patients and their family. The amended legislation is intended for provision of quality and comprehensive end-of-life care for those patients, allowing them to spend their final days in a familiar place of their choice such as their home, an elderly home or a nursing home. The Office considered that relevant departments or authorities including HA should provide more information on dying-in-place for users of prescribed care homes so that the public can better understand the new arrangements in the amended legislation.

Considering the provision of additional storage facilities for dead bodies in mortuaries

377. According to the data provided by DH, taking into account the population growth and the number of deaths in Hong Kong, it is estimated that the public mortuaries in Hong Kong will need to provide a total storage capacity of about 1 300 bodies by 2031 to meet the projected demand. DH has already reprovisioned the Fu Shan Public Mortuary in 2022 and plans to reprovision the Victoria Public Mortuary, so as to increase the total storage capacity of public mortuaries to cope with the demand in the longer term. In addition, HA has been closely monitoring the utilization of hospital mortuaries and has indicated that it will rationalize the planning and increase the storage capacity of facilities for storing dead bodies.

378. The Office was of the view that with the growth and ageing population in Hong Kong, DH and HA should review the utilisation of mortuaries from time to time and consider in a timely manner the need to

increase the number of storage facilities for the dead in public mortuaries and hospital mortuaries to cope with the challenges that may arise in the future.

Formulating Emergency Plans for Public Services Relating to Formalities for After-death Arrangements

379. All the departments and the authority concerned should explore the formulation of an emergency response system and make good plans for risk management to prepare for any upsurge in demand for public services relating to after-death arrangements following major accidents or emergencies. Specifically, the government departments should plan for measures and coordination for provision of such public services in case of different emergencies to ensure that they could respond to such emergencies in the most efficient and quickest way.

380. Meanwhile, all the departments and the authority concerned should arrange regular staff training to increase their staff's alertness to emergencies of difficult magnitude and enhance the coordination and capability of the departments and the authority in providing public services relating to after-death arrangements. In the long run, they should also consider redeploying manpower or adding resources to meet the rising demand for public services relating to after-death arrangements in view of the ageing trend in Hong Kong's population.

381. The Office recommended DH, FEHD, HA and ImmD that –

(a) all the departments should discuss and examine the feasibility of developing a one-stop thematic website providing information about the public services provided by each of them regarding after-death arrangements;

(b) all the departments should explore using a one-stop thematic website to further digitalise public services relating to after-death arrangements. They should consider providing more electronic

application procedures and personalised services to make it more convenient for the bereaved;

(c) all the departments should examine how the content of the thematic website can meet the needs of people of different races and cultures;

(d) all the departments should consolidate previous experiences and explore the establishment of an emergency response system and implementation of relevant measures regarding provision of public services relating to after-death arrangements at the time of emergencies or major accidents to prepare for sudden challenges;

(e) all the departments should conclude previous experiences and arrange regular training to staff providing public services relating to after-death arrangements at the time of emergencies or major accidents, with the aim of increasing the staff's alertness and capability in handling emergencies of a sizeable magnitude; and

(f) all the departments and the authority concerned should be flexible in redeploying internal resources to meet the rising demand for public services relating to after-death arrangements alongside the ageing trend in Hong Kong's population.

The Office recommended that FEHD and the department or authority concerned –

(g) should organise seminars or forums to explain information and share experiences relating to after-death arrangements on a regular basis;

The Office recommended HA and the department or authority concerned –

(h) should provide more information on dying in place to their service users as well as giving more publicity to the new arrangements in the amended legislation that make it more convenient for patients to choose to die in place;

The Office recommended that DH –

(i) should regularly review the availability of body storage facilities in public mortuaries and consider installing additional units in response to the population growth and the ageing trend in Hong Kong;

The Office recommended that HA –

(j) should regularly review the availability of body storage facilities in hospital mortuaries and consider installing additional units in response to the population growth and the ageing trend in Hong Kong.

Government's response

382. DH, FEHD, HA and ImmD accepted the Office's recommendations and have taken the following follow-up actions.

Recommendations (a) to (c)

DH

383. Upon further discussion with the FEHD, the Port Health Division (PHD) of the DH obtained consent from FEHD for adding a hyperlink of "Application for Cremation Permit" under "A Guide for the Bereaved" on the FEHD's "After-Death Arrangements" Thematic Website to facilitate access by the bereaved to the Notes for Application of Cremation Permit and related information. The Thematic Website also sets out other major processes of after-death arrangements, providing the public with one-stop

information on after-death arrangements. The Thematic Website address is as follows: https://www.greenburial.gov.hk/afterdeatharrangements/en/step1/index.html

384. Apart from providing the existing Chinese and English versions of "Application for Cremation Permit", the PHD of the DH has included instructions in eight other ethnic minority languages in the application form to help various ethnic groups to complete the application. The DH will upload the instructions in ethnic minority languages to the one-stop online platform when it is officially launched for reference by the bereaved of different ethnic groups.

FEHD

385. Before receiving the recommendation of the Office, FEHD had initiated to construct a Platform for Cemeteries and Crematoria Services. This one-stop portal provides the public a single integrated platform to apply for all cemeteries and crematoria services provided by FEHD, making it easier and more convenient for the public to handle the affairs of the deceased. The public members can apply for cremation services, allocation of public niches, cemetery services, green burial and Internet Memorial Service through this platform. The platform also includes booking of cremation services, online application for allocation of public niches, online payment for temporary storage of ashes, and cemetery and crematorium fees. These services were made available on the platform in two phases. The first phase was launched in late October 2024, covering online booking of cremation sessions. The second phase had been launched in March 2025, expanding to other cemetery and crematorium services.

386. At the same time, FEHD had launched a new thematic website on "After-death Arrangements" (Thematic Website) in November 2024 to provide the public with a convenient channel to understand practical information on after-death arrangements such as various options and relevant application procedures, covering death registration, funeral

arrangements, burial or cremation of remains, green burial or placement of ashes in niches and other ways of handling the ashes of the deceased. The list of licensed funeral parlours and undertakers and registered masons and marble contractors has been uploaded for public reference.

387. To cater for the needs of different ethnic groups and cultures, in addition to the existing Chinese and English versions of the Thematic Website, FEHD is currently translating the content into eight minority languages (that is, Indonesian, Hindi, Nepali, Punjabi, Tagalog, Thai, Urdu and Vietnamese) to facilitate other ethnic groups to understand the after-death arrangements. Upon clearance by respective Consulates-General, the translated version is expected to be uploaded to the website in Q3 2025.

HA

388. HA will offer necessary facilitation and support to the development of the thematic website by providing information and content related to application for death documentation and body collection.

389. Moreover, under the coordination of the Digital Policy Office (DPO), HA, ImmD, DH and FEHD are planning the development of a one-stop web platform to streamline the application and processing of after-death related services through data sharing and digitalisation of relevant procedures, thereby facilitating bereaved families and the industry to handle relevant applications via electronic means while enhancing the operational efficiency of departments / organisation concerned. The departments concerned, HA and DPO have been working closely to iron out issues in taking forward the initiative, including seeking legal advice on necessary legislative amendments from the Department of Justice and acquiring funding for developing the one-stop web platform. Depending on the procedures and time required for legislative amendment, relevant departments / organisation will firm up the implementation details and timeline of the initiative.

ImmD

390. In response to the Office's observation that family members handling after-death arrangements had to click on the links to the websites of relevant departments one by one to look for information (for example the death registration related forms of ImmD) which was not easy to find, ImmD has optimised the website design of "Birth and Death Registration" so that the forms are now arranged and categorised in a clearer and more concise manner, making it easier for members of the public to access and download the forms required.

Recommendations (d) to (f)

DH

391. The Forensic Pathology Service (FPS) of the DH has reviewed the internal contingency plan for managing death upsurges during pandemics and updated the plan in May 2025. To ensure that all relevant mortuary staff are familiar with the internal contingency plan for managing death upsurges during pandemics, the FPS conducted a table-top exercise on 28 April 2025 and reviewed the internal contingency plan. A total of 29 FPS staff participated in the table-top exercise. In order to enhance the responsiveness to emergencies, FPS will continue to conduct the table-top exercise to ensure relevant mortuary staff are familiar with the internal contingency plan.

392. Likewise, to ensure that all relevant mortuary staff are familiar with the setting-up of modular refrigerated mortuary units, the FPS has conducted eight drills between January and August in 2025. The FPS has arranged for all relevant mortuary staff to complete at least one drill per year to enhance their responsiveness to emergencies.

393. For Recommendation (f), DH agrees with the recommendations of the Office and has conveyed the recommendations to middle and senior

staff to enhance their awareness of response measures and ensure appropriate follow-up actions.

FEHD

394. FEHD has formulated relevant contingency mechanisms, which will be reviewed from time to time and revised accordingly in light of the changing actual situation and service needs; FEHD will continue to arrange relevant training for its staff on a regular basis to enhance their crisis awareness and response capabilities; FEHD will review from time to time through additional allocation or internal redeployment of human resources, meet the foreseeable increase in service demand as Hong Kong's population ages.

HA

395. Based on past experience and the Office's recommendations, HA has reviewed and enhanced the contingency measures, in particular on roles and responsibilities delineation, strategies in maximising body storage capacities and the handling of body overflow beyond the capacity of HA's mortuaries, in order to address potential surges in demand of body storage. The contingency measures are subject to an annual review to ensure their relevance and effectiveness. Moreover, HA has also established designated communication channels with the relevant bureaux/departments to tackle the challenges presented by emergencies.

396. In the event of emergencies or major incidents leading to a surge in demand for death documentation service, the responsible department will internally redeploy staff from other posts and when necessary, request manpower support from other departments to meet service needs.

397. HA has established a structured training programme to enhance the capability of its staff in managing emergencies of varying complexities. The inaugural "Train-the-Line Coach Workshop: Relative-centric

Communication Training for Supporting Staff," organised by the HA Academy, was successfully conducted on 29 April and 8 May 2025.

398. In addition, hospitals will arrange for staff to work in rotation to gain experience in death registration service. Appropriate training will also be provided to strengthen the hospitals' talent pool and ability to respond to emergencies.

399. HA will monitor the demand for death documentation and body collection services, and will redeploy or allocate additional manpower resources as appropriate.

ImmD

400. ImmD has all along been maintaining emergency response mechanisms to ensure the continuity of public services under various emergency scenarios. Such mechanisms are reviewed regularly to ensure they are up-to-date and effective.

401. Death registration services provided by ImmD are not subject to prior appointment or quota limit, and all applications are processed within the same day. During the epidemic, the deaths registries continued to provide services and, in response to surged service demand for death registration, ImmD collaborated with DH and FEHD to extend the service hours of the Joint Offices for handling death registration and related matters from 25 March to 15 May 2022. The experiences gained and relevant records during that period provide valid references for future contingency planning and response. Moreover, on 31 March 2023, ImmD launched the online service for death registration, which allows greater flexibility in the provision of services during future emergencies or major incidents. To tie in with the emergency response mechanism for operations of death registration services, internal training is arranged by ImmD to ensure its staff are familiar with contingency arrangements and to enhance their emergency response capabilities.

402. ImmD reviews the manpower deployment and workflow for death registration services from time to time. In light of the ageing population in Hong Kong, ImmD will continue to closely monitor the service demand and operational situation, and make flexible manpower and resources deployment. Having regard to the actual circumstances, ImmD will consider applying for additional resources to ensure smooth delivery of the death registration service.

Recommendation (g)

FEHD

403. To facilitate the public's understanding about after-death arrangements, FEHD has been organising seminars related to such topics in different districts regularly since 2022. The seminars covered green burial services and facilities, allocation arrangements for public niches and regulation of private columbaria, and addressed public enquiries at scene. In addition, FEHD has been further promoting green burial and encouraging the public to plan ahead their after-death arrangements in the community since 2023 through various activities as follows –

(a) "Life and Death Expo" had been held in different community halls in the period from May to October 2023; and

(b) Through the interactive expositions in August and October of 2024 and March and May of 2025, speakers from the funeral industry, scholars, private cemetery management, non-governmental organizations, service users and other relevant stakeholders had been invited to introduce the procedures for handling the death of ancestors from different perspectives and explain how to make good plan ahead their after-death arrangements. After-death arrangement services agents had also set up booths attended by professionals and funeral industry operators, addressing concerns of the public at scene and providing practical information to the public.

404. FEHD will continue to launch a series of programmes to disseminate after-death arrangement information and promote green burial.

HA

405. HA regards the participation in relevant seminars and forums as an important means of community engagement and information dissemination. As such, HA will proactively send representatives to attend these events with a view to providing the public with professional explanations on procedures for obtaining death documentation and body collection.

ImmD

406. To enhance public awareness and education, ImmD, in addition to providing practical information on death registration to the public through the Internet and leaflets, also coordinates with the publicity efforts of other departments and organisation, including participating in seminars on post-death arrangements regularly organised by FEHD to explain information related to death registration and introduce relevant leaflet to the public.

Recommendation (h)

407. Facilitating terminal patients to die in place is an important policy initiative in end-of-life (EOL) care, which aims to respect patients' choice and enhance their quality of life during the final stages of their lives. To this end, HA actively takes forward EOL care services which are centred on patients and their family members, whereby patients' wishes are respected and appropriate support are provided. To foster cross-sectoral collaboration and exchange of experience, as well as to enhance the quality of service in Residential Care Homes for the Elderly (RCHEs) in terms of EOL care, dying-in-place and after-death arrangements, HA had organised a seminar titled "Journeying Together in the Last Voyage" on

21 March 2025. The seminar brought together approximately 1 000 participants from different sectors, including the Health Bureau, DH, Social Welfare Department, elderly healthcare service professionals, social service providers, RCHE operators and non-governmental organisations, fostering medical-social collaboration to support elderly to spend their last stage of life in peace in RCHEs. In addition, the HA has incorporated important topics, such as advance care planning and dying-in-place, etc., in a training programme for hospital volunteers on life and death education, which was held on 9 April 2025 with approximately 300 participants.

408. To enhance the understanding of EOL care by the public, patients and caregivers, HA launched another round of "Smart Patient Series" forums on life-and-death education in mid-2025. Healthcare professionals and patient caregivers were invited to engage with the public in a simple and easy-to-understand manner on life and death topics, covering areas such as advance preparation, palliative care and arrangement for dying-in-place. Moreover, the Patient Resource Centres of HA hospitals regularly organise life and death education talks and related activities for patients, caregivers, volunteers and patient groups. In 2025, a total of 55 programmes have been planned, including life-and-death education talks, workshops, visits, guided tours, group activities, exhibition booths, and other related resource-sharing initiatives. These programmes cover EOL care, sharing on Advance Medical Directives, Wills and Enduring Powers of Attorney, bereavement support, and funeral services, with an estimated number of over 5 000 participants. To further promote life-and-death education, HA has also arranged for healthcare professionals to publish monthly public education articles in newspapers from mid-2025 to mid-2027, focusing on topics related to palliative care and life-and-death education.

Recommendation (i)

409. The Victoria Public Mortuary (VPM) re-provisioning project was approved by the Finance Committee of the Legislative Council on 21 March 2025. After the re-provisioning, the VPM is expected to come into

operation by 2029-30, increasing the body storage capacity from 76 to more than 1 000 bodies (including fixed storage facilities for 358 bodies and modular refrigerated mortuary units for more than 750 bodies). By that time, the total capacity for public mortuaries under the DH can accommodate more than 2 000 bodies, which should be able to meet the overall demand of the society up to 2046 (with the projected ongoing ageing of the population and increasing mortality taken into account), and cater for the upsurge in demand amid epidemics. In the long run, the DH will continue to review the situation and draw up plans accordingly.

Recommendation (j)

410. HA attaches great importance to the management of hospital mortuaries. Trend analysis is conducted daily to monitor the overall usage, allowing for early intervention when necessary through internal communication and coordination across hospital clusters. The Mortuary Task Force under HA is responsible for overseeing mortuary service and will strengthen the review of service demand from an annual basis previously to a bi-annual basis to better plan for the operation of body storage facilities in hospital mortuaries. With the implementation of various hospital redevelopment and expansion projects, the number of body storage facilities in hospital mortuaries is also expected to increase.

Government Secretariat - Development Bureau, Buildings Department and Labour Department

Case No. DI/464 – Government's Regulation of Occupational Safety and Health in Construction Industry

Background

411. Engaging in works projects of different scales ranging from major infrastructures, public works[3], housing development and building repairs to small-scale flat renovation works, the construction industry makes significant contribution to the economic development of society and improvement of people's living environment. In recent years, fatal industrial accidents in construction works have occurred frequently, attracting widespread public concern. At present, the main legislation regulating occupational safety and health (OSH) includes the Occupational Safety and Health Ordinance (Cap. 509, Laws of Hong Kong), the Factories and Industrial Undertakings Ordinance (Cap. 59, Laws of Hong Kong) and their subsidiary regulations.

412. In this direct investigation operation, the Office of the Ombudsman (the Office) thoroughly examined various aspects of OSH in the construction industry, covering the Labour Department (LD)'s inspections and enforcement actions, monitoring of registered safety auditors and registered safety officers, regulation of high-risk operations, and follow-up action on accidents; the Buildings Department (BD)'s regulation of registered contractors; the Development Bureau (DEVB)'s monitoring of public works and contractors; the use of innovation and technology; safety education and training; as well as publicity and promotion.

[3] Public works refer to works carried out at construction sites under the Architectural Services Department, the Drainage Services Department, the Electrical and Mechanical Services Department, the Highways Department, the Water Supplies Department and the Civil Engineering and Development Department.

413. During the Office's direct investigation operation, the current-term Government has proactively introduced an array of improvement measures, which include amending the OSH legislation to increase the overall level of penalties for greater deterrent effect; revising various codes of practice to enhance technical requirements; conducting a number of special enforcement operations to curb unsafe operations; updating the content of mandatory safety training courses to raise workers' safety awareness; improving the mechanism for processing renewal of contractors' registration; formulating proposed amendments to the Buildings Ordinance to tighten the regulation of contractors; strengthening the regulation of contractors on the "List of Approved Contractors for Public Works" and the "List of Approved Suppliers of Materials and Specialist Contractors for Public Works" (collectively referred to as the "approved lists") with unsatisfactory safety performance; and making great efforts to promote the adoption of the Smart Site Safety System. The Government's endeavours are highly commendable.

414. Nevertheless, the Office continues to see occurrence of fatal industrial accidents, and the situation is worrying. Based on the Office's findings, the Office considered that there is still room for improvement in different areas on the part of the three authorities.

The Ombudsman's observations

(I) LD's Regulation of High-Risk Operations

Strengthening Monitoring of "Competent Persons" Engaging in Various High-risk Operations

415. The construction industry involves high-risk operations such as bamboo scaffolds (including truss-out scaffolds), suspended working platforms, lifting operations and confined spaces, which can only be carried out after a "competent person" or a "competent examiner" (collectively referred to as "competent persons") has certified their safety pursuant to relevant legislation.

416. The Office's investigation revealed a number of cases where the "competent persons" signed a prescribed form without properly inspecting the high-risk plant or machinery, or even signed the form in advance. In certain cases handled by LD and its inspections that the Office joined, a "Form 5" signed by a "competent person" certifying that a bamboo scaffold had been inspected and that it was in safe working order was displayed on the scaffold. However, the date of inspection shown on the form was a future date. There were also cases where a "Form 5" had already been signed before the completion of the bamboo scaffolding or no inspection date was recorded on the form. Obviously, in practice, "Form 5" is unable to show that the subject scaffold has been inspected and is in safe working order. Moreover, in its investigation into a fatal industrial accident concerning a lifting appliance, LD found that two registered professional engineers acting in the capacity of "competent examiners" signed prescribed forms certifying that the lifting appliance was in safe working condition, but they actually had not carried out the required tests and examination.

417. The Office understood that even with a full-fledged regulatory regime and diligent performance by all parties, accidents cannot be completely avoided. That said, some "competent persons" did fail to carry out inspections or examinations properly but irresponsibly signed forms to certify the safety of the equipment. Such reckless acts put the safety of workers and the public at risk. These persons failed to live up to their obligation and the public's expectation, and should be ashamed of themselves for failing on their part as professionals.

418. LD has put in place codes of practice for different kinds of high-risk operations to provide guidelines on how "competent persons" should carry out inspections or examinations, but the codes of practice generally do not contain any inspection checklists. The Office recommended that LD explore formulating templates of inspection checklist for different types of high-risk operations and attach them to the relevant codes of practice for use by "competent persons" during inspections or examinations to tighten control.

419. The prevailing legislation only requires various kinds of "competent persons" to sign a prescribed form to state the result of inspection or examination, i.e. whether the plant or machinery is in safe working condition, and to deliver the signed form to the contractor for record and inspection by LD's occupational safety officers (OSOs) upon request. As regards the actual inspection or examination records of "competent persons", LD's requirements for various kinds of high-risk operations differ pursuant to the risk-based principle. "Competent persons" should base their judgement on facts and evidence, and they should provide evidence to prove that they have duly conducted the inspection or examination. The Office recommended that LD should conduct a comprehensive review of the existing requirements for maintenance of inspection records by "competent persons" regarding different types of high-risk operations, specifying the inspection records to be maintained and the need to produce such records upon the instruction of LD officers.

420. Furthermore, the Office is of the view that LD should consider implementing a random checking system to examine the inspection records of "competent persons" during visits to construction sites so as to enhance monitoring. In case of any breach of OSH legislation by "competent persons" found, LD should continue to take stringent enforcement actions. Apart from instituting prosecutions, LD should also refer cases of misconduct of "competent persons" to the organisations responsible for their registration for examining their professional qualifications or taking disciplinary action. In the long run, LD should explore the development of an electronic platform for contractors and "competent persons" to upload inspection records and forms to facilitate monitoring and random checking so as to curb unprofessional or even fraudulent conduct such as filling in the inspection date in advance.

Utilising Experience from Special Enforcement Operations to Enhance Effectiveness of Routine Safety Inspections

421. In recent years, apart from various types of planned special enforcement operations as preventive measures, LD has also carried out a number of special inspection or enforcement operations subsequent to fatal industrial accidents. Each operation usually lasted for two weeks during which LD would intensively conduct a round of territory-wide inspections at construction sites undergoing the same work processes involved in those accidents. LD's operations have revealed multiple cases of irregularities and on each occasion, LD issued a large number of statutory notices and instituted prosecutions, reflecting serious non-compliance in the industry.

422. In the Office's opinion, LD should examine how to utilise the experience gained in the special enforcement operations against high-risk operations in further enhancing the effectiveness of routine safety inspections so as to identify and handle unsafe operations in construction sites as soon as possible.

(II) LD's Inspections

Reviewing Guidelines on Inspections

<u>In-depth Surprise Inspections</u>

423. LD arranges in-depth surprise inspections to construction sites with poor safety performance and suspected deficiencies in the safety system. In one case, LD had conducted an in-depth surprise inspection at a construction site and issued a number of improvement notices and instituted prosecutions, but a fatal incident of falling from height still happened. There is another case where LD had received many complaints and issued a number of improvement notices within two years prior to the fatal accident, and the construction site involved incidents resulting in injuries. Yet, LD still did not conduct any in-depth surprise inspection.

424. LD puts in a great amount of resources in conducting in-depth surprise inspections and should strive to ensure their effectiveness. The Office recommended that LD review the operational guidelines on the conduct of in-depth surprise inspections for more precise selection of high-risk construction sites and proper follow-up on sites inspected to ensure systemic improvement of site safety.

Area Patrols

425. As LD may not be notified of some renovation and repair works under the notification mechanism, its OSOs conduct regular area patrols to inspect construction sites with higher risk (in particular those involving truss-out scaffolds) but not reported to the Department so as to ensure site safety. In this regard, LD has not issued any guidelines on how OSOs should identify high-risk construction sites systematically and prioritise the sites to be inspected. Hence, OSOs can only identify high-risk sites by their own professional judgement and prioritise the sites according to the risk-based principle. The Office recommended that LD should provide guidelines on area patrols to OSOs to guide the identification of construction sites with higher risk for inspection.

Improving Site Inspection Records and Their Compilation

426. When inspecting construction sites, LD's OSOs record results of inspections and follow-up recommendations on inspection worksheets, site information tables, machinery lists, inspection checklists and file notes. Having scrutinised the files provided by LD, the Office noticed that not all OSOs would complete the inspection checklists and that the file notes were very brief, usually containing only the number of workers and a general description of the processes undergone at the construction sites. However, the work processes, equipment and documents that had been inspected were not specified, and the inspection results were not recorded.

427. In the Office's view, the inspection records currently compiled by LD officers are too brief to provide an objective basis to facilitate internal

review for improving the inspection quality. To ensure effective monitoring through inspections, LD should remind OSOs of the importance of proper compilation of inspection records and provide guidance on ways of improvement so as to facilitate examination of the inspection quality by the management.

428. Further, there was a case where a subcontractor had failed to conduct safety audit as required by law and no safety committee was set up. However, the OSOs had not noticed these breaches during routine inspections. The Office believes that this has to do with the absence of the item "Safety Committee" on the existing inspection checklist such that the OSOs omitted to check for compliance during inspections. LD should thoroughly review and improve the inspection checklist to ensure that all important items are included, and require OSOs to record the results of each item during inspections.

429. During the Office's site inspections with LD, the Office noticed that OSOs would make records of various items of information on paper and take photographs. Upon returning to office, the OSOs would tidy up the inspection records using computer, and the records would then be printed in physical file and submitted to senior officers for approval. Besides, when compiling certain statistical figures, LD has to collect and collate reports from frontline staff of different districts. The process consumes manpower resources. The Office considered that LD should review the process of reporting work by OSOs to identify areas for streamlining, and explore how to utilise information management systems to reduce document processing for efficiency enhancement. Furthermore, as the current-term Government is vigorously pursuing the development of digital government, LD should explore wider use of advanced technology and procurement of suitable electronic products to facilitate inspections and enforcement actions by frontline staff.

Selecting Suitable Construction Sites of Private Developments for Participating in Meetings of Safety Committees

430. Where the number of workers employed for a construction site or the contract value of a construction works project reaches a prescribed number or amount, the contractor is required by law to set up a safety committee. Offering a platform for the principal contractor, subcontractors, registered safety officers, worker representatives, etc. to exchange views on OSH matters, the safety committee plays an important role in ensuring OSH of construction sites. The contractor should make sure that the committee holds a meeting at least once every three months. The Office's case studies revealed that some subcontractors failed to set up a safety committee while some were frequently absent from meetings of the safety committee. These examples show that some contractors ignore the importance of safety committees.

431. LD assesses the compliance with the requirement of setting up safety committees through vetting the audit reports compiled by registered safety auditors and checking the minutes of meetings of safety committees during OSOs' site inspections. In the Office's view, LD's current monitoring places too much emphasis on checking of documents and is of limited effectiveness. LD should consider devising a mechanism for selecting suitable construction sites of private developments to participate in meetings of safety committees, so as to stay in tune with the safety risks of the sites and give advice and urge contractors to manage site safety.

Enhancing Statutory Notification Mechanism for Construction Works As Soon As Possible

432. Under the current legislation, contractors are required to notify LD of construction works which has a construction period not less than six weeks and employs more than ten workers, within seven days after the commencement of the works. Having analysed previous fatal industrial accidents in the construction industry, LD found that many of them involved high-risk operations of a shorter construction period or hiring a

small number of workers. In this light, LD started in 2021 to formulate a proposal to expand the scope of statutory notification of construction works and to shorten the time frame for such notifications. The Office recommended that LD should continue to pursue the legislative amendment work to enhance the statutory notification mechanism for construction works.

Reviewing Methods of Calculation and Maintenance of Data Regarding Construction Sites and Inspections

433. Upon receipt of a contractor's statutory notification of construction works, the OSOs of LD are required to conduct the first inspection within a stipulated period and give specific OSH advice according to the situation of the site. Without a designated office to coordinate the processing of notification forms received, LD has not maintained the number of construction sites reported under the statutory notification mechanism. Nor has LD compiled the compliance rate for the conduct of the first inspection, making it difficult to monitor staff's performance. The Office recommended that LD should maintain the number of construction sites reported under the statutory notification mechanism through an information computer system, and compile the compliance rate for the conduct of the first inspection for monitoring purposes.

434. Meanwhile, LD currently maintains only the number of routine safety inspections conducted but not the corresponding number of construction sites inspected. Also, the inspection figures are calculated on the basis of the number of LD staff involved in the inspections. In the Office's view, such calculation method could not demonstrate the relationship between the actual number of inspections conducted and the number of construction sites involved. Moreover, while LD has maintained data on the number of unfinished construction works (a total of 35 971 construction sites as at the end of 2024), no breakdown figures on "new works" and "renovation and repair works" are available. The Office does not find LD's current mode of data calculation and maintenance

useful for analysis purposes. LD should review and improve the current mode of calculation and maintenance of data regarding construction sites and inspections to ensure effective analysis for formulation and adjustment of work strategies.

(III) LD's Enforcement Actions and Prosecutions

Taking More Proactive Steps to Handle Construction Sites Subject to Multiple Improvement Notices

435. In case of irregularities found, LD will issue an improvement notice to the contractor concerned to demand rectification. A case shows that LD had repeatedly issued improvement notices to a contractor regarding unsafe operations of different situations of work-at-height prior to the occurrence of a fatal accident. But the contractor still had not made improvement and the fatal accident of falling from height happened. In the Office's opinion, when the same kind of irregularities (such as unsafe operations of work-at-height) has been found repeatedly in a construction site, LD should, in addition to issuing improvement notices to demand rectification of individual irregularities, strengthen the intensity of enforcement and even adjust its strategies so as to urge systemic improvement of the construction site.

Ongoing Review of Penalties for Convicted Cases

436. The average amounts of penalty imposed on offenders of OSH legislation in the construction industry between 2018 and 2023 ranged from $8,127 to $10,522, which is obviously inadequate to bring about deterrent effect. Among those offenders, the two contractors having the largest and the second largest numbers of convictions during the six years had been convicted for 77 and 56 times respectively. This reflects that some contractors in the construction industry are repeated offenders, and their disregard for OSH was indeed staggering.

437. The Office is pleased to learn that the Occupational Safety and Occupational Health Legislation (Miscellaneous Amendments) Ordinance 2023, which took effect on 28 April 2023, has significantly increased the penalties for contravention of OSH legislation and extended the time limit for prosecution, so as to enhance the deterrent effect and allow LD more time to collect evidence. Since the new penalty levels had taken effect for only a short period of time, data on LD's prosecutions brought under the amended legislation and court sentence is limited. For the time being, the Office was unable to comment on the deterrent effect of the new penalty levels. As the construction industry has still recorded fatal industrial accidents from time to time, LD should take stringent enforcement actions and make good use of the extended time limit for prosecution to collect evidence as well as institute prosecutions against suitable cases on indictment to increase the deterrent effect. Moreover, LD should, after the new penalties for OSH offences have been in force for a period of time, conduct a systemic analysis to review its prosecution work and the penalties imposed by the Court in convicted cases.

(IV) LD's Monitoring of Registered Safety Auditors and Registered Safety Officers

Taking More Proactive Steps to Monitor Registered Safety Auditors And Registered Safety Officers

438. For larger-scale construction sites, contractors are required by law to employ a full-time registered safety officer to assist in promoting the safety and health of employees in the construction sites. The contractors are also required to appoint a registered safety auditor to carry out safety audit of the site's safety management system at least once every six months and to make recommendations for improvement to the contractors. These two types of safety personnel are required to obtain registration from the Commissioner for Labour.

439. LD will put any safety personnel in a monitoring list for one year if the safety personnel fail to properly perform their duties; serious or fatal

industrial accidents have taken place at the construction sites where they work; they have been complained against for their performance or professional conduct; or LD has conducted in-depth surprise inspections at the construction sites where they work.

440. Our case studies revealed that LD's monitoring of registered safety auditors and registered safety officers on the monitoring list has been very passive. For example, after the occurrence of fatal accidents, LD only interviewed once the registered safety officers on the monitoring list because the registered safety officers had resigned or taken up other positions and no longer worked as safety officers. After one-year monitoring, LD removed the safety officers from the list in the absence of obvious inadequacy found on the part of the safety officers. Similarly, when handling registered safety auditors on the monitoring list, LD was more concerned whether they have notified the Department of the commencement or completion of safety audit and submitted an audit report in a timely manner. The Office reckoned that LD should consider taking more proactive steps in following up on the performance of registered safety auditors and registered safety officers on the monitoring list by, for example, making close observations of their actual performance at construction sites and careful examination of the reports they submit so as to enhance the quality of their work.

441. Meanwhile, LD assesses whether registered safety auditors have duly performed their duties by scrutinising the safety audit reports submitted and inspecting the conduct of safety audits by registered safety auditors. Between 2018 and 2023, LD received a yearly average of 3 253 safety audit reports involving 1 844 construction sites. During the period, LD, however, had only inspected four times the conduct of safety audit by registered safety auditors. In the Office's view, the number of site visits made by LD was too low even taking into account the impact of the pandemic on its work. It would be difficult for LD to exercise comprehensive and effective regulation simply by examining the reports compiled by registered safety auditors. LD should more proactively inspect the conduct of safety audit by registered safety auditors and

consider setting a percentage of random checks. By doing so, LD can alert registered safety auditors to its random checks on their work in order to urge upon them the need to carefully perform their duties. It can as well enable LD to monitor safety auditors' performance and give advice on any areas for improvement through means other than scrutiny of audit reports.

Assisting Registered Safety Auditors and Registered Safety Officers to Enhance Quality of Work

442. Having examined a number of fatal accidents, the Office noticed that many of them are attributable to irregularities in site operations which were not easily detectable from routine safety inspections and such irregularities resulted in unsafe situation. The Office considered that LD should, drawing on the painful lessons from previous fatal accidents, remind site personnel including registered safety officers and registered safety auditors of the issues to which they should pay attention during routine inspections or safety audit so as to strengthen their ability to detect irregularities in site operations and enhance the quality of their work.

(V) BD's Regulation of Registered Contractors

Omission of LD's Referrals for Consideration of Disciplinary Action

443. BD and LD have established a referral mechanism for disciplinary action against registered contractors with poor performance in construction safety. According to relevant guidelines, BD considers two criteria in determining whether disciplinary action should be taken against a registered contractor: the contractor has been convicted of five or more site safety offences relating to building works in the same construction site in six consecutive months (Criterion 1); or the contractor has been convicted of site safety offences relating to building works which involved serious accidents (including death, amputation of limbs or serious damage to works or property) (Criterion 2).

444. Our investigation revealed that BD had taken disciplinary action against a registered contractor in only one case between 2011 and 2021. Against the annual average of 20 fatal industrial accidents in the construction industry and even though not all such accidents related to building works, the caseload of disciplinary action taken by BD obviously could not reflect the actual situation. In fact, as revealed in the nine convicted cases that the Office randomly selected from LD's referrals to BD between 2012 and 2014, which were all fatal accidents relating to building works (i.e. cases meeting Criterion 2), BD had failed to take necessary follow-up action.

445. The Office is glad to see that BD has responded positively to the Office's observations by taking the initiative to clarify with LD the procedures for provision of information under the referral system and striving to process cases previously omitted. BD has now proactively requested LD to provide details of 58 convicted cases of site safety offences relating to building works and fatal incidents. The Office recommended that BD should speed up processing of the cases previously omitted and promptly refer those warranting disciplinary action to the Registered Contractors' Disciplinary Board so as to bring non-compliant contractors to account.

Cumbersome Procedures of Disciplinary Action

446. As regards the only case that BD had taken disciplinary action between 2011 and 2021 mentioned above, it took more than six years from the occurrence of the fatal accident to BD's completion of disciplinary action. The Office examined the sequence of events of this case and found delays in different time points. The Office is glad to note that BD agreed with the Office's observations that improvement should be made to enhance efficiency. BD has put in place new arrangements since October 2023 and implemented time indicators for handling cases of disciplinary action since early 2025. The Office recommended that BD should set up a mechanism for internal monitoring to ensure timely follow-up on all

referrals from LD for consideration of disciplinary action against convicted contractors.

447. On 31 December 2024, DEVB launched a public consultation exercise for proposals to amend the Buildings Ordinance. Some of the proposed amendments related to enhancement of the disciplinary system, which include simplifying the composition of the disciplinary boards of registered contractors and increasing the maximum fine for disciplinary sanction from $250,000 to $400,000. The Office reckoned that these proposed amendments should be able to enhance the deterrent effect. DEVB and BD should expedite the amendment to the Buildings Ordinance to enhance the disciplinary system.

Reviewing the Criteria for Taking Disciplinary Action

448. The referral mechanism established with LD has been in place since 2002. In more than 20 years from 2002 to 2023, BD had identified only three cases that met Criterion 1 for consideration of disciplinary action. This shows that the threshold is too high to serve its purpose. In particular, this criterion only deals with a contractor's convictions relating to one single construction site, barring circumstances where a contractor has repeatedly contravened OSH legislation in different construction sites. In the Office's view, BD should review Criterion 1 under the disciplinary system and consider whether the threshold should be lowered for more effective prevention.

Exploring Closer Collaboration with LD on Accident Investigations

449. Fatal industrial accidents in the construction industry may result in prosecutions instituted by LD pursuant to OSH legislation, and if they are related to building works, BD may also institute prosecutions under the Buildings Ordinance. While the focus of follow-up actions by BD and LD vary, there is room for collaboration between the two departments on investigation of facts including the cause of accidents. The Office noted that in recent years BD and LD have enhanced their collaboration in this

regard. The Office recommended that BD and LD explore any room for further collaboration on accident investigations to enhance the efficiency and effectiveness of their investigation work.

(VI) DEVB's Monitoring of Public Works

450. Relevant data shows that site safety has obviously been better maintained in public works than in the entire construction industry. While it is not by luck but achieved by effective regulation, the Office considered that there is still room for improvement.

Adequate Consideration Not Given to Contractors' Previous Performance of Site Safety under Tender Evaluation System for Public Works

451. The Office randomly selected 12 public works projects involving fatal industrial accidents between 2020 and 2023 and examined the scores that the contractors concerned (i.e. the successful tenderers) were given regarding site safety performance in the tender evaluation. The Office found in many contracts that the successful tenderer was given a rather low score regarding site safety performance, and some were even given the lowest score among all the tenderers. Yet, given other considerations in the tender evaluation, those successful tenderers still managed to win the bid because of their higher scores in respect of the tender price or technical performance. The score gaps regarding site safety performance among tenderers were insignificant.

452. Although the Office found no systemic occurrence of "the lowest bid wins" situation in the tender evaluation of public works, the Office's case studies did show that adequate consideration had not been given to tenderers' previous performance of site safety. The reason is that items relating to site safety did not weigh much and the score gaps between tenderers were narrow, thereby bringing insignificant impact on the overall outcome. During this direct investigation operation, DEVB introduced a new tender evaluation system whereby a merit or demerit point would be applied having regard to the tenderer's previous performance of site safety.

The Office recommended that DEVB should continue to review the tender evaluation system for public works in a timely manner to ensure that only contractors whose performance meets the safety standards would be awarded contracts.

Reviewing Requirements for Taking Regulating Action against Public Works Contractors

453. Under the existing regime, DEVB may initiate a panel of enquiry and take regulating action against a contractor on the approved lists if the contractor: (1) has recorded serious incidents[4] in the construction sites under its operation (regardless of whether the incidents took place in the construction sites of public works or private development projects); or (2) has convicted of five or more site safety offences in any six-month period. The second regulating requirement aims to allow early intervention by relevant departments to urge contractors with poor safety performance to adopt improvement measures so as to avoid more serious accidents. Between 1999 and 2008, there were 27 regulating actions taken in accordance with the second regulating requirement. The number of such actions drastically dropped to one between 2009 and 2018, and further dropped to zero between 2019 and 2023. This shows that the threshold may be too high for accident prevention.

454. The Office is pleased to note that DEVB introduced a new measure in July 2023 to require that any contractors on the approved lists having recorded dangerous occurrences[5] in their construction sites (regardless of whether the accidents took place in the construction sites of public works or private development projects) must conduct an independent safety audit to review its safety management system. In the Office's opinion, such amendment can help the authorities to address the safety risk of contractors as early as possible. That said, the number of

[4] Serious incidents refer to fatal incidents, amputation due to serious injuries, etc.

[5] Dangerous Occurrences refer to those set out in Schedule 1 to the Factories and Industrial Undertakings Regulations or those in Schedule 1 to the Occupational Safety and Health Ordinance. For example, collapse of a crane or any part thereof used in raising or lowering persons or goods; or the overturning of a crane; electrical short circuit or failure of electrical machinery, plant or apparatus, attended by explosion or fire or causing structural damage thereto.

fatal industrial accidents has not dropped, with six recorded for construction sites of public works in 2023. The Office considered it necessary for DEVB to continue to review the regulating requirement regarding contravention of legislation related to site safety for more effective prevention of accidents.

Instructing Works Departments to Learn from Previous Accidents and Strengthen Monitoring of Site Safety

455. The Office examined three fatal accidents taken place in the construction sites of public works projects. According to LD's accident investigation reports, there were a number of obviously unsafe operations but they went unnoticed. Works departments are duty bound to ensure site safety of public works projects. The Office noted that, after occurrence of serious incidents, DEVB would issue safety alerts to works departments and request them to convene seminars to share the circumstances of the serious incident and improvement measures implemented with all other works departments. DEVB's management also holds regular meetings with the heads of works departments to review cases of serious incident, discuss improvement measures and supervise their implementation.

456. In the Office's view, conducting post-incident reviews and taking remedial measures are of paramount importance. DEVB should continuously instruct all works departments to learn from previous accidents and stringently monitor the site safety performance of contractors to ensure safety.

(VII) Use of Innovation and Technology

Encouraging and Supporting Wider Use of Smart Site Safety System

457. In recent years, DEVB has made great efforts to promote wider use of the Smart Site Safety System in the construction industry to provide workers with a safer working environment. Relevant data show that the adoption of the Smart Site Safety System has contributed to improvement

in site safety in public works projects. DEVB and the Construction Industry Council (CIC) have also implemented various measures to promote the use of the Smart Site Safety System in private development projects. The Office recommended that after various promotional measures have been implemented for a period of time, DEVB reviews the adoption of the Smart Site Safety System and, with reference to the feedback from the industry, makes greater efforts to encourage and support wider use of the system in private development sites so as to enhance site safety by means of technology.

Investigating the Cause of Accidents in Public Works Project Sites with Full Adoption of Smart Site Safety System

458. Meanwhile, there were accidents in certain public works project sites where the Smart Site Safety System has been fully adopted. In the Office's view, DEVB should thoroughly examine the causes of those accidents to identify the problem, implement improvement measures and share the lessons learnt with the industry, thereby maximising the effectiveness of the system in preventing accidents.

(VIII) Safety Education and Training

Exploring Extension of Safety Training in Public Works to Private Works Projects

459. Our case studies of fatal accidents revealed inadequate safety training for site personnel of private works projects including workers and foremen. For example, a worker was not provided specific training for working on bamboo scaffolding, and the foremen of the principal contractor failed to supervise the worker on the day of accident. A foreman of a contractor revised the design of installation of stanchion on his own and failed to monitor the installation of stanchions. A worker operating drilling units simply relied on his own experience to determine the progress of drilling and the control of air pressure. A worker was not provided with

safety training on the lifting of deck panels by the contractor and no personnel was arranged on the site to guide and supervise the worker.

460. Industrial accidents and resultant casualties are obviously less serious a problem in public works than in the entire construction industry. The Office reckoned this may be attributable to the safety training of public works projects. The Office recommended that DEVB share with CIC the experience of safety training in public works for its consideration of offering subsidies as incentive, with a view to extending such safety training to private works projects to enhance site safety.

Stepping up Monitoring of Mandatory Safety Training Courses

461. By law, construction site workers and workers engaging in specified high-risk industries, high-risk activities or machinery operation must attend mandatory safety training courses recognised by LD and obtain the relevant certificate. Apart from vetting applications for recognition of mandatory safety training courses and nominated trainers, LD also conducts surprise checks and handles complaints to ensure the quality of course providers and trainers. In 2024, LD announced a number of cases involving serious irregularities. While LD has taken necessary actions, such cases inevitably affect public confidence in the quality of course providers and even the personnel working in the construction industry.

462. As an important part of LD's education and training strategy, mandatory safety training courses are crucial to improving OSH in the construction industry. The Office recommended that LD should step up the monitoring of course providers and trainers engaging in mandatory safety training courses and carry out surprise checks in a timely manner to ensure their quality. In case of irregularities, LD should be decisive in taking regulatory action.

Continuously Enriching the Content of Safety Training Courses

463. LD conducts routine safety inspections to construction sites and investigates the cause of accidents after their occurrence. The Department has a full grasp of the safety performance of frontline site workers, and such information and analysis are very useful reference for training. The Office recommended that LD continue to share with CIC and the Occupational Safety and Health Council (OSHC) its observation from routine inspections and enforcement actions as well as lessons learnt from accidents for designing or reviewing the content of safety training courses.

(IX) Publicity and Promotion

Coordinating Release of Information on OSH in Construction Industry

464. Currently, LD, BD, DEVB, OSHC, CIC and the Property Management Services Authority (PMSA) are among the government departments and public organisations participating in the promotion of OSH in the construction industry. Each of them releases information through their website on their own. With no coordination, the Office finds current information rather disorganised. It may be difficult for the industry and the public to look for the information they need, thereby undermining the dissemination of messages.

465. In the Office's view, LD being the primary department responsible for the regulation of OSH in the construction industry should consider coordinating efforts of relevant departments and organisations to set up a thematic website on OSH in the construction industry to provide a convenient platform for various stakeholders and the public to look for information they need, saving them troubles of checking different channels. The Office believes that setting up a thematic website on OSH in the construction industry can facilitate publicity and promotion among stakeholders. Recognising that setting up a one-stop website is a complicated task requiring massive resources and coordination, the Office opined that LD may, as a short-time measure, consider providing on its

website hyperlinks to information from various departments and organisations in a systematic manner, categorised by topics relating to OSH in the construction industry, for reference by stakeholders and members of the public.

Raising Awareness of OSH in Renovation and Repair Works

466. Between 2018 and 2023, there were 45 fatal accidents relating to renovation and repair works in total, accounting for a significant 42% of the total number of fatal accidents (i.e. 108 cases) in the construction industry. Renovation and repair works for buildings often involve truss-out scaffolding which is a high-risk operation. Yet, as renovation and repair works usually require a shorter construction period and fewer workers to complete, they are often not subject to statutory notification to LD.

467. Based on the case studies of fatal accidents and LD's site visits that the Office joined, the Office's investigation identified many safety issues associated with renovation and repair works. Workers showed inadequate safety awareness, which was reflected in their failure to wear a safety helmet, or their wearing a full body harness in a wrong way or even not wearing it. No "competent person" monitored scaffolding by workers on the site. Eye bolt was not examined by a "competent examiner". Staff of property management companies (PMC) and residents did not know about the safety requirements for scaffolding. All these reflect serious inadequacies of safety measures for renovation and repair works and a lack of safety awareness among workers and even PMC and residents.

468. Of the 45 fatal accidents relating to renovation and repair works between 2018 and 2023, only 16 cases (36%) were reported via the statutory notification mechanism to LD for commencement of works prior to the accidents as required by law. As regards the remaining 29 cases (64%), LD had not received any voluntary notification. In the Office's view, LD should step up its publicity and encourage owners' corporations,

owners and residents engaging in renovation and repair works to notify LD of such works via PMC for timely action by LD.

469. The Office recognised the sheer volume of renovation and repair works undergoing throughout the territory. In 2024, LD received a total of 9 179 notifications of works from the Hong Kong Association of PMC Limited and the Housing Department. LD alone can hardly ensure the safety of this kind of works, and PMC, owners' corporations and residents should also take part in the monitoring. Nevertheless, based on the Office's observation, members of the public have very limited understanding of their legal liability concerning renovation and repair works and the risk of claims arising from such works, mistakenly believing that only contractors would be liable. Although LD's leaflets do mention that PMC, owners' corporations and residents may be legally liable to any accidents involving casualties that arise from renovation and repair works of buildings or flats and the pertinent claims, the Office has reservation whether the message has been effectively conveyed to the public.

470. The Office considered that LD should step up publicity and education among owners, owners' corporations, PMC and residents through mass media and the platform of PMC, stressing in particular their legal liability in relation to renovation and repair works and the legal consequence and loss in case of accidents. This is to ensure these stakeholders understand that it is in their interest to protect the safety of workers, and at the same time give them an incentive to engage contractors with good safety record.

Utilising Lessons Learnt from Accidents

471. Currently, LD informs the public and the industry of the cause of fatal accidents and preventive measures by way of Work Safety Alerts and Accident Casebooks. For more effective sharing of lessons learnt from accidents, thereby educating different stakeholders on how to fulfil their responsibilities properly, the Office recommended that LD should enrich the content of the publications and information on analysis of accidents,

adding the role and responsibility of various stakeholders and how they can avoid accidents.

472. The Ombudsman recommended LD to –

(a) explore formulating templates of inspection checklist for different types of high-risk operations and attach them to the relevant codes of practice for use by "competent persons" during inspections or examinations to tighten control;

(b) conduct a comprehensive review of the existing requirements for maintenance of inspection records by "competent persons" regarding different types of high-risk operations, specifying the inspection records to be maintained and the need to produce such records upon the instruction of LD officers;

(c) consider implementing a random checking system to examine the inspection records of "competent persons" during visits to construction sites so as to enhance monitoring;

(d) continue to take stringent enforcement actions against any breach of OSH legislation by "competent persons" if found. Apart from instituting prosecutions, LD should also refer cases of misconduct of "competent persons" to the organisations responsible for their registration for examining their professional qualifications or taking disciplinary action;

(e) in the long run, explore the development of an electronic platform for contractors and "competent persons" to upload inspection records and forms to facilitate monitoring and random checking so as to curb unprofessional or even fraudulent conduct such as filling in the inspection date in advance;

(f) examine how to utilise the experience gained in the special enforcement operations against high-risk operations in further

enhancing the effectiveness of routine safety inspections so as to identify and handle unsafe operations in construction sites as soon as possible;

(g) review the operational guidelines on the conduct of in-depth surprise inspections for more precise selection of high-risk construction sites and proper follow-up on sites inspected to ensure systemic improvement of site safety;

(h) provide guidelines on area patrols to OSOs to guide the identification of construction sites with higher risk for inspection;

(i) remind OSOs of the importance of proper compilation of inspection records and provide guidance on ways of improvement so as to facilitate examination of the inspection quality by the management;

(j) thoroughly review and improve the inspection checklist to ensure that all important items are included, and require OSOs to record the results of each item during inspections;

(k) review the process of reporting work by OSOs to identify areas for streamlining, and explore how to utilise information management systems to reduce document processing for efficiency enhancement;

(l) explore wider use of advanced technology and procurement of suitable electronic products to facilitate inspections and enforcement actions by frontline staff;

(m) consider devising a mechanism for selecting suitable construction sites of private developments to participate in meetings of safety committees, so as to stay in tune with the safety risks of the sites and give advice and urge contractors to manage site safety;

(n) continue to pursue legislative amendment work to enhance the statutory notification mechanism for construction works;

(o) maintain the number of construction sites reported under the statutory notification mechanism through an information computer system, and compile the compliance rate for the conduct of the first inspection for monitoring purposes;

(p) review and improve the current mode of calculation and maintenance of data regarding construction sites and inspections to ensure effective analysis for formulation and adjustment of work strategies;

(q) when the same kind of irregularities (such as unsafe operations of work-at-height) has been found repeatedly in a construction site, in addition to issuing improvement notices to demand rectification of individual irregularities, strengthen the intensity of enforcement and even adjust its strategies so as to urge systemic improvement of the construction site;

(r) take stringent enforcement actions and make good use of the extended time limit for prosecution to collect evidence as well as institute prosecutions against suitable cases on indictment to increase the deterrent effect;

(s) after the new penalties for OSH offences have been in force for a period of time, conduct a systemic analysis to review its prosecution work and the penalties imposed by the Court in convicted cases;

(t) take more proactive steps to follow up on the performance of registered safety auditors and registered safety officers on the monitoring list by, for example, making close observations of their actual performance on the site and careful examination of the reports they submit so as to enhance the quality of their work;

(u) more proactively inspect the conduct of safety audit by registered safety auditors and consider setting a percentage of random checks. By doing so, LD can alert registered safety auditors to its random checks on their work in order to urge upon them the need to carefully perform their duties. It can as well enable LD to monitor safety auditors' performance and give advice on any areas for improvement through means other than scrutiny of audit reports;

(v) drawing on the painful lessons from previous fatal accidents, remind site personnel including registered safety officers and registered safety auditors of the issues to which they should pay attention during routine inspections or safety audit so as to strengthen their ability to detect irregularities in site operations and enhance the quality of their work;

(w) step up the monitoring of course providers and trainers engaging in mandatory safety training courses and carry out surprise checks in a timely manner to ensure their quality. In case of irregularities, the Department should be decisive in taking regulatory action;

(x) continue to share with CIC and OSHC its observation from routine inspections and enforcement actions as well as lessons learnt from accidents for designing or reviewing the content of safety training courses;

(y) consider coordinating efforts of relevant departments and organisations to set up a thematic website on OSH in the construction industry to provide a convenient platform for various stakeholders and the public to look for information they need;

(z) as a short-term measure, consider providing on its website hyperlinks to information from various departments and organisations in a systematic manner, categorised by topics

relating to OSH in the construction industry, for reference by stakeholders and members of the public;

(aa) step up its publicity and encourage owners' corporations, owners and residents engaging in renovation and repair works to notify LD of such works via PMC for timely action by LD;

(bb) step up publicity and education among owners, owners' corporations, PMC and residents through the mass media and the platform of PMC, stressing in particular their legal liability in relation to renovation and repair works and the legal consequence and loss in case of accidents;

(cc) enrich the content of the publications and information on analysis of accidents, adding the role and responsibility of various stakeholders and how they can avoid accidents;

The Ombudsman recommended BD to –

(dd) speed up processing of the cases previously omitted and promptly refer cases warranting disciplinary action to the Registered Contractors' Disciplinary Board so as to bring non-compliant contractors to account;

(ee) set up a mechanism for internal monitoring to ensure timely follow-up on all referrals from LD for consideration of disciplinary action against convicted contractors;

(ff) review Criterion 1 under the disciplinary system and consider whether the threshold should be lowered for more effective prevention;

The Ombudsman recommended DEVB to –

(gg) continue to review the tender evaluation system for public works in a timely manner to ensure that only contractors whose performance meets the safety standards would be awarded contracts;

(hh) continue to review the regulating requirement regarding contravention of legislation related to site safety for more effective prevention of accidents;

(ii) continuously instruct all works departments to learn from previous accidents and stringently monitor the site safety performance of contractors to ensure safety;

(jj) after various promotional measures have been implemented for a period of time, review the adoption of the Smart Site Safety System and, with reference to the feedback from the industry, step up efforts to encourage and support wider use of the system in private development sites so as to enhance site safety by means of technology;

(kk) as regards public works project sites having records of accidents despite full adoption of the Smart Site Safety System, thoroughly examine the causes of the accidents to identify the problem, implement improvement measures and share the lessons learnt with the industry, thereby maximising the effectiveness of the system in preventing accidents;

(ll) share with CIC the experience of safety training in public works for its consideration of offering subsidies as incentive, with a view to extending such safety training to private works projects to enhance site safety;

The Ombudsman recommended LD and BD to –

(mm) explore any room for further collaboration on accident investigations to enhance the efficiency and effectiveness of their investigation work; and

The Ombudsman recommended DEVB and BD to –

(nn) expedite the amendment to the Buildings Ordinance to enhance the disciplinary system.

Government's response

473. DEVB, BD and LD accepted the Ombudsman's recommendations and have taken the following follow-up actions.

Recommendations (a) to (e)

474. LD has optimised the regulation of "competent persons", including –

(a) A working group was set up in July 2025 to formulate Inspection Checklist templates for high-risk operations for reference by "competent persons" during inspections or examinations and LD will incorporate them into relevant codes of practice or guidance notes in a timely manner. LD estimates that more than 10 Inspection Checklists will be formulated and consultation with representatives of the industries and professionals during the process will be required. The relevant work will be completed in phases;

(b) LD has started drawing up an Inspection Checklist for the code of practice relating to tower crane, which is expected to be completed in the second quarter of 2026. By then, LD will require contractors / owners of specific plant to maintain the Inspection Checklists issued by "competent persons" for random inspection by OSOs of LD during law enforcement;

(c) Special inspection exercise was conducted from January to May 2025 to combat and eradicate illegal activities such as issuance of false documents. LD is actively following up on the suspected false statements or documents identified during the exercise. The cases will be referred to relevant law enforcement agencies for follow-up should there be sufficient evidence;

(d) Keeping the compliance situation under monitoring and strengthening inspection and enforcement efforts;

(e) Reminding major PMC in writing in August 2025 of the legal obligations of competent persons in inspecting scaffolds as well as issuing "Form 5"; and

(f) Further reviewing the feasibility and cost of establishing an electronic platform for uploading the inspection records and approved forms in light of actual circumstances.

Recommendation (f)

475. LD has shared experiences on inspections, enforcement operations and accident investigations, etc. with frontline OSOs through various ways, including organising a sharing session on enforcement experience in respect of scaffolding safety in July 2025. LD will continue to organise sharing sessions of various themes to enhance the enforcement capabilities of frontline OSOs.

Recommendations (g) and (q)

476. LD has set up a working group and the first meeting was held in June 2025, in which the existing operational guidelines on the conduct of in-depth inspection were optimised and revised, including incorporating more objective indicators (such as the number of legal notices received by a particular site in a specified period) as one of the factors for selecting

construction sites. The revision work is expected to be completed in the first quarter of 2026.

Recommendation (h)

477. LD has set up a working group and the first meeting was held in June 2025 to draw up guidelines for identifying construction sites with higher risk during area patrols for compliance by frontline OSOs. The relevant work is expected to be completed in the first quarter of 2026.

Recommendation (i)

478. LD has been regularly circulating internal guidelines on compiling inspection records through e-mails to remind frontline OSOs to compile inspection records properly. LD has also required the management in internal meetings to remind and monitor frontline OSOs to ensure frontline OSOs' compliance with relevant guidelines. LD will also draw up administrative directives requiring more senior management officers regularly spot check inspection records to ensure compliance with requirements.

Recommendation (j)

479. LD has commenced the review and enhancement of the Inspection Checklist again in June 2025. The relevant work is expected to be completed within 2025.

Recommendation (k)

480. LD has confirmed the feasibility of optimising the existing intranet system and is following up on the necessary administrative procedures for the implementation. LD is also reviewing the process of reporting work by frontline OSOs so as to further improve work efficiency.

Recommendation (l)

481. LD conducted the first run of using small unmanned aircraft (SUA) to assist in incident investigation in April 2025 and will start using SUA for aerial photography to assist in evidence collection and law enforcement work in the second half of 2025.

482. Besides, LD will continue to explore the wider use of advanced technology and procurement of suitable electronic products to facilitate inspections and law enforcement by frontline OSOs, including exploring the adoption of speech-to-text technology to assist in statement taking, thereby improving the efficiency of frontline officers in evidence collection.

Recommendation (m)

483. LD has set up a working group in June 2025 to review the existing manpower and allocate resources for participation in the safety committees' meetings of private construction sites as well as to draw up guidelines for selecting private construction sites with high risk and poor safety performance and participating in their safety committees' meetings.

Recommendations (n), (aa) and (bb)

484. LD has introduced a series of measures to enhance OSH of Renovation, Maintenance, Alteration and Addition (RMAA) works, including –

(a) Studying the refinement of relevant statutory notification mechanism for construction works and assessing the feasibility of implementation with existing resources;

(b) It is clearly set out in the Code of Conduct and Best Practice Guide on Handling Scaffolding Works issued by the PMSA that, in respect of scaffolding works at individual flats, the flat owners or

their authorised persons have to submit an application to a licensed PMC and obtain a written permit before commencing such scaffolding works. In accordance with the above-mentioned requirements and under the promotion by PMSA, PMCs have strengthened the voluntary efforts on notification of the erection of truss-out scaffolds. Since 2023, the number of voluntary notifications received by LD has increased significantly;

(c) LD assisted PMSA in revising the Code of Conduct and Best Practice Guide on Handling Scaffolding Works in 2024, including (i) enhancing frontline property management personnel's understanding of safety of bamboo scaffolding work, thereby helping them monitor the bamboo scaffolding work within their properties; and (ii) reminding individual flat owners or their authorised persons to refer to the publicity leaflets issued by LD on RMAA works (including scaffolding work) to alert the flat owners to the legal consequences and losses that may arise from accidents;

(d) Collaborating with PMSA to organise seminars to specifically promote safety in RMAA works and work-at-height, (including scaffolding work) among property management personnel, fostering an OSH culture to prevent recurrence of accidents;

(e) The Code of Practice for Bamboo Scaffolding Safety has been updated in 2024 to strengthen the regulation of bamboo scaffolding work, including further specifying the training requirements of workers engaged in truss-out bamboo scaffold works to bolster safeguards for workers. Collaboration has also been made with the scaffolding and insurance industries as well as other stakeholders to enhance the occupational safety performance of the bamboo scaffolding industry, enabling employers in the industry to take out employees' compensation insurance at relatively reasonable prices;

(f) Strengthening efforts to promote and explain relevant information to the participants of building management seminars and talks organised by the 18 District Building Management Liaison Teams across Hong Kong under the Home Affairs Department (HAD), including property owners and representatives of owners' corporations; and

(g) An inter-departmental/organisational meeting was held with the OSHC and HAD in June 2025 to discuss the publicity and promotion efforts in enhancing the OSH culture among members of the public. The participants reached a consensus to strengthen the existing collaboration, including enhancing participation in or organisation of activities to be held at community halls and service centres, in an effort to significantly step up publicity and education among property owners, owners' corporations, PMCs and residents.

Recommendation (o)

485. LD is optimising the existing information computer system and data entry procedures to (i) maintain the number of construction sites reported under the statutory notification mechanism; and (ii) record the compliance rate for the conduct of the first inspection to the relevant construction sites within a specified time. The optimisation work is expected to be completed within 2025.

Recommendation (p)

486. LD has started to collect the data in respect of the number of inspections broken down by the construction site since January 2023.

Recommendation (r)

487. LD has made every effort to make optimal use of the extended time limit for prosecution to collect evidence and has for the first time

taken out prosecution against the duty holder by way of indictment in 2024. LD will, as always, take out prosecutions against the relevant duty holders by way of indictment when sufficient evidence is available to show that individual cases could meet the prosecution threshold for "indictable offence".

Recommendation (s)

488. LD is collecting the sentencing data from the court for preliminary analysis after the OSH Amendment Ordinance came into effect. A systemic analysis will commence after the accumulation of sufficient data.

Recommendations (t) and (u)

489. LD is reviewing and optimising operational guidelines to enhance the quality of reports compiled by safety practitioners and monitoring in an effort to ensure their compliance with the requirements of relevant codes of practice/guidance notes. LD has also gradually increased the number of on-site inspections on registered safety auditors, stepping up random checks of their work. The above-mentioned work is expected to be completed within 2025.

Recommendations (v) and (x)

490. LD has issued Work Safety Alerts and Systemic Safety Alerts to registered safety officers and registered safety auditors via emails following fatal or serious accidents, enabling them to better comprehend how such accidents happened and the necessary safety measures to prevent their recurrence.

491. As far as routine inspections, law enforcement and occurrence of serious incidents are concerned, LD introduced Safety Hints/Messages in 2024, urging and reminding duty holders to pay attention and implement safety measures when conducting high-risk operations or operating mechanical facilities.

492. LD will continue with the above-mentioned work and disseminate OSH information to the industry and members of the public through various channels such as the LD's website and the "OSH 2.0" mobile application, so as to raise the awareness and standards of OSH among different sectors.

Recommendation (w)

493. LD is currently conducting a holistic review of the existing mandatory safety training system and will further enhance the monitoring mechanism on training course providers and trainers based on the review findings.

Recommendations (y) and (z)

494. LD will consider uploading the links of OSH information from various departments and organisations to the LD's website for reference by stakeholders and continue to strive to promote collaboration among different departments and organisations, so as to further step up the exchange and sharing of information. The relevant work is expected to be completed in the first quarter of 2026.

Recommendation (cc)

495. LD is enriching the content of the publications and information on analysis of accidents by including the roles and responsibilities of various duty holders.

Recommendation (dd)

496. BD has expedited the processing of a total of 58 cases related to building works involving fatal site accidents in the monthly summary of conviction records provided by LD from 2015 to 2023. As of 18 August 2025, excluding 26 cases where disciplinary action was not warranted after seeking legal advice, BD has referred 26 cases to the Registered

Contractors' Disciplinary Board for disciplinary actions and is currently consulting the Department of Justice (DoJ) on the remaining six cases for legal advice.

Recommendation (ee)

497. In early 2025, BD further strengthened the internal monitoring system for case handling. In addition to regularly monitoring the progress of all disciplinary hearing cases at senior management meetings, BD has established processing time indicators for the following three stages, i.e. requesting detailed case information from LD, seeking legal advice from DoJ, and referring cases to the Registered Contractors' Disciplinary Board –

(a) Within one month of receiving LD's monthly summary of conviction cases covering all conviction records of contraventions under the Occupational Safety and Health Ordinance, Cap. 509 and the Factories and Industrial Undertakings Ordinance, Cap. 59 irrespective of whether the conviction records are related to building works or offences under the Ordinance, identify fatal site incident cases related to building works and registered contractors, and request detailed information from LD.

(b) For general cases, seek legal advice from DoJ within one month after receiving detailed information from LD.

(c) If DoJ determines that there is sufficient legal basis, refer the case to the Registered Contractors' Disciplinary Board within two months to initiate disciplinary proceedings.

Recommendation (ff)

498. BD is reviewing Criterion 1 under the referral mechanism for considering disciplinary actions to enhance deterrence. Criterion 1 sets the threshold for disciplinary action in cases of non-serious incidents,

where a registered contractor is convicted of five or more offenses related to building works or street works on the same site within a rolling six-month period. Having consulted stakeholders, BD decided to tighten the threshold of the criterion to four or more offenses, which has commenced at the end of August of 2025.

Recommendation (gg)

499. When evaluating tenders for public works contracts, the Government considers not only the tender prices but also the technical capabilities and past performance of tenderers. Among these factors, the tenderer's ability to ensure site safety and its past safety performance are key considerations. Under the current tender evaluation system, safety-related scores can account for about 30% of the overall technical score or performance score. Besides, if a contractor's safety performance fails to meet acceptable standards (e.g. involving in serious site safety incidents or having very poor site safety performance in a public works contract), DEVB will suspend that contractor from tendering for public works contracts in accordance with the established mechanism. In other words, if a contractor is eligible to bid, it indicates that its safety performance meets an acceptable level. On this basis, contractors with better safety performance will receive higher technical scores when bidding for public works contract.

500. DEVB has been continuously reviewing the tender evaluation system for public works contracts and introduces enhancement measures where appropriate to ensure only contractors meeting safety standards will be awarded contracts. For the tender exercises mentioned by the Ombudsman in his report, their tender invitation dates ranged from 2007 to 2020. In fact, DEVB has further enhanced the tender evaluation system, including: (i) in November 2023, introducing a merit and demerit point mechanism in the tender evaluation system based on contractors' past site safety records; and (ii) starting from January 2025, lowering the accident rate limit for public works contracts and, following this revision also tightening the standards for calculating "safety ratings" in the tender

assessment system, and hence amplifying the disparity in "safety ratings" obtained by contractors with better and poorer safety performance, making the differentiation more apparent.

Recommendation (hh)

501. On the regulation of contractors on the approved lists upon conviction of site safety offence, DEVB is exploring a more stringent threshold to limit their participation in public works. A proposal has been formulated. If a contractor has been convicted of four or more (against "five or more" under the prevailing system) site safety offence in any six-month period, DEVB can take appropriate regulating actions against the contractor concerned. DEVB is consulting relevant industry stakeholders.

Recommendation (ii)

502. Whenever a serious site safety incident in public works sites occurs, DEVB will promptly issue a safety alert to all works departments and request the relevant works department to organise a seminar as soon as possible to brief the preliminary findings of the investigation for the incident and corresponding improvement measures with all relevant frontline staff. The management of DEVB will hold regular meetings with the heads of the works departments to review and discuss serious site safety incidents, and instruct them to fully implement the relevant improvement measures.

Recommendation (jj)

503. Since 1 July 2025, BD has extended the mandatory conditions on adoption of relevant alert system on mobile plant and tower cranes in private development projects from superstructure works to demolition works, excavation and lateral support works, foundation works, pile cap works and site formation works. On the other hand, even if such mandatory conditions were not imposed during the approvals of the

building plans for private development projects, they will be imposed when the first consent for the commencement of building works is granted. These mandatory conditions also apply to alterations and additions projects involving structural works.

Recommendation (kk)

504. DEVB will continue the practice of analysing the causes of accidents in public works contracts in detail and introduce respective improvement measures. For instance, the analysis in 2024 was disseminated to works departments and uploaded to the website of DEVB in June 2025 for sharing with the construction industry.

Recommendation (ll)

505. DEVB already shared the safety training requirements of public works with CIC. Starting from September 2025, CIC will provide subsidies as an incentive, with a view to promoting such safety training to site personnel of private development projects tentatively for four years. CIC will regularly review and timely refine the scheme to suit the actual circumstances.

Recommendation (mm)

506. BD and LD had strengthened the referral mechanism in the third quarter of 2022. BD will proactively request details from LD regarding convicted cases of serious site incidents involving fatalities, including case summaries, incident reports, evidence, summonses, trial records and conviction records, to consider disciplinary actions against the registered contractors involved. Both parties have also enhanced collaboration by establishing communication within a month following major incidents, sharing information and relevant evidence, considering joint prosecution, and notifying LD about proposed prosecution matters, allowing DoJ to determine appropriate prosecution procedures.

507. In addition, BD has further strengthened collaboration with LD in investigations of major incidents, including jointly conducting witness interviews where the circumstances warranted and regularly holding investigation meetings to exchange investigation findings, thereby improving the efficiency and effectiveness of the investigation process. LD and BD held an inter-departmental meeting in July 2025 to discuss matters relating to improving the efficiency and effectiveness of accident investigations and reached a consensus. A liaison point will be set up to strengthen the coordination of accident investigations and further enhance the existing collaborative effort.

Recommendation (nn)

508. DEVB and BD proposed amendments to the Ordinance in the end of 2024. The proposals to enhance the disciplinary system include expanding the number of disciplinary board panel members, streamlining the composition of the disciplinary board to accelerate disciplinary hearings, increasing the maximum fines for disciplinary actions and allowing multiple disciplinary sanctions for each charge (such as imposing fines alongside reprimands or removal from the register). The public consultation was completed in February 2025. The Government is finalising the proposals taking into account the views received, as well as working on the drafting of the amendments to the Ordinance. The aim is to submit the amendment bill to the Legislative Council in the first half of 2026.

Housing Department

Case No. DI/478 – Housing Department's Management of Public Housing: Illegal Parking

Background

509. Currently, there are 195 public housing estates in Hong Kong, with more than 780 000 households and about two million residents. The Housing Department (HD) is responsible for the day-to-day management of estates and handles a wide range of issues, including objects falling from height, noise nuisance, water dripping from air-conditioners, unauthorised building works and smoking offences. Illegal parking is one of the common problems.

510. As proper management of public housing is a vital livelihood issue, the Office of The Ombudsman (the Office) has decided to probe into it. Given the broad scope, the Office will initiate direct investigation operations into various aspects of public housing management in phases. This direct investigation operation focuses on illegal parking.

511. From time to time, the Office takes note of public complaints and media reports about illegal parking in public housing estates, where many vehicles are illegally parked on restricted roads for lengthy periods of time and overnight. Particularly, the Office is concerned about illegal parking along emergency vehicular access, which might hinder the access of emergency vehicles and rescues in the event of contingencies. The Office considers that urgent attention is required to probe the problem of illegal parking in public housing estates. Hence, the Office notified HD on 17 December 2024 of the launch of a direct investigation operation pursuant to section 7(1)(a)(ii) of The Ombudsman Ordinance (Cap. 397) to examine in depth and extensively HD's management and enforcement mechanism against illegal parking in its public housing estates. Where necessary, pertinent recommendations will be made for improvement.

The Ombudsman's observations

512. In this direct investigation operation, the Office has examined HD's enforcement against illegal parking in public housing estates and selected four estates, namely Estate A, Estate B, Estate C and Estate D, for site inspections. The Office's observations are as follows.

Case Studies

Estate A

513. Allegedly, illegal parking is prevalent on certain road sections in Estate A, where many vehicles are even parked illegally overnight. In this connection, HD has specifically strengthened road controls outside office hours (i.e. between 6 pm on Mondays to Fridays and 9 am on the following day, and 24 hours on Saturdays, Sundays and public holidays). Apart from enforcement in collaboration with the Mobile Operations Unit, HD has also enlisted the support of the Hong Kong Police Force (HKPF) on a case-by-case basis to conduct joint operations for greater deterrence.

514. Between January and December 2024, a total of 389 enforcement operations against illegal parking were carried out, of which nearly 80% or 307 were outside office hours. HD issued a total of 1 925 fixed penalty notices (FPNs) and impounded 303 vehicles. More than 95% of the FPNs were issued and 65% of the vehicles were impounded outside office hours.

515. According to HD, there are a large elderly population and many wheelchair users in the estate, who often need to be transported by relatives and friends for medical appointments or meals, and escorted to and from their homes. Moreover, there are also school buses transporting pupils and delivery vehicles catering for people's livelihoods. These drivers usually enter the estate boundaries to park their vehicles temporarily, and frontline enforcement staff will handle the short-term parking of these vehicles in a sensible and considerate manner.

516. Besides, the extensive area of Estate A with many branch roads creates significant challenges for road management. As a result of HD's commitment to improvement and continuous efforts over the months, since mid-August 2024, the vast majority of vehicles often parked illegally on the estate's restricted roads have nearly disappeared. The situation of illegal parking has been alleviated, with a significant drop of more than 80% from the peak in the number of FPNs issued and vehicles impounded during enforcement operations. HD would continue to enforce the law stringently and impartially.

517. The geographical situation of Estate A is unique, as its main public road is so designed that the vehicular lanes and the Light Rail Transit tracks are running parallel through Estate A. As a result, not all road access points of the estate are equipped with vehicle barrier gate systems to facilitate road management. To enhance the effectiveness of road controls, the Estate Office has acquired more immobilisation devices. On a need basis, the security service contractor deploys 40% more security guards dedicated to patrolling estate roads and enforcement. The Estate Office has also installed an additional closed-circuit television (CCTV) system especially for monitoring and video recording of road situations to facilitate the remote surveillance of traffic by staff in real time. The Internet of Things (IoT) sensors are piloted on specific road sections, which send real-time data on illegal parking to the smartphones of staff, so that they can keep track of the latest situations and take proper action.

Other public housing estates with similar situation

518. In January 2025, the Office conducted two night-time inspections in other public housing estates, namely Estate B, Estate C and Estate D, where the installation of vehicle barrier gate systems at all road access points is also infeasible due to geographical constraints.

Estate B

519. Estate B covers an extensive area with five road access points. Vehicle barrier gate systems are installed at three access points, but not on the remaining two branch roads due to road width constraints. During the Office's night-time inspection for about 30 minutes in Estate B, the Office found 30 vehicles suspected to be illegally parked on the roadside, but did not encounter any patrolling security guards. Nor did the Office see any FPNs or warning slips affixed to the windscreens of the non-compliant vehicles.

520. According to HD's records, a total of 208 FPNs were issued against illegal parking and 185 vehicles were impounded in Estate B between January and December 2024.

Estate C

521. In Estate C, vehicle barrier gate systems are installed at four of the five road access points, but not on the branch road leading to one block due to road width constraints similar to those in Estate B. During the Office's night-time inspection for 45 minutes in Estate C, the Office found alleged illegal parking of more than 30 vehicles on the roadside, including one near the emergency vehicular access. While the Office encountered patrolling security guards during the inspection, the latter did not take enforcement action against illegal parking. Also, the Office did not see any FPNs or warning slips affixed on the windscreens of the non-compliant vehicles.

522. HD explained that security guards are tasked with multiple duties and might not handle the situation of illegal parking immediately. According to HD's records, no FPN was issued against illegal parking but 264 vehicles were impounded in Estate C between January and December 2024.

Estate D

523. Estate D is served by a public transport terminus, a taxi stand, a green minibus terminus, etc. The traffic flow is high on two main roads, which are used by public transport vehicles. Moreover, the community complex and car park in the estate, two primary schools and a housing estate under the Home Ownership Scheme in the vicinity are also accessible by vehicles via the two main roads. To avoid blocking public road outside the estate and affecting public transport, the estate's access points on the two main roads are not equipped with vehicle barrier gate systems.

524. During the Office's 30-minute night-time inspection in Estate D, the Office found 20 vehicles suspected to be illegally parked on the roadside, but did not encounter any patrolling security guards. Nor did the Office see any FPNs or warning slips affixed to the windscreens of the non-compliant vehicles.

525. According to HD's records, a total of 31 FPNs were issued against illegal parking and 181 vehicles were impounded in Estate D between January and December 2024.

526. HD has kept statistics on the FPNs issued and vehicles impounded in all three public housing estates aforesaid, but only compiled statistics on the written warnings on a need basis.

Overall comments

527. Due to geographical and environmental constraints, specific roads in some public housing estates not equipped with vehicle barrier gate systems are prone to illegal parking, which is more prevalent outside office hours and undoubtedly poses challenges to the road management work of frontline staff. Not only would it obstruct residents, but it might also hinder the access of emergency vehicles in the event of contingencies, causing delay in rescues and dire consequences.

528. The Office recognises that estate management is closely related to people's livelihood and covers a wide range of issues. The relevant staff are also tasked with essential duties and heavy workloads. Nevertheless, given the prolonged illegal parking of many vehicles at night time, some of which might affect emergency vehicular access, the Office considers that improvement is required for the situation.

529. As shown in the case of Estate A, strengthening enforcement is conducive to alleviating the situation of illegal parking. Further observation is required to evaluate the effectiveness of other measures, such as additional CCTV surveillance and application of innovative technologies. Overall, the Office considers that there is room for improvement on the part of HD in handling illegal parking and stepping up enforcement, in particular to ensure that emergency vehicular access is unobstructed.

530. The Office recommended HD to –

(a) continue to closely monitor the situation of illegal parking in public housing estates, especially on roads where the installation of vehicle barrier gate systems is infeasible, and formulate effective enforcement strategies;

(b) step up enforcement against blackspots of illegal parking;

(c) take enforcement action against illegal parking along emergency vehicular access immediately without warning, including impounding or towing away the vehicles;

(d) strengthen collaboration with HKPF to arrange for joint operations for greater deterrence and increasing the non-compliance costs of offenders if necessary;

(e) step up monitoring the follow-up actions taken by contractors, consider stipulating key performance indicators for contractors

under their services contracts and requiring them to report enforcement results regularly;

(f) consider compiling statistics and analysing the records of written warnings against illegal parking issued by the Estate Offices to facilitate their monitoring of illegal parking by frontline staff, with a view to supervising staff and reallocating resources where necessary;

(g) conduct timely review on the effectiveness and results of the pilot use of CCTV surveillance and IoT sensors;

(h) if the results of pilot arrangement are positive, proactively explore expanding the pilot arrangement to more public housing estates to facilitate effective detection by frontline staff of illegal parking;

(i) organise sharing sessions and training for the Estate Offices and security service contractors regarding enforcement against illegal parking from time to time;

(j) review existing manpower and, according to actual circumstances, explore any need to internally redeploy or obtain additional resources for enforcement;

(k) step up publicity and education for motorists, stressing the importance of refraining from illegal parking on emergency vehicular access; and

(l) draw up an implementation timetable for the above recommendations and conduct regular reviews.

Government's response

531. HD accepted the Office's recommendations and has taken the following follow-up actions.

Recommendations (a), (b) and (d)

532. Apart from stepping up inspections and measures such as issuing FPNs and impounding vehicles through internal manpower redeployment, HD will, having regard to the geographical situation of individual housing estates, formulate strategies to combat illegal parking, including installing temporary fences on roads, acquiring immobilisation devices, adopting innovative technologies, and deploying the Mobile Operations Unit to carry out enforcement operations outside office hours and conducting joint operations with the HKPF, to increase the cost of illegal parking to vehicle owners continuously.

Recommendation (c)

533. HD has strictly enforced in public housing estates the practice of taking enforcement action against illegal parking along emergency vehicular access immediately without warning.

Recommendation (e)

534. HD has revised the terms of new service contracts with contractors, requiring them to implement the following: (i) security guards' daily patrol routes and frequency of patrols shall be in accordance with the estate managers' instructions based on the situation of the housing estates; and (ii) contractors are required to regularly meet with estate managers to review the effectiveness of the road control and to submit reports, including the numbers of written warnings issued and vehicles impounded for illegal parking. Additionally, HD has stipulated in the revised service contracts that contractors must achieve a "satisfactory" rating for the item of road control in at least two monthly performance management reports per quarter, which will affect their chances of successful tender for future contracts. District senior management staff will also conduct surprise inspections at public housing estates on a regular basis to assess the performance of the contractors.

Recommendation (f)

535. Regarding the statistical analysis of the records of written warnings issued against illegally parked vehicles, HD has enhanced its computer system by adding a new column, namely "Written Warnings Issued" in the monthly report on enforcement actions in housing estates. Staff will report the numbers of written warnings issued by inputting them into the system to facilitate the Estate Offices' statistical analysis, monitoring and supervision of frontline staff in respect of their follow-up actions against illegal parking, and formulation of strategies for resource deployment.

Recommendations (g) and (h)

536. The Housing Authority (HA) actively promotes smart estate management by introducing various innovative technologies. Estate A, Estate B, Estate C and Estate D mentioned in the Office's Investigation Report have been selected to pilot the installation of CCTV systems and IoT sensors at certain road sections, which transmit real-time data on illegal parking to frontline staff to keep them abreast of the latest situation. Frontline staff have given positive feedback on the effectiveness of innovative technologies in detecting illegal parking. HD will timely review the installation of such devices in other estates as needed.

Recommendation (i)

537. HD will organise training courses regularly for frontline staff and contractors to enhance their knowledge of enforcement against illegal parking. In addition, estate managers will meet with service contractors to review the points to note in enforcement against illegal parking according to the situation of the estates. Meanwhile, contractors will arrange for frontline security guards to attend on-site training for better enforcement results.

Recommendation (j)

538. Estate management staff will review from time to time manpower arrangements and resource deployment to meet different road management needs, particularly in housing estates where illegal parking is more prevalent. In addition, in light of technology advancement, HA has also embarked on adopting the concept of smart estate with a view to making use of innovative technologies to assist frontline estate staff in enforcement work.

Recommendation (k)

539. HD has all along attached great importance to road management in its rental housing estates, and has conveyed law-abiding messages to residents through publicity and education such as posting warnings or banners on restricted roads and through channels such as estate newsletters and electronic notice boards.

Recommendation (l)

540. To conclude, HD has fully implemented and will continue to put in place the Office's recommendations. HD staff and frontline security guards will continue to carry out the above enforcement measures against illegal parking in housing estates, while HD will also review and refine the above measures against illegal parking regularly to provide residents and other road users with safe and smooth access to the estates.

Housing Department, Hong Kong Housing Authority and Hong Kong Housing Society

Case No. DI/468 – Government's Work in Combatting Abuse of Public Housing Resources

Background

541. The current-term Government has done a lot of work on housing policy. By adopting the strategies of enhancing speed, efficiency, quantity and quality, the Government has endeavoured to increase the supply of public rental housing (PRH). Public housing resources are precious to society. In tandem with increasing supply, it is crucial to ensure that existing PRH flats are optimally used and rationally allocated to people in genuine need. At present, there are more than 840 000 households, comprising more than 2.18 million tenants (combined figures for Hong Kong Housing Authority (HKHA) and Hong Kong Housing Society (HKHS)), living in PRH estates across Hong Kong. the Office of The Ombudsman (the Office) believes that most public tenants are law-abiding and abusers are very much in the minority. Nevertheless, abusive behaviours will lead to a waste of valuable PRH resources and unfairness to families and people on the waiting list. As an authority responsible for managing PRH, the HKHA is duty bound to formulate practical mechanisms and measures to monitor the occupancy status of tenants, thereby ensuring fairer and more effective allocation of PRH. The allocation of scarce resources should be focused on those in genuine and pressing need to improve their living conditions immediately and further enhance the public's sense of happiness and contentment.

542. In recent years, various sectors in the community have formed a strong consensus in supporting the Government to step up efforts in combatting PRH abuse and increasing penalties. The current-term Government has spared no effort in combatting PRH abuse with a range of improvement measures. The substantive progress so far is certainly commendable. During this direct investigation operation, HKHA and

HKHS have taken the initiative to review seriously and implement the enhanced Well-off Tenants Policies (WTP). New measures to step up combatting PRH abuse are also introduced in succession, such as exploring amendments to the Housing Ordinance for greater deterrent effect, establishing a data matching and verification mechanism with the Land Registry (LR), and launching the Report Public Housing Abuse Award. Since the current-term Government took office in July 2022, the Housing Department (HD) has recovered more than 7 000 flats on the grounds of abuse or breaches of tenancy terms. The number of recovered flats has already exceeded the total number of flats in a large estate. Their positive attitude and remarkable results achieved are worthy of recognition. Nevertheless, in view of the widespread concern about PRH abuse and relevant complaints lodged with the Office by members of the public from time to time, the Office considers it worthwhile to go the extra mile with an in-depth investigation into HD and HKHS, thereby ensuring that their work against PRH abuse is more precise, comprehensive and effective.

543. The Office has examined the work of HD and HKHS in monitoring tenants' occupancy status, vetting tenants' declaration of income and assets, investigating and following up on suspected PRH abuse cases.

The Ombudsman's observations

(I) Applicable Scope of WTP

HKHS Should Explore Covering All PRH Tenants under WTP

544. HKHS's WTP implemented in 2018 only covers applicants with the tenancy coming into effect on or after 1 September 2018, and household members (except the spouse of original tenants) granted a new tenancy on or after that date for "take-over tenancy". Even the enhanced WTP introduced in 2024 does not cover all HKHS tenants. As at November 2024, only 14.1% of HKHS tenants were covered by WTP. In other words, for the majority of HKHS tenants not covered by WTP, it is

entirely up to the tenants to voluntarily notify HKHS and surrender their flats upon household income or assets exceeding the limits or domestic property ownership acquired in Hong Kong. Such a loophole allows tenants to intentionally withhold information and persist with PRH abuse.

545. To plug the loophole earlier and treat all PRH tenants fairly, the Office urges HKHS to seek further legal advice according to circumstances, and proactively explore ways to cover all tenants of its rental estates under the WTP as soon as possible.

(II) Detection of Tenancy Abuse Relating to Income and Assets Declaration

HKHS's Former Mechanism Inadequate for Vetting the Eligibility of Applicants for "Take-over Tenancy"

546. Case (6) detailed in the investigation report revealed that HKHS's former mechanism for vetting the eligibility of applicants for "take-over tenancy" was inadequate. Given that the WTP does not cover all HKHS tenants, it is especially essential for HKHS to conduct stringent vetting when handling rental or tenancy matters. The spot checks conducted by HKHS according to the procedural guidelines at that time were obviously inadequate. During the Office's direct investigation operation, HKHS has established a new mechanism with the Land Registry (LR) since January 2024, under which HKHS will verify tenants' domestic property ownership in Hong Kong when handling their rental or tenancy matters.

547. The Office urges HKHS to take advantage of this new mechanism in proactively performing its gatekeeping role. All staff of the Estate Management Offices and the Tenancy Management Offices should be reminded to strictly adhere to the guidelines in their daily management of rental or tenancy matters, and critically vet the PRH eligibility of relevant applicants or families in accordance with the policy.

HKHA Should Consider Strengthening the Vetting on the Applications for "Take-over Tenancy"

548. The Office opines that HKHA should consider drawing on the practice of HKHS and explore conducting land search on applicants for "take-over tenancy" and their adult family members through the Integrated Registration Information System or the data matching and verification mechanism, thereby vetting their domestic property ownership in Hong Kong. HKHA should only approve the "take-over tenancy" applications after confirming their eligibility.

HKHA Failing to Stringently Scrutinise the Declaration Forms Submitted by Tenants

549. The Office's investigation revealed that due to manpower constraints, HKHA and HKHS would not thoroughly scrutinise the truthfulness of the particulars in each declaration form in the past. However, spot checks of declaration forms only are inadequate to curb PRH abuse. The failure of HKHA and HKHS staff to stringently scrutinise suspicious or incomplete declaration forms might give tenants a perception that the authorities would simply accept anything they submitted, and those intending to withhold information might gamble on not being detected. The Office recommends that HKHA and HKHS should remind all estate management staff to critically scrutinise the particulars in the declaration forms submitted by tenants, clarify any suspicious or incomplete information, and proactively obtain tenants' relevant information from other government departments or organisations where necessary.

550. Before June 2023, each land search cost $640 and had to be conducted by manual input of data one by one. Due to manpower and resource constraints, HD was unable to conduct a land search on each tenant aged 18 or above in all applications. Nevertheless, HKHA has implemented a new declaration system since October 2023, under which all tenants, upon admission to PRH, are required to declare biennially their occupancy status and any domestic property ownership in Hong Kong.

With the new mechanism with LR established in 2023, land search will be conducted on all adult family members required to make a declaration. The financial efficiency has been enhanced with the average cost per land search substantially reduced to around $4. Since January 2024, HKHS has conducted land searches through the data matching and verification mechanism established with LR on the adult family members of about 1 900 households required to make declarations in 2024; it will conduct land search on the household members required to declare their property ownership thereafter.

HKHA and HKHS Should be More Proactive in Liaison and Communication with Mainland Authorities and Agencies to enhance information exchange

551. The public widely considers that HKHA and HKHS should strengthen communication with Mainland authorities or agencies to detect any property ownership of PRH applicants and tenants in the Mainland. In the past year or so, HKHA has been more proactive in liaison with the relevant Mainland authorities or agencies. With more experience in cooperation and communication, HKHA has established effective means of liaison with Mainland authorities and agencies to facilitate the detection of tenants' property ownership in the Mainland. The Office is pleased to note that HKHS will follow the practice of HKHA in strengthening this aspect.

HKHA and HKHS Should Strengthen Communication with Transport Department (TD)

552. It is not a violation for PRH tenants to own motor vehicles, but ownership of luxury vehicles can provide a clue for tracing whether they have made any false statements or omitted declaration. In recent years, HKHA and HKHS have indicated that closer attention will be paid to vehicles parked in the monthly parking spaces of PRH estates under their management as a clue for investigating the income and assets of the tenants concerned. As a result, they have successfully detected tenants who were

withholding information. However, some PRH tenants intending to evade investigation may choose to park their vehicles in private car parks at higher fees instead of PRH car parks. To plug the loophole and obtain tenants' information more conveniently, HKHA and HKHS should further strengthen communication with TD for obtaining the information of registered vehicle owners whose registered residential or correspondence addresses are PRH flats where necessary. It will enable HD and HKHS to check any ownership of expensive vehicles and Mainland vehicle licences, whether tenants have withheld any information or made any false statements, and whether their income and assets exceed the prescribed levels.

(III) Detection of Tenancy Abuse Relating to Occupancy Status

HKHS Too Lenient with Serious Tenancy Abuse

553. Before August 2024, HKHS would require the tenants in substantiated abuse cases to rectify the breach according to the time frame specified in its operational manual. Under the Warning Letter System, HKHS classified tenancy abuse into two main categories: (1) non-occupation, engaging in illegal activities in the flat, non-domestic usage and false declaration; and (2) subletting or reletting the flat. From issuing a written confirmation to the tenant after the abuse is substantiated to issuing the third warning letter, a period was allowed for rectification.

554. The Office considers it essential to take decisive action against PRH abuse. Once such cases are detected and substantiated, HKHS should initiate the process immediately to terminate the tenancy and recover the flats. However, HKHS's Warning Letter System in the past allowed tenants in serious abuse cases to continue residing in their flats after rectification. They were also given a very lenient period to rectify the breach, which in effect allowed them to continue with PRH abuse before the final deadline.

555. The Office is of the view that HKHS's Warning Letter System significantly undermined the vigour and effectiveness of its efforts in combatting and preventing tenancy abuse. Following the Office's intervention, HKHS has reviewed its former practice of being too lenient with serious tenancy abuse. Once serious abuse is substantiated, it will now initiate the process immediately to terminate the tenancy without giving any warning to the tenant. The Office urges HKHS to remind all staff to strictly adhere to the new practice and review its implementation in a timely manner

Routine Home Visits of HKHA and HKHS Ineffective for Detecting PRH Abuse

556. Routine home visits form one of the measures to detect PRH abuse relating to occupancy status. These visits also serve other purposes, such as understanding the change in family circumstances, conditions of PRH facilities and occupancy status of tenants, and maintaining communication with tenants.

557. During this direct investigation operation, the Office had specially arranged officers to accompany HD and HKHS staff during routine home visits. The Office considers that the effectiveness of home visits in combatting PRH abuse largely depends on the investigation methods and techniques of estate management staff and their subsequent actions. If they are just going through the motions, home visits will not achieve the intended purposes. Even though estate management staff have conducted routine home visits according to operational guidelines, their success rate of detecting abuse relating to occupancy status is not high, given the large amount of manpower and time required. HD might not be able to detect whether the tenants' occupancy status is in compliance with the tenancy terms simply relying on home visits.

558. In the long run, the Office recommends that HKHA and HKHS review whether there is any duplication of resources or possibility of revamp between the arrangement of routine home visits and other

measures against PRH abuse, thereby ensuring that the measures for combatting abuse are complementary and more effective as a whole.

559. After review, if routine home visits are still considered essential for combatting abuse, HKHA and HKHS should ensure the efficiency and cost effectiveness of home visits for detecting abuse. HKHA and HKHS should comprehensively review the existing arrangements from the perspectives of raising the success rate of surprise visits and the success rate of abuse detection, provide estate management staff with specific training on investigation techniques for home visits, and draw up clear guidelines on the subsequent actions after home visits and the monitoring measures; HKHS should also review the arrangements for home visits by appointment.

<u>To Obtain Tenants' Information from Relevant Departments More Proactively</u>

560. Under the existing mechanism, the Social Welfare Department (SWD) will notify HD of the personal data of elderly persons admitted to subsidised places of residential care home, and the information of PRH tenants participating in the Guangdong and Fujian Schemes. At the request of HD, SWD will also provide the information of individual tenants relating to social security assistance. The Immigration Department will provide, at the request of HD, individual tenants' registration of persons records, immigration records, marriage registration records and death registration records.

561. In the past, HKHA and HKHS adopted a risk-based strategy and focused resources on in-depth investigation of high-risk or suspected abuse cases revealed by tip-off or detection. It was impossible to conduct in-depth investigation on all tenants. Therefore, the crux of the matter is whether HKHA and HKHS staff can promptly detect PRH abuse and approach other government departments for relevant information of the tenants concerned. To avoid oversight, the Office recommends that estate management staff immediately and proactively consider obtaining

information of tenants from the relevant departments whenever they are aware of possible PRH abuse for stronger crackdown.

HKHA's New Award System Inadequate to Incentivise Individual Staff of Property Services Agents and Security Services Contractors

562. In their daily performance of management or patrol duties, the staff of property services agents and security services contractors should be able to grasp the occupancy status of PRH flats. For example, they might become aware of tenants' prolonged absence from home, flats frequented by strangers, flats persistently without lights at night time, or overflowing mailboxes. These suspicious cases should be reported to HD and HKHS for further monitoring or investigation. However, the Office's investigation revealed that in most cases, property services agents and security services contractors often only took action at the request of the Estate Management Offices or the Public Housing Resources Management Sub-section (PHRM), such as monitoring suspected cases of PRH abuse, tracking the records of water and electricity consumption, and assisting in surprise home visits. They seldom took the initiative to report suspected cases to HD.

563. Since the third quarter of 2023, HKHA has incorporated an award system in the performance assessment scoring for property services agents and security services contractors. Under this system, HKHA will award additional marks in their performance assessment for putting in extra resources leading to HKHA's issuance of Notice-to-quit (NTQ) in PRH abuse cases, which will increase their opportunity of tender submission and tender award in future. However, the award system may not be adequate to encourage individual staff members to proactively monitor the situation of flats or tenants and report their observations to superiors.

564. To promote a greater monitoring role for the staff of property services agents and security services contractors, HKHA should consider formulating specific incentive schemes motivating individual staff members to participate in combatting PRH abuse The Office considers

that to enhance effectiveness, HKHA should provide the staff of property services agents and security services contractor with observation training for detecting PRH abuse, raise their vigilance and sense of responsibility in reporting suspected cases to the Estate Management Offices, and draw up guidelines for reference and compliance by staff.

HKHS Should Step up Monitoring Water Consumption of Tenants

565. When examining some early cases of HKHS, the Office noted that it had not taken the initiative to monitor the water consumption of tenants for clues to initiate in-depth investigation. It was often only after commencement of investigation that HKHS deployed staff to monitor the water consumption of a suspected flat for evidence of PRH abuse. The Office urges HKHS to follow the practice of HD and step up monitoring of water consumption of rental flats, thereby detecting those with abnormal water consumption for further investigation.

HKHS Has Not Established a Notification Mechanism with SWD

566. HKHA has established a notification mechanism with SWD years ago, under which SWD will notify HD of the personal data of elderly persons admitted to subsidised places of residential care home, and the information of PRH tenants participating in the Guangdong and Fujian Schemes. The mechanism has been operating smoothly. HKHS should consider following suit and liaising with SWD to set up a similar notification mechanism as HD's, so as to gain a more comprehensive understanding of the situation of tenants.

(IV) Follow-up Actions on PRH Abuse Cases

HKHA's Prosecution Rate Too Low to Create Deterrent Effect

567. Over the past seven years, the prosecution rate of HKHA in respect of PRH abuse cases ranged from only 1.7% to 4.2%. As the prosecution rate is extremely low, there are public views that the deterrence

is inadequate, leading tenants to be heedless of the consequences of concealing their income or assets, with a wrong perception that the worst-case scenario will be surrendering the flat and no legal liability will be incurred.

568. After examining the case files, the Office found that the time limit for prosecution had expired in many cases when the PRH abuse was discovered. Consequently, HKHA was unable to prosecute tenants for making false statements even though sufficient evidence was available. To enhance deterrent effect and cost efficiency, the Office recommends that HKHA consolidates experience and comprehensively reviews how to identify and collect sufficient evidence for prosecution within the limitation of time, thereby raising prosecution rate to the extent that PRH abusers will be compelled to surrender their flats voluntarily. The Office is pleased to note that HD is currently exploring amendments to the Housing Ordinance to extend the time limit of prosecution against PRH abuse involving false statements.

<u>To Explore Heavier Penalties Against PRH Abuse</u>

569. Before the enhanced WTP was implemented by HKHA, only abuse relating to "income and assets declaration" will be prosecuted on the grounds of making false statements. As for abuse relating to "occupancy status", even for such serious cases as subletting or engaging in illegal activities in the flat, the most serious consequences would only be termination of tenancy, surrender of the flat to HKHA and disqualification from applying for public housing again within two years.

570. In chapter 5, case (5) of the Office's Investigation Report, the tenant had sublet the flat to non-household members for financial gain at the expense of public resources. Even after the abuse was substantiated, HD eventually took about five months to recover the flat, while the subletting continued in the interim. Such serious abuse only resulted in surrender of the flat, which is an extremely insignificant consequence for the tenant who had already left Hong Kong and no longer lived in the flat.

571. As HKHS is not vested with the statutory power to prosecute, its tenancy management is entirely based on the terms of tenancy agreement. The penalties imposed by HKHS in PRH abuse cases are even milder and less deterrent than those imposed by HKHA. In view of the current situation of inadequate deterrence and lenient penalties, the Office recommends that HKHS should explore any room for imposing heavier penalties on tenants for PRH abuse, including additional sanctions through administrative measures to achieve a greater deterrence.

HKHA Lacking Records and Analysis of Data

572. The Office considers that to ensure the desired effect achieved by the policies and measures against PRH abuse, prevent loopholes from occurring and refine the measures and operational guidelines where necessary, HKHA should regularly review the effectiveness in implementing the policies. The collection and analysis of statistical data on cases is an integral part of the review. However, HKHA currently has no centralised data about information obtained from other departments or organisations, nor has it compiled breakdown data on PRH abuse. To gain a more comprehensive understanding of the actual situation, analyse the work efficiency, and adjust the relevant strategies and enhancement measures, the Office recommends that both HKHA and HKHS step up the collection and analysis of data relating to crackdown on PRH abuse.

(V) Others

Lack of Computerised Management of Case Investigations and Follow-up Actions

573. Although HD has a dedicated computerised management system to record and follow up on daily management of tenancy matters and routine home visits, it has not computerised the management of investigation of PRH abuse cases. The staff of the Estate Management Offices and PHRM still record information on paper files, which are passed on to responsible officers at the next stage for further action. Entirely

relying on paper files for recording and managing case investigations and follow-up actions has an impact on the subsequent case monitoring, data collection and analysis, and even the speed of case processing. If HD intends to study and review the follow-up actions, the handling procedures at various stages, and the effectiveness of combatting PRH abuse, it will need to go through the paper files one by one, which is a time-consuming and cumbersome exercise.

574. Following the launch of the Office's direct investigation operation, HKHA has reviewed its existing practice and set up a new computer system for storing the case information, procedures and investigation results of frontline Estate Management Offices and PHRM in relation to work against PRH abuse for better monitoring. The Office urges HKHA to equip the computerised management system with data collection and analysis functions to enhance the effectiveness of its work against PRH abuse. While HKHS has already followed HKHA's practice in using an electronic platform to facilitate home visits, the Office recommends that HKHS further considers computerising the management of its work against PRH abuse.

Lack of Transparency in Following up on Reports

575. Apart from the occasional complaints received, the Office has been informed by members of the public that after reporting cases of PRH abuse to HD, they were refused disclosure of HD's follow-up actions and investigation results on the grounds of protecting third-party privacy. The public considered that the lack of transparency gave the impression that HD was slipshod and ineffective in investigation. Some even queried whether HD had followed up on the reports received at all.

576. The Office recognises the importance of protecting third-party privacy. However, with the launch of the Report Public Housing Abuse Award launched for provision of accurate information on PRH abuse, it is expected that more reports will be received, and informants will be anxious to know whether HD has followed up on their reports seriously. To

enhance transparency and avoid misunderstanding, the Office recommends that HKHA and HKHS consider giving a concise account of their follow-up actions to informants as far as possible without disclosing the personal data of third parties or affecting the progress of investigation.

HKHA and HKHS Should Strengthen Communication and Liaison on Combatting PRH Abuse

577. There are many areas of mutual reference and complementarity between HKHS and HD in their strategies and efforts against PRH abuse. Currently, HKHA and HKHS have formulated their own WTP and anti-abuse measures. Although their measures and practices are similar, as mentioned above, HKHS still has room for improvement in the handling of substantiated abuse cases, arrangements for routine home visits, notification mechanism with other departments, detection of PRH abuse, and formulation of new measures. HKHS should consider drawing on the more extensive experience of HKHA in handling PRH abuse. To facilitate synergy and mutual exchange, the Office recommends that HKHA and HKHS step up information exchange and experience sharing on their work against PRH abuse.

Training on Investigation Techniques to be Strengthened

578. Low water consumption, rent arrears, unreachable tenants or household members are probably signs of PRH abuse. The ability of frontline estate management staff to discern these signs and take proactive action is one of the important factors in the successful detection of PRH abuse. Moreover, online advertisements or posts for subletting of PRH flats appear from time to time. If HKHA and HKHS staff can track down the relevant tenants more accurately and effectively, they can prevent PRH abuse at an early stage.

579. In this light, the Office recommends that HKHA and HKHS consolidate experience from various cases of PRH abuse and formulate a targeted and effective approach to detect and investigate such cases.

Relevant training should be provided for frontline estate management staff or PHRM staff to enhance their sensitivity in discerning PRH abuse and capability to take corresponding actions on the clues or information obtained, resulting in more effective detection of PRH abuse.

Flexible Allocation of Resources for Investigation of PRH Abuse

580. With the strengthened efforts and publicity campaigns against PRH abuse, the workloads of HD and HKHS are expected to increase significantly. Meanwhile, HKHA has launched the Report Public Housing Abuse Award in January 2025 for provision of accurate information on PRH abuse, thereby detecting more abuse cases. To prevent misuse and ensure the truthfulness of the information provided, Award participants have to provide their real names and be interviewed by dedicated personnel. HD needs to deploy additional manpower to implement the Award and conduct in-depth investigation into the reports, so as to enhance the success rate under the Award and avoid discouraging the public from reporting.

581. To effectively implement the enhanced efforts in combatting PRH abuse and the recommendations made in this direct investigation operation, the Office recommends that HKHA and HKHS review the allocation of resources according to actual circumstances, with timely increase of resources and adjustment of workflow to ensure continued effectiveness of their work against PRH abuse.

(VI) Vetting Assets of PRH Applicants

HKHA and HKHS Failing to Stringently Vet PRH Applicants' Property Ownership

582. The Office considers that if HKHA and HKHS deepen the reform of the mechanism against PRH abuse and adopt the improvement measures detailed above to eliminate ineligible PRH applicants at source, the effectiveness will increase exponentially. It is therefore crucial to tackle

the problem of PRH abuse at source by cancelling ineligible applications and allocating PRH resources to those in genuine need.

583. Case (2) in chapter 5 of the Office's Investigation Report showed that before the new system implemented in 2023, HD apparently did not conduct a comprehensive vetting on all household members of each PRH application for any domestic property ownership in Hong Kong.

584. The Office considers that to achieve effective gatekeeping and cost efficiency, HKHA and HKHS should consider adopting the effective data matching mechanism with LR mentioned above to screen PRH applicants and their household members for any domestic property ownership in Hong Kong before confirming their eligibility for PRH allocation. During the waiting period of PRH applicants, the authorities should also conduct in-depth investigation of randomly selected cases to detect if any applicants have withheld information on income or assets, and cancel the applications of those who fail to pass the eligibility test.

585. Since mid-2023, HD and LR have in place a data matching and verification mechanism for conducting a land search on all PRH applicants before confirming their eligibility for PRH allocation, so as to robustly screen them for any domestic property ownership in Hong Kong. Apart from cancelling the applications, HKHA will consider prosecuting the applicants found to have made false statements.

586. In addition, the issue of vetting the assets of PRH applicants outside Hong Kong has all along been a matter of concern. To combat PRH abuse at source, HKHA and HKHS should proactively consider vetting PRH applicants' property ownership in the Mainland or Macao, and establishing channels or platforms for such purpose in liaison with Mainland and Macao authorities or agencies. As for the vetting of overseas property ownership, the Office understands that it depends on whether overseas governments or relevant organisations are willing to cooperate in providing information on the tenants concerned. Nonetheless, the Office recommends that HKHA and HKHS continue to explore feasible ways of

tracing the overseas property ownership of PRH applicants and tenants, thereby further enhancing the effectiveness of their work against PRH abuse.

587. The Office recommended HD and HKHS to –

(a) remind all staff of the Estate Management Offices and the Tenancy Management Offices to strictly adhere to the guidelines in their daily management of rental or tenancy matters, and vet the PRH eligibility of relevant applicants or families in accordance with the policy;

(b) consider strengthening the vetting of "take-over tenancy" applications, and checking any domestic property ownership in Hong Kong of principal tenants and their family members;

(c) remind estate management staff to stringently scrutinise the particulars in the declaration forms submitted by tenants, to be more vigilant in clarifying suspicious or incomplete information, and to be more proactive in obtaining tenants' relevant information from other government departments or organisations where necessary;

(d) explore the feasibility of comprehensive screening of all PRH tenants through land search regularly;

(e) explore ways to enhance communication with Mainland and Macao authorities and agencies, and establish channels as far as practicable, for more convenient access to information about tenants' property ownership in the Mainland or Macao;

(f) consider strengthening communication with TD for obtaining the information of registered vehicle owners whose registered residential or correspondence addresses are PRH flats where necessary;

(g) explore any room for improvement in the existing arrangements and monitoring system for home visits, especially the deployment of manpower, whether estate management staff have enough time to complete home visits within the time limit, and whether the proportion and practice of reviews and spot checks of records can be strengthened;

(h) in the long run, review whether there is any duplication of resources or possibility of revamp between the arrangement of routine home visits and other measures against PRH abuse, thereby ensuring that the measures for combatting PRH abuse are complementary and more effective as a whole;

(i) after review, if routine home visits are still considered essential for combatting abuse, comprehensively review the existing arrangements from the perspective of raising the success rate of surprise visits, such as deploying manpower flexibly to increase the number of surprise visits during non-office hours, and adjusting the timing of surprise visits according to the flat types and demographic composition of specific PRH estates;

(j) after review, if routine home visits are still considered essential for combatting abuse, comprehensively review the existing arrangements from the perspective of raising the success rate of abuse detection, such as providing estate management staff with specific training on investigation techniques for home visits, and drawing up clear guidelines on the subsequent actions after home visits and the monitoring measures;

(k) proactively consider obtaining information of tenants from the relevant departments whenever estate management staff are aware of possible PRH abuse;

(l) consider formulating specific incentive schemes to motivate staff members of property services agents and security services contractors to participate in combatting PRH abuse;

(m) for the sake of enhancing effectiveness and if feasible under contractual terms, provide the staff of property services agents and security services contractor with observation training for detecting PRH abuse, and raise their vigilance and sense of responsibility in reporting suspected cases to the Estate Management Offices;

(n) explore any room for imposing heavier penalties on tenants for PRH abuse, especially for misconduct not in breach of the law, where HKHA can still impose additional sanctions through administrative measures to achieve a greater deterrence;

(o) step up the collection and analysis of data relating to crackdown on PRH abuse to gain a more comprehensive understanding of the actual situation, analyse the effectiveness of work, and adjust the relevant strategies and enhancement measures;

(p) for the sake of enhanced transparency and avoidance of misunderstanding, consider giving a concise account of their follow-up actions to informants as far as possible without disclosing the personal data of third parties or affecting the progress of investigation;

(q) for the sake of facilitating synergy and mutual exchange between HKHA and HKHS, strengthen communication and liaison with more information exchange and experience sharing on their work against PRH abuse;

(r) continue to consolidate experience from various PRH abuse cases, formulate a targeted and effective approach to detect and investigate such cases, and provide relevant training for frontline estate management staff or PHRM staff to enhance their

sensitivity in discerning PRH abuse and capability to take corresponding actions on the clues or information obtained;

(s) review the allocation of resources according to actual circumstances, with flexible deployment of manpower and adjustment of workflow to ensure continued effectiveness of their work against PRH abuse;

(t) consider conducting a land search on all PRH applicants through the data matching and verification mechanism established with LR before confirming their eligibility for PRH allocation, robustly screening them for any domestic property ownership in Hong Kong, and randomly selecting cases for in-depth investigation during the waiting period of PRH applicants, so as to intercept PRH abuse at source;

(u) proactively consider liaising with Mainland and Macao authorities or agencies to establish channels for vetting PRH applicants' property ownership in the Mainland or Macao;

(v) explore feasible ways of tracing the overseas property ownership of PRH applicants and tenants;

The Office recommended HKHA to –

(w) draw on experience and comprehensively review its strategies and policies to raise prosecution rate, and explore ways to identify and collect sufficient evidence for prosecution within the limitation of time for prosecution, thereby enhancing deterrent effect and cost efficiency to the extent that tenants who have been abusing PRH will surrender their flats voluntarily; and

(x) equip the new computerised management system with data collection and analysis functions to enhance the effectiveness of its work against PRH abuse.

The Office recommended HKHS to –

(y) study anew the full implementation of the WTP, seek legal advice and seriously explore ways to cover all tenants of its rental estates under the WTP as soon as possible;

(z) remind all staff to strictly adhere to the practice of issuing the Notice-to-Quit (NTQ) outright to tenants in serious breach of the tenancy agreement without prior warning, and review the implementation of the new practice in a timely manner;

(aa) review the existing arrangements of accepting appointments for routine home visits;

(bb) continue to follow HKHA's practice in monitoring the water consumption of rental flats, and conduct further investigation if anomaly is detected;

(cc) consider liaising with SWD to set up a notification mechanism in the same way as HKHA;

(dd) consider following HKHA's practice in computerised management of work against PRH abuse;

(ee) consider drawing on the more extensive experience of HKHA in handling PRH abuse.

Government's response

588. HD, HKHA and HKHS accepted the Office's recommendations and have taken the following follow-up actions.

Recommendations (a), (c) and (k)

589. HD will, through the guidelines / reminders sent via email and the training regularly provided to frontline staff, remind all staff of estate

offices and Tenancy Management Offices to strictly follow the guidelines on their daily work regarding tenancy matters or tenancy management and to review whether the applicant or the family is still eligible for PRH in accordance with the policies. Staff should stringently scrutinise the particulars in the declaration forms submitted by tenants, be more vigilant in clarifying suspicious or incomplete information, and be more proactive in obtaining tenants' relevant information from other government departments or organisations where necessary.

590. HD issued the above email to frontline staff in March 2025 and will re-circulate relevant email in due course. In addition, staff will be frequently reminded of the relevant key points during regular training courses, as well as during training / refresher courses organised for frontline staff who are new recruits or transferred to estate offices (e.g. the half-yearly training courses held on 6 August 2024 and 11 February 2025, and the annual briefing on the WTP held on 12 March 2025).

591. PHRM of HD will regularly issue guidelines via email to estate management staff on the handling methods of suspected cases of PRH abuse. All staff of the Estate Management Offices and the Tenancy Management Offices are reminded to strictly adhere to the established work procedures in handling each case or report of suspected PRH abuse, including checking with SWD on whether the tenants are residing in residential care homes, and checking with the Immigration Department for death records, registration of persons records and movement records, etc. Any suspected case of PRH abuse detected by frontline staff must be referred to PHRM for in-depth investigation in a timely manner.

592. HKHS has established clear policy guidelines and regularly strengthened staff understanding and execution accuracy through different communication channels. During the rental housing section meetings held in December 2024 and May 2025, estate management staff were reminded that, when handling suspected cases of PRH tenancy abuse and applications involving income and asset declarations, they must conduct thorough investigations and verifications in strict accordance with the

existing policies and guidelines, and the cases should be monitored by Senior Managers. HKHS also reiterated these requirements via an internal email in May 2025 so as to ensure consistency in execution, and will issue further reminders and provide support to staff as necessary.

593. In April 2025, HKHS conducted two practical training sessions about income assessment and asset declarations to enhance investigative capabilities and vigilance of estate office staff. Staff were reminded to proactively follow up on suspicious or incomplete information, and verify the data concerned with relevant government departments or organisations as necessary. HKHS will continue to strengthen staff's understanding of assessment procedures based on operational needs to ensure execution consistency.

594. At the rental housing section meeting held in December 2024, estate management staff were reminded that, if a flat is suspected of being misused, they should proactively seek tenant information from relevant government departments, so as to enhance the effectiveness of investigations and anti-abuse efforts. During investigations, in addition to carrying out surprise inspections and recording electricity and water meter readings, staff may also, in accordance with the "Consent and Authorization for Transfer of Personal Data" and relevant operational guidelines, contact departments such as the Immigration Department, Hospital Authority or Correctional Services Department to verify whether the tenant is unable to reside in the flat due to departure from Hong Kong, hospitalisation, or detention. By utilising the interdepartmental data flexibly, investigators can gain a more comprehensive understanding of tenants' actual occupancy status, thereby strengthening the identification and handling of abuse cases.

Recommendations (b), (d) and (t)

595. To combat PRH abuse with a view to safeguarding the rational use of PRH resources, HKHA, starting from October 2023, has required all PRH tenants to declare their occupancy status and whether they have

domestic property ownership in Hong Kong every two years, irrespective of the length of their residence in PRH. According to HKHA's existing Policy on Grant of New Tenancy, Comprehensive Means Test (CMT) is not required if the tenancy is taken over by the tenant's spouse (tenant has passed away), which is of similar handling of deletion of family members. These families are still required to declare their occupancy status and domestic property ownership in Hong Kong every two years as scheduled after the take-over of tenancy; to declare family income and assets if the households are already included in the declaration cycle of the WTP. As for granting new tenancy to family member other than spouse (e.g. offspring), the applicant's family must pass the CMT and Domestic Property Test, after which they are required to declare their income, assets, and whether they own any domestic property in Hong Kong every two years in accordance with the housing policies. Moreover, all PRH tenants are required to declare in the declaration form that they should declare to HKHA after having acquired a domestic property in Hong Kong within one month of entering into any agreement, including provisional agreements.

596. Starting from June 2023, HD has been conducting land searches on all the declarations made by tenants through the data matching and verification mechanism established with LR. The first three rounds of searches (October 2023, April 2024 and October 2024), covering about 358 000 households that are required to declare whether their adult family members own any domestic property in Hong Kong, have been completed, while the fourth round of searches, involving about 210 000 households, are underway in an orderly manner. HD will complete the searches in batches, and the families which have made a declaration will be included in the next declaration cycle after two years. HD will continue the land searches, i.e. regular searches to inspect all PRH tenants will be conducted.

597. The above new measures will ensure the timely declaration of domestic property ownership in Hong Kong by all PRH tenants, and enable HKHA to conduct vetting for all tenants (except those exempted from the WTP) in a timely and orderly manner. Nevertheless, HD will adopt the

recommendations of the Office by strengthening the vetting on applicants regarding their domestic property ownership in Hong Kong when they apply for taking over the tenancy. In line with the tightening of the WTP starting from the declaration cycle in October 2025, HD will also update the application form for "take-over tenancy", requiring applicants and their family members to declare whether they own any domestic property in Hong Kong.

598. Since June 2023, HD has started implementing a data matching and verification mechanism with LR to carry out data matching for each PRH application that passes the detailed vetting to screen PRH applicants and their household members for any domestic property ownership in Hong Kong before confirming their eligibility for PRH allocation. In addition, HD will also conduct computerized random selection each year to select PRH applications for in-depth investigation.

599. Apart from cancelling the applications, HD will prosecute the applicants or their family members found to have made false statements, depending on the circumstance.

600. Since January 2024, HKHS has established a data-matching mechanism with the LR. All "take-over tenancy" and new public housing applications are now subject to verification through this mechanism to ensure that the applicant and their family members aged 18 or above do not own any domestic property in Hong Kong. This new data-matching mechanism has replaced the previous random checks approach and effectively enhanced the efficiency and accuracy of the vetting process. During the application period, HKHS will also randomly select cases for further in-depth investigation to tackle PRH tenancy abuse at its source.

601. In March and April 2025, HKHS organised six training sessions, including four workshops on system operation, so as to strengthen staff's understanding and execution capability. The effectiveness of the new mechanism will be monitored continuously and further reviewed as appropriate.

602. Since January 2024, HKHS has proactively vetted the declarations made by all tenants subject to the WTP to verify if they own any domestic property in Hong Kong through the data-matching mechanism with the LR in lieu of the past practice of random checks. With the full implementation of the WTP in phases, HKHS anticipates that the WTP will be extended to cover all its rental estate tenants by end 2026. All tenants will by then be required to declare every two years whether they own any domestic property in Hong Kong.

Recommendations (e) and (u)

603. HKHA has established communication mechanism with the building registration authorities in various provinces / cities in the Mainland (such as the bureaux of natural resources and real estate registration centers), and has set up direct liaison channels to enhance exchanges and cooperation.

604. In addition, HD has, through the Hong Kong Economic and Trade Office in Guangdong of the Government of the Hong Kong Special Administrative Region, strengthened liaison and streamlined verification processes with building registration authorities in various cities / towns in Guangdong Province.

605. In 2024/25, HD wrote to the authorities of different provinces or cities in the Mainland as well as in Macao to make enquiries after receiving reports or carrying out random checks. It was confirmed that 26 households had concealed their ownership of domestic or non-domestic property in the Mainland when applying for PRH. As a result, HKHA issued NTQ to the tenants concerned to recover their flats as their household asset value exceeded the prevailing limits for PRH application.

606. Since April 2024, HD has established an inquiry channel with the property registration authorities in some Guangdong cities. If PRH applicants or their family members are suspected of having property ownership in these cities, HD will write to the property registration

authority concerned through this channel and verify whether the PRH applicants and their family members have property ownership in the Mainland.

607. Furthermore, if PRH applicants are suspected of having property ownership in other Mainland cities or Macao, HD will write to the property registration authority of the relevant city / Macao for verification.

608. Apart from cancelling the applications, HD will prosecute the applicants or their family members found to have made false statements, depending on the circumstance.

609. HKHS is gradually establishing communication mechanisms with departments such as Real Estate Registration Centres in the Mainland. If a tenant is suspected of owning a property in the Mainland, HKHS will verify with the organisations concerned through established channels. As of end June 2025, HKHS had made enquiries to 35 Mainland organisations, mainly in the Greater Bay Area, as well as cities in the Guangdong and Fujian Provinces, Shanghai, etc. The verification process is expected to become more efficient as the mechanisms continue to develop.

610. HKHS will proactively initiate investigations if a suspected case is identified or reported. If concrete information, such as a specific property address, is available, HKHS will verify it with relevant Mainland departments through established channels. HKHS will continue to actively explore the possibility of establishing verification mechanisms with government departments or organisations in the Mainland and Macao with a view to verifying tenants' property ownership more accurately.

Recommendation (f)

611. When processing cases involving income and asset declaration, if tenants are found to have vehicle ownership and are suspected to have

made a false declaration on income or assets, HD will enquire with TD about the relevant vehicle registration information.

612. HKHS has established communication channels with TD, and would verify relevant information regarding suspected cases with it as necessary as part of the investigation and follow-up actions. This arrangement helps enhance the accuracy and efficiency of case processing. By June 2025, HKHS has identified through the above arrangement one case in which a tenant made a false declaration of assets, resulting in the issuance of an NTQ to the tenant in April 2025.

Recommendations (g) to (j) and (aa)

613. HD has all along been committed to combatting PRH abuses through prevention, detection, investigation, publicity and education, etc. Since 2008, routine home visits have been one of the major measures for HD to proactively detect PRH abuse. Housing Officers (HOs) from estate offices and Tenancy Management Offices will conduct surprise home visits to PRH flats to monitor the occupancy status of the households. If any signs of PRH abuse are observed (e.g. the furniture and fittings are found to be inconsistent with household registration information during home visits, or repeated unsuccessful attempts to contact the tenants, etc.), HOs will record the relevant information and refer the cases to PHRM of HD for in-depth investigation.

614. On the other hand, starting from October 2023, all PRH tenants are required to declare their occupancy status and domestic property ownership in Hong Kong every two years upon admission to PRH. The particulars of the principal tenant and all household members listed on the tenancy agreement are required to be provided, including whether they have retained regular and continuous residence in the PRH flat, and whether they have been subletting or using the flat for unauthorised purposes, etc. Tenants who fail to return the declaration forms by the deadline will be treated as cases of special concern subject to routine home visits. HOs are required to complete the home visit investigations

(including the investigations conducted during office and non-office hours) within three months. Any suspicious cases must be referred to PHRM for follow-up and in-depth investigations.

615. Apart from the biennial declaration of occupancy status and any domestic property ownership in Hong Kong, starting from the third quarter of 2022, HD has enhanced collaboration with the Water Supplies Department (WSD), whereby WSD will provide HD with information on cases of abnormal water consumption in PRH (including low and zero water consumption) monthly for follow-up checks on the operation of the water meters. Such cases will also be treated as special cases of concern where routine home visits should be prioritised.

616. In addition, HKHA launched the Report Public Housing Abuse Award on 15 January 2025 to encourage members of the public to report cases of PRH abuse for jointly safeguarding the PRH resources. Informants who can provide key information to assist HKHA in successfully issuing NTQs for PRH abuse cases will be given a reward of up to $3,000 and a certificate of appreciation. Since the launch of the scheme, HD has received 6 000 reports as at 31 May 2025, representing an increase of over 20% in average when compared with last year. Although not all informants have participated in the scheme, HD staff will conduct investigations as far as possible based on available information, including conducting home visits. Therefore, the existing home visit mechanism and arrangements are complementary to other measures for combatting PRH abuse. Estate staff will exercise flexible manpower deployment, prioritise the targets of home visits, and conduct home visit investigations strategically to enhance the success rate of detecting PRH abuse cases.

617. Regarding reviews of home visit cases and spot checks, Housing Managers (HMs) / Assistant Housing Managers (AHMs) of the estates are currently required to formulate an overall plan for each routine home visit and set a monthly target for the number of cases to be completed. They are also required to conduct spot checks on home visits completed by HOs to ensure the quality of home visits.

618. HD's Tenancy Management Policy Unit also issues guidelines via email from time to time to remind estate staff of the points to note during home visits, including reminding office staff to take note of whether the case completion rate has met the overall target. The completion rate and matters of concern will also be reported in the regular senior staff meetings chaired by the Assistant Directors (Estate Management).

619. As for training, HD has enhanced the training of estate frontline staff on investigation techniques of conducting home visits, including the points to note when entering the flat for investigation and finding out the latest occupancy status of the households they visited. The first training of this year was completed on 20 February, and training courses will continue to be offered in the second half of the year.

620. To ensure the sustainability of public finances, the civil service establishment has maintained zero-growth since 2021/22. To optimise the use of manpower resources and to control public expenditure, the Government will reduce the civil service establishment by 2% each year in 2026/27 and 2027/28. Meanwhile, the supply of public housing has also increased substantially year-on-year. To this end, HD needs to re-prioritise its tasks through management measures and digitalisation, internal redeployment and streamlining of work processes with a view to optimising the use of manpower resources. HD has recently conducted a review on the arrangements for routine home visits. As HKHA has introduced various measures for effective crackdown on PRH abuse, to avoid duplication of resources among these measures, HD is considering adjustments to the home visit cycle and strategy. This will enable estate staff to devote more efforts and precisely investigate suspected cases of PRH abuse amid the tight manpower resources.

621. Since June 2024, HKHS has launched the self-developed "eHome Visit" mobile application to enhance efficiency of home visits and strengthen record management. The mobile application replaces the previous paper-based record keeping system, reducing paperwork and minimising the risk of human error. HKHS has also established a new

monthly random check mechanism to verify the authenticity of home visit records. HKHS will continue to review manpower allocation and assess the effectiveness of execution to optimise home visit arrangements.

622. Regular home visits remain essential as they are not only for detecting tenancy abuse but also for facilitating the management of matters related to household particulars, tenancy agreement and maintenance. HKHS will review its tenancy policies and management arrangements from time to time to ensure the measures for combatting PRH abuse are coordinated and effective as a whole.

623. Regular home visits are one of HKHS's measures to combat PRH tenancy abuse, serving both preventive and monitoring functions. Since December 2024, HKHS has gradually extended its home visits without prior appointment to non-office hours, including evenings and weekends, so as to improve the success rate. Cases involving repeated unsuccessful visits will be referred to the "Housing Resources Management and Operations" (HRMO) team for follow-up. Estate management staff will continue to review implementation progress and manpower deployment and flexibly adjust the arrangements accordingly.

624. HKHS organises regular training courses to strengthen estate office staff's knowledge and skills in conducting home visits and investigations. New joiners are also offered training on HKHS's tenancy policy. In June 2025, training sessions were organised to enhance new joiners' understanding of home visits and their execution ability. In July 2025, meetings were also held to enhance their understanding of investigation techniques and execution procedures. To support the use of the "eHome Visit" system, HKHS also arranged three system operation training sessions over the past year and uploaded the training materials to HKHS's intranet for staff to review. HKHS will continue to review and monitor the post-home visit follow-up action and enhance the guideline to improve the efficiency and effectiveness in detecting PRH tenancy abuse as and when necessary.

Recommendation (l)

625. To encourage property services agents to collaborate in safeguarding PRH resources, an award system has been incorporated in the performance assessment scoring system of property services agents since the third quarter of 2023. Additional marks will be added to the total score of the performance assessment of property services agents for assisting HKHA in successfully issuing NTQ for PRH abuse cases. The additional marks may help increase the opportunity of tender submission as well as tender award. The above arrangement is also applicable to the performance assessment scoring system of security services contractors of estates under HD's direct management.

626. To encourage frontline staff including security guards of management companies / security services companies to proactively assist in detecting PRH abuse, besides the incentives provided by services contractors, the Best Security Operatives election under HD's annual Estate Management Services Contractors Awards and the new outstanding staff award launched this year for staff who have proactively participated in combatting PRH abuse also provide incentives for frontline staff of management companies to take extra steps to report suspected PRH abuse cases.

627. HKHA launched the Report Public Housing Abuse Award on 15 January 2025. Except direct employees of HKHA / HD (including body-shopped personnel employed through consultant company to execute the duties of HA / HD), anyone, including individual staff member who works as management company staff, security guard or even cleansing workers of cleaning services contractors, etc., can participate in the Award which provides incentives to assist HD in combatting PRH abuse.

628. HKHS launched the "Report Public Housing Abuse Award" Scheme on 1 April 2025. Except for employees directly hired by HKHS, any informants aged 16 or above who choose to participate in the Scheme and provide genuine and concrete information under their real names that

leads to the successful issuance of an NTQ against households with tenancy abuse, will receive a reward of up to HK$3,000 and a certificate of appreciation as recognition. The Scheme also covers staff members of HKHS's service contractors, including those providing security, cleaning, and horticultural services, so as to encourage their active participation in combatting abuse of PRH resources. HKHS has introduced the Scheme to the above-mentioned contractors and explained how they could participate.

Recommendation (m)

629. HD held meetings / seminars with security services contractors and property services agents on 26 June and 10 July 2025 respectively to brief them on investigation techniques for detecting PRH abuse and to provide experience sharing sessions on handling relevant cases. In future, HD will also organise regular meetings / seminars to services contractors to strengthen relevant training to enhance their awareness and sense of responsibility in handling suspected PRH abuse cases.

630. As HKHS does not outsource property management services of its rental estates to external agents, this recommendation mainly applies to staff of its security service contractors. Currently, estate office staff collaborate with security contractors as necessary to conduct preliminary investigations into individual cases. However, as detecting PRH tenancy abuse is not the primary duty of security contractors, it is not appropriate to formally include such duties in their service contracts. HKHS will continue to raise awareness and enhance the vigilance of security staff regarding PRH tenancy abuse to support estate office operations when necessary.

Recommendation (n)

631. To combat PRH abuse more effectively and to enhance the deterrent effect with a view to safeguarding the rational use of public housing resources, the Housing Bureau introduced the Housing (Amendment) Bill 2025 (the Bill) to the Legislative Council and it was

passed on 11 June 2025. One of the focuses of the Bill is the introduction of the offence of "serious PRH tenancy abuse". The definition of "serious PRH tenancy abuse" includes: (a) subletting a rental residential flat to another person or granting a licence (or sub-licence) for occupation of a PRH flat to another person for valuable consideration; or agreeing or offering to let a rental residential flat to another person, or agreeing or offering to grant a licence (or sub-licence) for occupation of a PRH flat to another person; or (b) the tenant household not residing in the rental residential flat, and carrying on a trade or business, or allowing another person to carry on a trade or business, in a rental residential flat. A person is liable on conviction to a fine of $500,000 and to imprisonment for one year. The relevant offence will come into effect on 31 March 2026.

632. HKHS does not have any statutory authority or empowerment under the Housing Ordinance in managing and operating its public housing. Enforcement is only possible pursuant to provisions outlined in tenancy agreements, and HKHS is unable to impose additional penalties through administrative means. Currently, HKHS has tightened several measures against PRH tenancy abuse. Tenants who have received an NTQ due to breach of tenancy or false declarations are barred from re-applying for public housing for five years. In addition, cases involving fraud or false declarations will be proactively reported to Police.

Recommendations (o), (x) and (dd)

633. HD started using the new Tenancy Abuse Information System (TAIS) on 28 October 2024 to store and track the flow and result of each PRH abuse case with combatting efforts made, so as to facilitate monitoring of case progress and data analysis. The effectiveness of relevant strategies and enhanced measures is also reviewed to optimise the workflow. HD will continue to improve the TAIS with a view to enhancing its work efficiency.

634. HKHS has earmarked funding in its 2025/26 financial budget for the development of a dedicated computer system to support frontline staff

in conducting statistical and case analysis to combat abuse of PRH resources. The tendering process has been completed and the system is expected to be in operation in the first quarter of 2026.

Recommendation (p)

635. HD will follow up on PRH abuse cases in accordance with the established policies, guidelines and procedures. Although the informants are very concerned about the investigation status and results of the cases, HD has to protect the privacy of personal data. As the investigation process and result involve others' personal data and privacy, HD will not disclose the details of the case to the informants. Nevertheless, HD will inform the informants that it will handle the cases concerned in accordance with the established policies and guidelines, such as providing brief information on whether follow-up actions are in progress or the follow-up is completed, etc.

636. As investigations involve personal privacy and sensitive information, HKHS will not disclose specific details or outcomes of the investigation to informants. However, without compromising the investigation efforts, HKHS will provide a brief update to informants indicating that the case is being followed up or has been properly handled to enhance transparency.

Recommendations (q) and (ee)

637. HKHA and HKHS have consistently maintained contact to exchange views and share experiences in combatting PRH abuse. In addition to communication via telephone and email, HKHA and HKHS held meetings on 30 December 2023 and 17 July 2024 to share experiences in enhancing WTP, addressing PRH abuse with technology and establishing task forces, etc. Furthermore, meetings were held on 12 March and 11 July 2025 again for sharing experiences in developing an information system, recent initiatives against PRH abuse and key considerations for executing WTP.

638. HKHS maintains close communication and collaboration with the HKHA's Public Housing Resources Management Sub-section. A communication mechanism has been established on the efforts in respect of combatting tenancy abuse. Over the past year, the two parties have held a number of work exchange meetings to share experiences and enhance overall operational effectiveness. At the latest meeting on 11 July 2025, in-depth discussions on anti-abuse efforts were conducted.

Recommendation (r) and (s)

639. PHRM of HD provides its frontline staff with regular training and sharing sessions on information and techniques for combatting PRH abuse cases. These include the biannual training courses held on 6 August 2024 and 11 February 2025, as well as the annual WTP briefing held on 12 March 2025, which aimed at raising staff vigilance in vetting the information on declaration forms, thus enabling the staff to take follow-up actions for any suspicious or incomplete information.

640. In July 2023, PHRM established a "dedicated team" consisting of former disciplined services officers. Apart from handling suspected PRH abuse cases, the dedicated team has consolidated experience from various cases of PRH abuse and formulated a targeted and effective approach to detect and investigate such cases. Two training courses will be held in the fourth quarter of 2025 to brief frontline estate management staff on how to investigate suspected cases of PRH abuse and false declarations on income and assets, as well as to provide experience sharing sessions on handling relevant cases.

641. HD will flexibly deploy resources to enhance the effectiveness of combatting PRH abuse through re-engineering of work processes, re-prioritisation of tasks (e.g. the aforesaid review of process and strategies for routine home visits; complementing with other measures against PRH abuse), optimal use of information technology (e.g. the aforesaid adoption of the new information technology system to monitor case progress and conduct data analysis to evaluate the effectiveness of related strategies).

HD will also proactively explore new methods and deploy human resources as appropriate to ensure the effective execution of relevant work.

642. HKHS will continue to draw lessons from PRH tenancy abuse cases and develop more targeted and effective investigation methods. Some suspected cases have been referred to the dedicated HRMO team for in-depth investigation.

643. The HRMO team, established in June 2024, comprises personnel with law enforcement experience to carry out investigation work. Members of the team are familiar with legislation and highly sensitive to false, omitted or suspicious declarations by tenants, facilitating early detection of potential PRH tenancy abuse cases. Their field investigations experience also enhances the accuracy and efficiency of case handling. HKHS will continue to review resource allocation and flexibly deploy manpower and adjust workflows to ensure the efforts of combatting tenancy abuse continue to be effective.

Recommendation (v)

644. If PRH applicants or tenants are suspected of having owned an overseas property, HD, where practicable, will verify with the authorised property registration authorities of relevant countries by letter or through the network system of the authorised agencies whether a PRH applicant or tenant owns any overseas property, provided that relevant information is available or detailed information / address of the overseas property has been provided by the informant.

645. Apart from cancelling the applications and issuing NTQ to terminate tenancies, HD will prosecute the applicants or their family members found to have made false statements, depending on the circumstance.

646. HKHS understands that tracing overseas property ownership of PRH applicants and tenants is a potentially effective way to strengthen the

vetting process and prevent PRH tenancy abuse. However, due to differences in legal systems, personal data protection regulations and levels of responsiveness across jurisdictions, this arrangement is practically challenging. Accordingly, HKHS will first focus its efforts on taking forward and optimising its investigation efforts regarding properties in the Mainland and Macao. It will then learn from the experience and explore the feasibility of furthering its investigation efforts regarding overseas properties.

Recommendation (w)

647. In handling each prosecution case, HD will consider whether there is sufficient evidence based on the information collected during investigation for instigating prosecution within the limitation of time in accordance with the Prosecution Code of the Department of Justice and will seek its legal advice where necessary.

648. To enable a more effective crackdown on abuse cases and enhance the deterrent effect so as to ensure the rational use of public housing resources, the Housing Bureau introduced the Bill to the Legislative Council. The Bill was passed by the Legislative Council on 11 June 2025 and will take effect on 31 March 2026. The Bill has expanded the scope of Section 25(4) of the Housing Ordinance to cover not only tenants but also members of the tenants' household. The amendment has enabled HKHA to issue the WTP declaration forms to tenants under the provision of Section 25(4) of the Housing Ordinance for their completion.

649. The limitation of time for prosecution of false statements in declarations under the WTP will be extended from "at any time within two years next after the commission of the offence or within six months after the discovery thereof by an authorised officer, whichever period expires first" to "at any time within six years next after the commission of the offence or within one year after the discovery thereof by an authorised officer, whichever period expires first". As a result, HKHA will have more

time to collect evidence and prevent members of the public from taking chances to commit the offence.

Recommendation (y)

650. HKHS has finished the study as well as sought legal advice on the full implementation of the WTP. The policy implements in phases starting from September 2025. HKHS will, through a simplified procedure, issue new tenancy agreements containing the WTP clauses to approximately 25 000 tenants who are yet to be covered by the policy, with no exemptions. The first batch of tenants is scheduled to be subject to WTP in the fourth quarter of 2025 and full implementation is scheduled to be completed by end 2026. Substantial manpower, system support, and cross-divisional collaboration have been deployed to support this exercise. In addition to engaging Legislative Council/District Council members and local stakeholders, HKHS has held nearly 200 resident briefings since April 2025. HKHS will closely monitor the progress and make necessary adjustments to ensure smooth implementation and achievement of the intended outcomes.

Recommendation (z)

651. This recommendation has been implemented since 1 August 2024. HKHS has adopted a two-tier mechanism to handle tenancy breaches, depending on the severity of each case. For tenants who have committed serious breach of tenancy agreements, HKHS will no longer issue warnings but will issue a NTQ direct to achieve greater deterrence. Estate office staff have also been reminded to strictly adhere to the relevant guidelines, and HKHS will review the operational effectiveness and consistency of the mechanism as necessary. HKHS has also updated its website to outline how serious breaches of tenancy agreement would be handled, enhancing transparency and reminding tenants of the consequences of non-compliance.

Recommendation (bb)

652. This recommendation has been implemented. Since January 2023, HKHS has been receiving data from the Water Supplies Department on rental flats with abnormal water consumption. By making reference to HKHA's practices, HKHS has strengthened its monitoring for early detection of potential PRH tenancy abuse cases. If abnormalities are found, HKHS will promptly conduct further investigations to ensure rational use of public resources and that tenancy agreements are observed by tenants.

Recommendation (cc)

653. HKHS has set up a notification mechanism with SWD regarding the "Portable Comprehensive Social Security Assistance Scheme", and is working with SWD to explore more comprehensive notification arrangements, such as SWD suitably assisting HKHS in verifying whether tenants still need to apply for or reside in HKHS rental flats. HKHS will continue its close dialogue with SWD to study the feasibility of such arrangements.

Other comments

654. Since the current-term Government assumed office, HKHA has commenced a series of reviews and explored ways to refine the measures to combat PRH abuse and enhance the WTP and Addition Policy, so as to ensure the rational use of public housing resources. Upon implementation of the new measures, remarkable results in combatting PRH abuse have been achieved, and the number of abused flats recovered has multiplied when compared with past years. From the current-term Government taking office up to May this year, HKHA has recovered 8 700 PRH flats on the grounds of tenancy abuse and breaches of tenancy agreement or housing policies. Tenants are required to declare their occupancy status and whether they own a domestic property in Hong Kong every two years. For the first three batches of declaration cycles (i.e. October 2023, April

2024 and October 2024), HKHA had screened about 478 000 households, of which over 8 900 households (about 1.9%) have voluntarily surrendered their flats or have had their flats recovered for various reasons. There were also PRH tenants who were sentenced by court to imprisonment for 30 days for false statements. We will continue with our efforts in combatting PRH abuse and proactively explore more feasible measures to enhance the accuracy, effectiveness and comprehensiveness of our detection and investigation efforts.

Housing Department and Hong Kong Housing Society

Case No. DI/473 – Government's Arrangements for Recovery, Refurbishment and Reallocation of Public Rental Housing Flats

Background

655. Public rental housing (PRH) is precious social resources, the demand for which has always been very keen. The current-term Government has been making every effort to increase PRH supply to meet people's housing needs, and its efforts are delivering tangible results. The average waiting time for PRH has reduced from 6.1 years before the current-term Government to 5.3 years as at the end of December 2024. Public housing resources should be optimised and properly allocated to those with genuine needs. On the part of PRH tenants, they are obliged to comply with the tenancy terms and should not leave their flat idle or sublet it to others.

656. Apart from increasing the supply of PRH by building more public housing estates, the Government has continued to recover flats and refurbish them for reallocation to PRH applicants. In the past five years, the Housing Department (HD) and the Hong Kong Housing Society (HKHS) had recovered 15 700 PRH flats on average each year. Upon recovering PRH flats, HD and HKHS will promptly refurbish the flats and arrange for reallocation so as to shorten the waiting time for PRH.

657. Since the current-term Government has stepped up its efforts to combat abuse of PRH, and more PRH tenants have surrendered their flats after purchasing subsidised sale flats, HD has adopted enhancement measures to accelerate reallocation of recovered PRH flats after refurbishment.

658. This direct investigation aims at examining in detail relevant work of HD and HKHS, including the specific procedures for refurbishing

recovered PRH flats for reallocation, the workflow of recovering PRH flats, and the disposal of items left in PRH flats by ex-tenants.

The Ombudsman's observations

(I) Procedures for Recovering Flats of Deceased Singleton Tenants Should Be Improved

659. According to the current procedures, HD and HKHS will attempt to contact the relatives of singleton PRH tenants after their death to seek the relatives' assistance in clearing and surrendering the flat in vacant position. In case no relative is available to do so, HD and HKHS will recover the flat by issuing a Notice-to-Quit (NTQ). The investigation of the Office of The Ombudsman (the Office) reveals that there is no mention in the prevailing guidelines of HD and HKHS of any time frames for surrender of the flat by relatives, or the procedures for following up on cases where the relatives cannot be reached.

660. There is a case where a singleton tenant of an HD housing estate passed away, and the respective estate office allowed her daughter to clear the tenant's belongings in the flat concerned. Nevertheless, the estate office had neither given the tenant's daughter a deadline for surrender of the flat nor explained what actions HD would take after the deadline (including that the items left in the flat might be discarded). The daughter misunderstood that she could keep the flat until she voluntarily surrendered it. As the office could not reach her despite a number of calls made, the Office recovered the flat. By the time she learned that the flat was recovered, the estate office had already disposed of the items left inside.

661. In the opinion of the Office, it is reasonable that the estate office allows time for relatives of tenants to clear the tenants' belongings. Nevertheless, HD should revise its guidelines to set reasonable time frames for the relatives of singleton tenants and explain the follow-up actions to be taken after the prescribed deadline. This could allow the relatives to clear the items left in the flats while ensuring that the flats concerned will

not be idled for too long in case HD cannot reach the relatives. HKHS should make reference to HD's procedures for recovering the flats of singleton tenants after their death and review its handling procedures and improve the relevant guidelines.

(II) HKHS Should Review Procedures for Disposing of Items Left by Previous Tenants

662. According to the current procedures, HKHS staff and the bailiff officer will enter a flat recovered by way of legal proceeding for checking and counting the items left inside. Afterwards, a notice will be posted outside the flat notifying related parties that they can claim the items found in the flat within seven days from the posting of the notice. For PRH tenants moving out after being issued an NTQ, if they only return the keys to the estate office but fail to clear their flat, HKHS staff will also check and count the items left in their flat and post a notice to inform the previous tenant or other related parties that they can go to the estate office to claim those items within fourteen days. During the aforementioned seven-day and fourteen-day periods, HKHS will not move those items to the estate office or other places but leave them in the flat concerned. HKHS explained that such arrangement is based on the consideration that there might be property or belongings of others inside the flat.

663. In the Office's opinion, there is room for improvement in such arrangements. Under the aforesaid circumstances, HKHS recovers possession of the flat by going through relevant legal proceeding. Based on the terms of the tenancy agreement between HKHS and the tenant, HKHS has no obligation to keep the items left in the flat given that such items are deemed as discarded after HKHS has recovered possession of the flat. Hence, such arrangement may hinder the progress of HKHS' refurbishment and reallocation of recovered flats.

664. In this regard, HKHS should make a comprehensive review of the current procedures for handling items left by tenants and seek legal advice where necessary. After the review, if HKHS still sees the need to

temporarily keep the items found in the recovered flat, it should consider moving them to other places to avoid affecting the turnover of flats.

(III) HKHS Should Be Proactive and Decisive in Handling Cases Involving Tenants' Failure to Surrender Their Flat

665. There is a case where a tenant of an HKHS housing estate assigned a representative in March 2021 to take over the keys of a subsidised sale flat he purchased. The tenant alleged that he could not surrender the original flat by the end of two calendar months from taking over of the keys (i.e. on or before 31 May 2021) as required because he was locked down in a place outside Hong Kong during the outbreak of COVID-19. However, it was not until November 2021, which was six months later, that HKHS recovered the flat concerned. During the period, HKHS and the tenant's son had maintained communication as regards the handling of items in the flat. In the Office's view, such passive handling amounts to conniving at the tenant's behaviour. On the premise that public resources should be optimised, HKHS should specify a time frame for surrender of flats and recover the flats in a decisive manner by taking prompt recovery action against those who fail to surrender their flat on time or provide the justification for their failure to do so.

(IV) HD Should Explore Feasibility of Expediting Recovery of PRH Flats after Issuing NTQs

666. According to the current procedures, HD will issue a Notice to Occupier and an Eviction Notice to the tenant or occupier of a PRH flat whose tenant fails to surrender the flat by the prescribed deadline in the NTQ issued by HD. The notices serve the purpose of giving the tenant or occupier 7-day and 21-day notice to vacate and surrender the flat. If the tenant or occupier still fails to surrender the flat upon expiry of the aforesaid 30 days' notice in total, HD will take action to recover the flat.

667. There is a case where a tenant who breached the tenancy terms due to failure to retain regular and continuous residence at the PRH flat

concerned. In August 2023, HD issued an NTQ to terminate the tenancy of the flat. During its investigation, HD also found that the tenant had leased out the flat. The tenant appealed against the NTQ. In November 2023, the Appeal Panel (Housing) rejected the appeal. HD then resumed the flat recovery action and issued two Notices to demand surrender of the flat by the occupier on or before 28 December 2023. There were some signs showing that the tenant continued to unauthorised leasing out the flat to make profit before the deadline of HD's recovery of the flat subsequent to the issuance of NTQ.

668. The Office considers that HD should be flexible and effective in handling cases, taking into consideration the actual situation of each case (especially in cases involving continuous abuse of public housing). For example, HD does not have to complete the procedures of issuing the above-mentioned notices before recovering the flat concerned, or the Department can set the deadline according to the actual situation. HD should explore how the procedures for handling cases involving tenants' failure to surrender their flat upon expiry of the deadline prescribed in the NTQ can be improved. It should also maintain close communication with members of the Appeal Panel (Housing) and give due consideration to various proposals for improvement to facilitate the smooth decision-making process of the Appeal Tribunal.

(V) HKHS Should Review Requirement of Issuance of Refurbishment Works Order within 14 Days after Recovering a Flat and Create a Monitoring Mechanism

669. After a tenant moves out, HD will inspect the PRH flat and issue a refurbishment works order to the contractor within 3 days. Previously, HKHS had not set any requirement as to when a works order should be issued. After the launch of the Office's direct investigation operation in early 2024, HKHS set the requirement of issuing the order within 14 days after recovering a flat, which is the general practice of estate offices of various housing estates in these few years to inspect a flat within 14 days after its recovery.

670. In the Office's opinion, HKHS' existing requirement of issuing such order within 14 days might raise doubts among members of the public as to whether it is reasonable. Such practice of HKHS is also contrary to the reasonable expectation of PRH applicants that the Government would enhance the speed and effectiveness to accelerate the turnover of PRH flats. HKHS should carefully review the existing arrangements and make revision as appropriate to enhance efficiency. Besides, it should create a monitoring mechanism to ensure that its staff will adhere to the requirements in performing their duties.

(VI) HD and HKHS Should Explore Setting of Target for Reallocation Arrangement after Recovery of PRH Flats Where Feasible

671. While the refurbishment works are in progress, HD and HKHS will start in parallel the arrangements for reallocating the vacant flats to eligible PRH applicants. Nevertheless, the authority does not have any internal guidelines or indicators in place to provide a time frame for reallocation of recovered flats. Moreover, HD's computer system does not include a function or an option for checking the time required for reallocation of PRH flats after their recovery, or a monitoring function for the same purpose.

672. The Office believes that PRH applicants could have more time preparing for the in-take if HD and HKHS could arrange reallocation of recovered flats as soon as practicable. In case the prospective tenant does not accept the offer of a recovered flat, the authority may proceed with the next eligible applicant on the waiting list. HD and HKHS should explore setting of target for reallocation arrangement after recovery of PRH flats where feasible, and enhance the computer system to add functions of data collection, statistics compilation and analysis so as to improve the efficiency of daily management.

(VII) HKHS Should Explore Feasibility of Shortening Refurbishment Period of Recovered Flats

673. At present, the key performance indicators of HKHS for refurbishing a vacant PRH flat is 60 days. The Office has noticed that in recent years, 92% of HKHS' refurbishment works (involving 1 923 units) were completed within 60 days. The number of PRH flats whose refurbishment works were completed in 61 days to 90 days decreased from 89 in 2022 to 27 in 2024. The Office considers that HKHS should target at excellence and make a comprehensive review of the workflow and standards of refurbishment works of vacant PRH flats so as to speed up works progress and shorten the refurbishment period.

674. Furthermore, HKHS should consider introducing a scheme similar to HD's Vacant Flat Refurbishment Allowance Scheme to simplify the process for refurbishment works, hence optimal utilisation of HKHS's resources and minimal wastage.

(VIII) Other Business Relating to Recovery of PRH Flats and Areas for Improvement

<u>HKHS Should Consider Following HD's Example in Issuing a Letter of Assurance to Tenants Who Surrender Their Flat Due to Admission to Residential Care Homes or Imprisonment</u>

675. Unlike HD's arrangements, HKHS only offers a Letter of Assurance to elderly tenants who surrender their flat after joining the Portable Comprehensive Social Security Assistance Scheme for Elderly Persons Retiring to Guangdong and Fujian Province, the Guangdong Scheme and the Fujian Scheme to offer accommodation in PRH for those elderly tenants if they return to Hong Kong in future provided that they can satisfy the prevailing eligibility criteria for PRH applicants. Such arrangements are not applicable to tenants who move out for admission to residential care homes or because of imprisonment.

676. Elderly tenants may hesitate over admission to a residential care home due to worries about adaptability. If the Government makes available accommodation in PRH for them in future, it will address their concern and encourage them to receive proper care in residential care homes. On the other hand, public housing resources will be better utilised and PRH flats so vacated can be reallocated to other families with housing needs. For tenants departing from PRH due to imprisonment, offering them assurance of public housing can help them reintegrate into society after their release from the prison.

677. The Office considers that HKHS should actively consider extending the coverage of issuance of Letters of Assurance to include tenants admitting to a residential care home or serving a sentence.

HKHS Should Re-examine Arrangements for Tenants' Surrender of Their PRH Flat After Acquiring Other Forms of Subsidised Housing

678. For tenants having acquired other forms of subsidised housing under the Hong Kong Housing Authority and HKHS (such as subsidised sale flats and transfer), they are required to surrender their original flat within 60 days from a prescribed date. Tenants of HD's housing estates may apply for extended stay, the period of which should not exceed 30 days. During the extended stay, tenants are required to pay an occupation fee. In the Office's opinion, such requirement can prevent abuse of HD's discretion.

679. Relevant requirements of HKHS are, however, different from HD's in that HKHS' tenants may apply for late surrender of their original flat and the maximum extension is 60 days, during which the tenants do not need to pay any additional fee. The Office finds it unreasonable that HKHS' tenants may apply for extended stay of a longer period, which is 30 days more than the extension granted by HD, and the extended stay of 60 days in total does not incur any occupation fee or additional cost. On the basis of fairness and optimisation of public housing resources, HKHS

should make reference to HD's practice and adopt the same requirements in handling tenants' applications for extended stay.

It Is Necessary to Improve Communication with Tenants and Require Tenants to Provide Contact Information Other Than Telephone Numbers

680. Case studies of the Office reveal that HD's estate offices were unable to contact the tenants or their relatives for the purpose of recovering the flats and handling items left in the flats in a timely manner despite a number of telephone calls made.

681. For better communication with tenants and their emergency contact persons (for singleton tenants), the Office considers that HD and HKHS should improve relevant arrangements by requesting tenants and their emergency contact persons to provide an email address as the electronic correspondence so that the authority can contact them when necessary.

682. The Office recommended HD to –

(a) improve the procedures for recovering the flats of deceased singleton tenants and revise the relevant guidelines;

(b) strengthen staff training on recovery of flats of deceased singleton tenants to enhance staff's understanding of the revised workflow;

(c) explore how the procedures for handling cases involving tenants' failure to vacate and surrender their flat upon expiry of the deadline prescribed in the NTQ can be improved;

(d) maintain close communication with members of the Appeal Panel (Housing) and give due consideration to various proposals for improvement to facilitate the smooth decision making of the Appeal Tribunal;

(e) explore setting of target for reallocation arrangement after recovery of PRH flats where feasible;

(f) enhance the computer system to add functions of data collection, statistics compilation and analysis so as to improve the efficiency of refurbishment and reallocation of recovered PRH flats; and

(g) improve communication with tenants and their emergency contact persons, requesting that tenants provide an email address to facilitate communication.

The Office recommended HKHS to –

(h) make reference to HD's procedures for recovering the flats of deceased singleton tenants and revise the relevant guidelines;

(i) arrange staff training after revising the guidelines on handling the tenancy matters of deceased singleton tenants;

(j) re-examine the procedures for handling items left in PRH flats by previous tenants;

(k) to be more proactive and decisive in handling cases of failure to surrender PRH flats;

(l) explore appropriate revision of relevant arrangements to shorten the time frame for issuance of the refurbishment works order after recovery of a flat to less than 14 days to enhance efficiency, and create a monitoring mechanism;

(m) re-examine the process of reallocation of recovered flats and explore setting of target for reallocation arrangement after recovery of PRH flats where feasible;

(n) improve the computer system for statistical analysis to effectively collate information on refurbishment and reallocation of recovered PRH flats for better efficiency;

(o) review the workflow and standards of refurbishment works of vacant PRH flats so as to speed up works progress and shorten the refurbishment period;

(p) consider introducing a scheme similar to HD's Vacant Flat Refurbishment Allowance Scheme and study the feasibility;

(q) consider following HD's example in issuing a Letter of Assurance to offer PRH accommodation to tenants who surrender their flat due to admission to residential care homes or imprisonment when they have housing needs in future;

(r) re-examine the arrangements for tenants' surrender of their PRH flats after acquiring other forms of subsidised housing; and

(s) request that tenants and their emergency contact persons provide an email address to facilitate communication.

Government's response

683. HD and HKHS accepted the Office's recommendations and have taken follow-up actions.

Recommendations (a) and (b)

684. HD has explored to improve the procedures for recovering the flats of deceased singleton tenants and will revise the relevant guidelines. HD regularly organises different training for staff to enhance their knowledge and skills in respective areas of work. In the past two years, HD had arranged six training courses on the enforcement of the Housing Ordinance and the recovery of PRH flats to provide frontline staff with a

better understanding of the policy background and points to note and skills required during operations.

685. HD will continue to strengthen training for estate frontline staff to enhance their skills in recovery action of PRH flats.

Recommendation (c)

686. As the circumstances of each case vary (e.g. the occupier of the flat may have urgent housing need or may be an individual requiring care), whether the flat can be recovered directly or whether the occupier should be issued with a Notice to Occupier and an Eviction Notice depends on a number of considerations, and HD has to spend a reasonable time and exercise great care when handling the matter according to procedures. If there are still occupiers in the flat, HD will try to avoid using forced entry to recover the flat lest there are any conflicts or unpleasant incidents during the recovery process. Therefore, on one hand, we make reference to the enforcement procedures of the Bailiff Section and give notice to the occupiers, allowing them to make accommodation arrangements. On the other hand, we also utilise this notice period to liaise with other departments, such as the Social Welfare Department or the Police, and to arrange temporary accommodation for the occupiers. While we must ensure the safety and housing need of the evictees, the personal safety of our enforcement colleagues is important as well. HD is now reviewing and exploring how to improve the procedures for handling cases involving tenants' failure to vacate and surrender their flat upon expiry of the deadline prescribed in the NTQ, including ways to handle the situations under different scenarios.

Recommendation (d)

687. The Appeal Panel (Housing) Secretariat organised a briefing-cum-sharing session on 7 April 2025 to brief Panel Members on the latest housing policy direction, answer their questions and solicit their views including ways to improve the appeal handling process. Such briefings

will be conducted on an on-going basis and the next briefing-cum-sharing session will be held in October or November 2025.

Recommendation (e)

688. HD has conducted a review of the recommendation, and explored setting of target for reallocation arrangement after recovery of PRH flats where feasible. Nevertheless, the key performance indicator of HD for refurbishing a vacant PRH flat is 44 days on average, which includes the time required for HD to issue a works order to the contractor, for the contractor to carry out refurbishment works, and for HD to inspect the works. To speed up allocation of PRH flats, while the refurbishment works are in progress, HD will start in parallel the arrangements for reallocating the vacant flats to eligible PRH applicants in advance, and will issue offer letters to applicants allocated with the flats after the issuance of refurbishment works orders. Once the refurbishment works are completed, PRH applicants can move into the flats immediately. Hence, the time taken for reallocation of recovered flats to PRH applicants will not affect the time of flat intake. HD will continue to expedite and enhance the refurbishment workflow. Since flat allocation runs parallel with refurbishment works and will be completed during the refurbishment period, it is not necessary to set a separate work target regarding the number of days taken for reallocation of recovered flats to PRH applicants. HD will continue to allocate flats to eligible PRH applicants as soon as practicable in accordance with the principles of optimising public housing resources as well as the established policy and procedures for PRH flat allocation.

Recommendation (f)

689. HD has been monitoring closely the overall vacancy situation and allocation progress of PRH flats by reviewing the relevant information in the computer system from time to time and regularly monitoring the allocation status of flats through preparation of reports so that prompt follow-up action will be taken on cases that are yet to be allocated. The computer system will also be enhanced in a timely manner to enhance the

allocation efficiency and ensure early intake for PRH applicants. Regarding the enhancement of the computer system, HD plans to complete relevant system enhancement in the fourth quarter of 2025 to strengthen the data processing and analysis functions, including function or option to facilitate staff to check the time required for reallocation of PRH flats after their recovery. Computer reports will also be generated to strengthen the relevant monitoring functions and further enhance the allocation efficiency.

Recommendation (g)

690. HD has included a field for tenants to fill in their email addresses as the electronic correspondence in the documents for completion during intake. Additionally, relevant field will be added to the various declaration forms where tenants are required to submit regularly (such as the "Well-off Tenants Policies" declaration form and "Declaration Form on Occupancy Status" to be submitted every two years). Moreover, during routine home visits by HD staff, officers will check the contact information as recorded with tenants. If tenants have any updates or additional information, including contact telephone numbers and email addresses, the officers will update the records. To facilitate communication in the future, tenants may also go to the estate office to update the contact information at any time.

Recommendations (h) to (j)

691. With legal advice sought in June 2025, HKHS has revised the tenancy clause to specify its right to remove and dispose of items left behind by former tenants upon repossession of the flat, and to charge storage and administrative fees. The revised clause is incorporated into the new tenancy agreements to be issued from September 2025 upon the full implementation of the "Well-off Tenants Policy" by phases.

692. In the process of revising the relevant work guidelines, HKHS has also developed in parallel a training programme to update estate office staff on the revised guidelines through multiple channels. This aims to assist

them in gaining a better understanding of the details and points to note to enhance the overall consistency and efficiency during execution.

693. Furthermore, HKHS is reviewing the current procedures for handling items left behind by former tenants, including the notification mechanism, storage arrangements and subsequent processing workflows. Due to limited storage space in some estates, HKHS is exploring the feasibility of shortening the current 14-day item retrieval period for former tenants or their family members in order to expedite flat turnover. HKHS has also engaged flat refurbishment contractors to handle the removal and disposal of such items, and this scope of work has been included in the contract. The aforementioned arrangements help reduce the workload of frontline staff during flat repossession and enhance overall efficiency.

Recommendations (k) and (r)

694. HKHS has made reference to HD's current practices and established a new flat handover arrangement for tenants who have purchased subsidised sale flats or private residential properties. The new arrangement has taken effect since 1 October 2025.

695. Under the new measure, tenants are required to return their original rental flats to HKHS within two months from a prescribed date if they have acquired subsidised sale flats or private flats. If an extension is needed due to special circumstances, tenants must submit an application for HKHS's prior approval and pay an additional occupation fee equivalent to three times of their rent. The grace period shall not exceed one month. The new measure aims to encourage timely move-out for expediting flat turnover and ensuring effective use of resources.

Recommendation (l)

696. Since January 2025, HKHS has significantly shortened the timeframe for issuing refurbishment works orders from 14 days to 7 days upon flat repossession, except under special circumstances.

697. HKHS's records indicate that, from January to June 2025, refurbishment works orders for around 300 repossessed flats requiring refurbishment were generally issued within 7 days, proving the new arrangement effective. However, since the layout designs of HKHS's 21 PRH estates as well as the interior fixtures of flats vary, it takes time for estate offices to assess and prepare refurbishment works orders with practicalities duly considered and balanced. HKHS has strengthened its monitoring mechanism to remind estate management staff to review cases where works orders could not be issued within the designated timeframe, such that timely follow-up actions can be taken.

Recommendation (m)

698. HKHS has conducted the relevant review and explored the setting of target for reallocation arrangement after recovery of PRH flats where feasible as recommended by the Office. However, it would be practically challenging to set an across-the-board target timeframe for flat reallocation after the recovery of PRH flats. In certain cases (such as those involving redevelopment households or transfer arrangements), tenants may have special needs, to which standard procedures are not applicable. In addition, some cases require cross-departmental coordination by HKHS to address the tenant's special needs.

699. Nevertheless, HKHS remains committed to enhancing allocation efficiency, and will continue to monitor the overall situation of vacant flats. Other measures, such as offering of rental concessions for unpopular flats, will be adopted to expedite flat turnover and optimise resource utilisation where appropriate.

Recommendation (n)

700. HKHS currently manages tenancy administration, flat refurbishment works and flat allocation through different computer systems, each with distinct functionalities, operating modes and data formats. HKHS will progressively enhance and review the relevant

systems based on resource availability, operational needs of its departments and work priorities as appropriate.

701. In addition, data integration involves various factors such as HKHS's overall system structure and technical compatibility. HKHS will conduct further studies and testing to ensure the feasibility of the relevant proposals.

Recommendation (o)

702. HKHS is piloting the integration of different regular maintenance contracts (including flat refurbishment works contracts of vacant units) in some of the rental estates. Under this new arrangement, temporary material storage within the estate will be centrally managed by a single contractor, enhancing operational efficiency and flexibility.

703. The new contract also specifies that upon receipt of a works order, the contractor must conduct door and window measurement and initiate the material ordering process by the next working day to expedite the progress. This arrangement will be trialled in two estates and is expected to shorten the 60-day refurbishment period by approximately seven days. HKHS will review the effectiveness of the trial to determine the feasibility of extending this arrangement to HKHS's other rental estates.

Recommendation (p)

704. HKHS had an on-site visit to HD's public housing estate on 8 May 2025 to learn about the latter's experience in provision of the Vacant Flat Refurbishment Allowance. Since over 90% of the rental flats under HKHS are over 30 years old, and outgoing tenants typically have resided in the flats for more than one or even two decades, most returned flats require extensive and complex refurbishment works and processes. Accordingly, HKHS faces operational challenges in introducing a similar allowance scheme, and its effectiveness may be limited.

705. Most rental estates managed by HKHS are relatively smaller in scale compared to those by HD. The administrative work and resources required to implement a similar scheme may not be proportionate to the actual time saved and effectiveness in expediting refurbishment works. HKHS therefore needs to carefully assess the cost-effectiveness of introducing a similar allowance scheme. Nevertheless, under suitable conditions, HKHS may consider piloting the aforesaid allowance scheme in selected estates to collect practical data for evaluating its effectiveness, which could serve as future reference in considering whether the scheme could be implemented in other rental estates.

Recommendation (q)

706. Under the coordination of the Housing Bureau, HKHS has obtained from HD details of the relevant arrangements and support, including its mode of collaboration with the Social Welfare Department and the Correctional Services Department. HKHS will make reference to HD's experience and assess the feasibility of extending the eligibility of the Letter of Assurance to tenants who surrender their flats due to admission to residential care homes or imprisonment. The factors of consideration include that HKHS must obtain consent from the Office of the Privacy Commissioner for Personal Data, as well as explore the establishment of appropriate system arrangements to facilitate the transfer of relevant personal data to relevant organisations in compliance with applicable laws and regulations. HKHS will carefully consider the legal, administrative and resource implications when determining the next steps.

Recommendation (s)

707. HKHS has enhanced its relevant computer systems and updated the form that tenants must complete upon flat intake. During home visits, estate staff will verify and update the emergency contact information including the email addresses of existing tenants and their emergency contacts. The information will be stored in the electronic system for easy communication.

708. HKHS's self-developed "eHome Visit" platform also includes designated fields for storing email addresses of tenants and their emergency contacts to facilitate communication.

Lands Department and Planning Department

Case No. DI/470 – Enforcement by Planning Department and Lands Department against Unauthorised Land Developments

Background

709. Land is a valuable resource of society. While ensuring prudent planning of land use for community development, the Government is duty bound to combat unauthorised developments rigorously to safeguard the environment. Pursuant to the Town Planning Ordinance (TPO), the Planning Department (PlanD) is empowered to take enforcement action against unauthorised developments within a development permission area (DPA) in the rural New Territories. The Lands Department (LandsD) also plays an enforcement role in cases involving unlawful occupation of government land or breaches of lease conditions of private land.

710. For many years, the TPO had not empowered PlanD to take enforcement action in rural areas not previously covered by DPAs. With the amended TPO coming into effect on 1 September 2023, the Secretary for Development may designate rural areas in the New Territories with ecological value, which are subject to development pressure and risks of environmental degradation, to be "regulated areas", so as to plug the loophole by enabling PlanD's enforcement action against unauthorised developments in such areas.

711. It is no doubt the Government's duty to tackle unauthorised developments rigorously, but lease control and law enforcement are only remedial measures. To prevent irregularities effectively, publicity and education are indispensable. To this end, PlanD has in recent years taken different measures to enhance private land owners' understanding of their obligations and its stringent enforcement. PlanD has also made continuous efforts to promote public awareness and enlist their support for its work.

712. In this direct investigation operation, the Office of The Ombudsman (the Office) has scrutinised the enforcement by PlanD and LandsD against unauthorised developments, including their ambit and demarcation of responsibilities, handling of complaints and unauthorised development cases, as well as inter-departmental collaboration.

713. On the whole, the Office considered PlanD and LandsD to have handled unauthorised development cases according to their purview and statutory powers, but there is still room for improvement regarding enforcement procedures and intensity. The Office is pleased to note that after the launch of this direct investigation operation, PlanD and LandsD have responded positively to the Office's observations and opinions on inter-departmental collaboration.

The Ombudsman's observations

PlanD's Enforcement Work

714. Currently, PlanD's Enforcement Section identifies unauthorised development cases through handling complaints and proactive inspections. If unauthorised development cases are confirmed by the Enforcement Section's investigation, PlanD would, having regard to the actual situation and after endorsement by its internal District Enforcement Conference (DEC), issue three types of statutory notices (namely the Enforcement Notice, Stop Notice and Reinstatement Notice) under the TPO to the land owners, occupiers or responsible persons requiring rectification. The notices will be registered in the Land Registry.

715. Between 2018 and 2023, PlanD identified a total of 2 549 unauthorised development cases with a downward trend from 522 cases in 2018 to 367 cases in 2023, representing a decrease of almost 30%. On average, PlanD could identify unauthorised development cases in around 67% of proactive inspections each year, far higher than the rate of around 15% through complaint investigation, indicating that both its large-scale screening inspections of DPAs and inspections targeting specific sites were

effective for monitoring irregularities. Moreover, the majority of statutory notices issued by PlanD had been complied with. The annual compliance rate ranged from 69% to 88% during the above period, reflecting the deterrent effect of existing enforcement measures against most offenders.

716. For the remaining cases of non-compliance with statutory notices, PlanD would make assessment for the sake of prosecution. Among the cases where the statutory notices lapsed without compliance, only a tiny minority of them averaging only 1.2% between 2018 and 2022 were not prosecuted. Between 2018 and 2023, the PlanD instigated prosecutions in a total of 475 cases of unauthorised development, among which 65 involved repeated prosecutions.

717. Two cases of repeated prosecutions that the Office examined involved unauthorised use of private land for storage and car parking. The breaches involved were easy to rectify or prone to recur. The offenders in both cases had complied with the Enforcement Notices issued by PlanD but regressed to unauthorised land use subsequently. In accordance with the prevailing procedures, PlanD shortened the compliance period of the second and subsequent Enforcement Notices from the normal three months to one month. The respective land owners were repeatedly prosecuted for non-compliance with the Enforcement Notice and ultimately convicted and fined by the court.

718. The Office recognised that shortening the compliance period of statutory notices could expedite the handling of cases involving repeated breaches. According to its current practice, PlanD would, depending on the extent of spatial overlap between the present and previous cases and whether the unauthorised development recurred within one year, shorten the compliance period to a minimum of one month. However, it might not be sufficient to deter some repeated offenders by considering whether the unauthorised development recurred within one year alone. In a particular case, the respective land owners undertook the same unauthorised development thrice within a couple of years. The breaches were obviously intentional. The Office recommended that regarding repeated cases in

breach of the TPO, PlanD should explore considering more factors in setting the timeframe for compliance with statutory notices and progressively shortening the timeframe upon subsequent breaches, so as to raise offenders' costs of non-compliance proportionately.

719. PlanD's information revealed that the average processing time for unauthorised development cases (i.e. from confirming the unauthorised development, issuing statutory notices to instigating prosecution) decreased from 17 months in 2018 to 14 months in 2023, indicating its enhanced efficiency. Following the inclusion of more sites in DPAs and the newly-added "regulated areas" as designated by the Secretary for Development under the amended TPO, the scope of land under PlanD's enforcement purview is expected to expand continuously. The Office is pleased to note that to expedite the handling of unauthorised development cases, PlanD has revised its enforcement procedures by reducing the number of compliance inspections after issuance of the statutory notices and shortening the interval between inspections.

720. Nevertheless, the total manpower of the two sections responsible for handling unauthorised development cases (namely Enforcement Section and Prosecution Section) under PlanD has shrunk in recent years. The gap between the staff establishment and the actual strength of these two sections has also continued to widen. The Office reckoned that PlanD should keep under review the existing manpower condition and fill vacancies through internal redeployment where necessary to cope with the heavy enforcement work.

721. The Office also found room for improvement in PlanD's handling of cases with change in land ownership. PlanD should draw up guidelines on the procedures and target timeframe for handling unauthorised development cases involving a change in ownership for periodic circulation to staff to avoid omission of necessary action.

722. Separately, some of the public opinions reaching us showed that the requirements specified by PlanD in Reinstatement Notices were

considered inadequate to restore the damaged ecological habitat completely. PlanD explained that, depending on the actual circumstances, it would consider the requirements for reinstatement in accordance with the principle under section 23(3) of the TPO. Where necessary, the department would seek professional advice from other departments like the Agriculture, Fisheries and Conservation Department (AFCD) to ensure that the notices issued can balance the statutory requirements and the need for conservation. Having enquired with AFCD, the Office learned that PlanD had sought its professional advice in various cases in the past. AFCD also remarked that the way to restore a damaged habitat varies from case to case, depending on the location, scope and surroundings of the site. According to AFCD's professional advice, by replanting vegetation (including grass) on a site after removing the waste or fill materials (such as construction waste) not originally existing thereon or directly filling the site with soil, the damaged habitat could be gradually restored to its former condition by natural succession.

723. The Office noticed that pursuant to the TPO, a Reinstatement Notice may require reinstatement of the land to the condition it was in upon the gazettal of the DPA plan or, where appropriate, to any other condition more favourable to the notice recipient that the Planning Authority considers satisfactory. The Office accepted that in drawing up the requirements in statutory notices, PlanD should have regard to numerous factors such as the statutory requirements, the nature of the case and the need for environmental protection. Nevertheless, the term "Reinstatement Notice" may easily give the public a misconception that the notice recipient would be obliged to fully reinstate the site to its former landscape or condition. As such, the Office recommended that PlanD step up explaining the basics of Reinstatement Notice through such publicity channels as official website to promote public awareness of its enforcement measures and avoid misunderstanding.

724. At the same time, the Office reckoned that PlanD should step up education and publicity to enhance private land owners' understanding of their obligations, the damage caused by unauthorised developments to the

environment, the enforcement role of the department, the price to be paid by offenders and the essential features of the TPO, so as to raise law-abiding awareness.

LandsD's Enforcement Work

725. LandsD enforces against unauthorised development cases from the perspectives of unlawful occupation of government land or breaches of lease conditions of private land. In respect of private land, a vast majority of unauthorised development cases involve private agricultural land. There is generally no restriction on the land use. However, except squatter structures surveyed in 1982 or with prior permission, it is a breach of lease conditions to erect any structures on agricultural land, against which LandsD may take lease enforcement action.

726. In relation to unlawful occupation of government land, LandsD would, upon confirmation of irregularities after investigation, post a statutory notice pursuant to section 6(1) of the Land (Miscellaneous Provisions) Ordinance (LMPO) on site requiring the occupation to cease before the specified date; otherwise, LandsD would take further action including demolishing and taking possession of any property and structure on the land, as well as considering prosecution. Given the vast number of cases involving unlawful occupation of government land received each year, LandsD has drawn up guidelines to prioritise cases under a risk-based approach having regard to the gross area of the site, its planned use and the severity of breaches.

727. The Office's investigation revealed that for cases of unlawful occupation of government land involving both priority and non-priority circumstances, LandsD's existing guidelines were unclear about how the case should be classified as a whole. The Office recommended that LandsD comprehensively review its existing guidelines and specify clearly the various factors for determining whether a case falls within the priority category, supplemented with real cases to illustrate how to assess cases,

for compliance by staff. LandsD should also put in place a monitoring mechanism to ensure proper prioritisation of different cases by staff.

728. On the other hand, a case showed LandsD's failure in timely completion of a priority case involving unlawful occupation of government land. LandsD should step up training to ensure the staff clearly understand the enforcement role of the department and take timely action against non-compliance with the law and lease conditions according to its performance indicators. The Office also noticed that each year LandsD has to handle a large number of cases involving unlawful occupation of government land and breaches of lease conditions. In this light, LandsD should in parallel review its existing manpower and examine the need for redeployment or even additional resources having regard to the actual situation to cope with the enforcement work.

Inter-departmental Collaboration between PlanD and LandsD

729. PlanD and LandsD handle unauthorised development cases in accordance with their respective purview and powers. Currently, PlanD refers unauthorised development cases involving mostly or only government land to LandsD for further action. The Office understood that a pre-requisite for enforcement by PlanD is that the identity of the land owner, occupier or responsible person of the site in question could be confirmed so that a statutory notice may be issued. As for cases of unlawful occupation of government land, however, it is more difficult to confirm the identity of the occupier or responsible person. Hence, a more practicable way is for such cases to be handled by LandsD under the LMPO by posting a statutory notice and then demolishing and taking possession of any property and structure on the land.

730. The Office noticed that during the initial stage of this direct investigation operation, there was indeed room for enhancement in the efficiency of the collaboration between PlanD and LandsD. The Office was pleased to note that upon the Office's coordination, both departments were receptive to the Office's observations and opinions and strived to

further strengthen their collaboration. PlanD and LandsD have since established a joint working group co-led by their deputy directors. The first meeting of the joint working group was held in March 2024. The two departments have also introduced a pilot scheme with two large-scale unauthorised developments involving private agricultural land selected for joint enforcement operations. The positive attitude of these two departments in taking improvement measures is commendable. The Office expects them to make use of the newly-established high-level communication platform to reinforce their collaboration thereby bringing synergy effect to their enforcement work.

731. As the joint working group has been newly established, the Office recommended PlanD and LandsD to consider drawing up a mechanism and timetable for timely review of the joint working group's guiding direction and the effectiveness of the pilot scheme on joint enforcement operations, thereby ensuring that the new measures can serve the purpose of enhancing inter-departmental collaboration.

732. Moreover, there is room for improvement in the maintenance of data on inter departmental collaboration by PlanD and LandsD. The two departments should respectively review the data they maintained on inter-departmental unauthorised development cases and enforcement action, and discuss any need to incorporate more data items, thereby providing a more precise and comprehensive basis for monitoring and analysing enforcement work.

733. Taking a step further, PlanD and LandsD should consider establishing a database for unauthorised development cases to facilitate inter-departmental intelligence sharing and enforcement. The two departments may make use of the database to formulate targeted measures for high-risk sites having regard to such factors as the severity of breaches and whether repeated breaches are involved, so as to nip problems in the bud.

734. With the amended TPO came into effect in September 2023, PlanD is empowered to take enforcement action against unauthorised developments within "regulated areas". In light of the continuous increase in the area of land under regulation, PlanD and LandsD should review the enforcement and case referral procedures in a timely manner and explore room for further streamlining and consolidation, so as to optimise the use of resources for coping with an anticipated increase in enforcement work.

735. Looking ahead, as the current-term Government proactively implements various land development projects, land use in the rural New Territories would undergo vast changes. Unauthorised developments may differ in terms of their mode and scale, etc. PlanD and LandsD, as the enforcement authorities should conduct a systemic review after the implementation of the various improvement measures. The two departments should also adapt to the circumstances, continuously deepen reform and innovate, as well as improve the operational mechanism and collaboration to strengthen the ability to prevent and handle unauthorised developments.

736. The Ombudsman recommended PlanD to –

(a) regarding cases involving repeated breaches of the TPO, explore considering more factors (including the total number of breaches committed by the offender, the gross area of the site, the nature of irregularities and the impact on environmental hygiene) in setting the timeframe for compliance with statutory notices and progressively shortening the timeframe upon subsequent breaches, so as to raise offenders' costs of non-compliance proportionately;

(b) review the manpower for handling unauthorised development cases and fill vacancies through internal redeployment where necessary to cope with the enforcement work;

(c) draw up guidelines on the procedures and target timeframe for handling unauthorised development cases involving a change in ownership for periodic circulation to staff to avoid omission of necessary action;

(d) step up explaining the basics of Reinstatement Notice through such publicity channels as official website to promote public awareness of its enforcement measures and avoid misunderstanding;

(e) step up education and publicity to enhance private land owners' understanding of their obligations, the damage caused by unauthorised developments to the environment, the enforcement role of the department, the price to be paid by offenders and the essential features of the TPO, so as to raise law-abiding awareness;

The Ombudsman recommended LandD to –

(f) comprehensively review its existing guidelines and specify clearly the various factors for determining whether a case falls within the priority category, supplemented with real cases to illustrate how to assess cases involving both priority and non-priority circumstances, for compliance by staff;

(g) put in place a monitoring mechanism to ensure proper prioritisation of different cases by staff;

(h) step up training to ensure the staff clearly understand the enforcement role of the department and take timely action against non-compliance with the law and lease conditions according to its performance indicators;

(i) review its existing manpower and examine the need for staff redeployment or additional resources having regard to the actual circumstances to cope with the enforcement work;

The Ombudsman recommended PlanD and LandsD to (Inter-departmental Collaboration) –

(j) consider drawing up a mechanism and timetable for timely review of the joint working group's guiding direction thereby ensuring that the new measures can serve the purpose of enhancing inter-departmental collaboration;

(k) conduct timely review of the effectiveness of the pilot scheme on joint enforcement operations;

(l) respectively review the current data on inter-departmental unauthorised development cases and enforcement action, and discuss any need to incorporate more data items, thereby providing a more precise and comprehensive basis for monitoring and analysing enforcement work;

(m) consider establishing a database for unauthorised development cases with such information as the identity of offenders, subject locations, irregularities and results of follow-up action, thereby facilitating inter-departmental intelligence sharing and enforcement;

(n) making use of the above newly established database, formulate targeted measures for high-risk sites having regard to such factors as the severity of breaches and whether repeated breaches are involved, so as to nip problems in the bud;

(o) review the enforcement and case referral procedures in a timely manner and explore room for further streamlining and

consolidation, so as to optimise the use of resources for coping with an anticipated increase in enforcement work; and

(p) conduct a systemic review after the implementation of the various improvement measures. The two departments should also adapt to the circumstances, continuously deepen reform and innovate, as well as improve the operational mechanism and collaboration to strengthen the ability to prevent and handle unauthorised developments.

Government's response

737. PlanD and LandsD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendation (a)

738. The compliance period of the Enforcement Notices issued by PlanD regarding repeated cases in breach of the TPO (repeated cases) was tightened, and concerned colleagues were informed through internal guidelines on 28 November 2024. The amended guidelines enable coverage of more cases recurring within a short period and repeated cases in conservation-related land use zones, while setting a stricter compliance period for such cases.

Recommendation (b)

739. As at 31 December 2023, the staff establishment and actual total staff strength of PlanD's Enforcement and Prosecution Section were 83 and 72 respectively (excluding general administrative and clerical supporting posts). PlanD alleviated the manpower shortfall through internal manpower redeployment. As at March 2025, the actual total staff strength increased to 79. PlanD will keep under review the manpower condition from time to time, so as to ensure effective execution of the enforcement work. Facing the challenge of manpower shortfall, PlanD

will leverage applied technologies (including the use of drones to assist in inspection and evidence collection) to enhance efficiency. Also, priorities for case handling will be set according to the nature and impacts of the unauthorised developments as well as the zonings of their locations, with a view to enhancing the efficiency of handling unauthorised development cases under the existing manpower.

Recommendation (c)

740. In the second half of 2024, PlanD duly issued the internal guidelines on the procedures for handling unauthorised development cases involving any claims of change in ownership. To ensure proper service of statutory notices to relevant land owners and appropriate follow-up actions, PlanD also revised the relevant guidelines, requiring initiation of additional land search prior to prosecution assessment.

Recommendation (d)

741. A dedicated page (https://www.pland.gov.hk/pland_en/planning_e-p/index.html) for providing the public with information on unauthorised developments and enforcement work (including the essential features of enforcement work under the TPO, the environmental impacts of unauthorised developments, the explanations on Reinstatement Notices, owners' obligations, prosecution and penalty, etc.) is now available on the departmental website of PlanD.

Recommendation (e)

742. Starting from August 2024, PlanD released a series of posts/clips in phases on its social media pages, including Facebook (https://www.facebook.com/plandgovhk/) and Instagram (https://www.instagram.com/plandgovhk/), providing more real case examples and relevant information on enforcement work and unauthorised developments (such as requirements for site reinstatement).

743. PlanD launched a one-year broadcasting plan in December 2024 on local TV and radio stations to remind the public of the impacts of unauthorised developments as well as the prosecution and fine against offenders.

744. PlanD will continue to maintain communication with relevant stakeholders, such as the Rural Committees, to promote public awareness of enforcement matters.

Recommendations (f), (h) and (i)

745. In April 2023, LandsD began consolidating the enforcement duties of its District Lands Offices, centralising all land enforcement duties (including government land control, squatter control and enforcement of lease conditions) under one single team so that complaints/enquiries/referrals in respect of land enforcement cases could be handled in an integrated manner. After the consolidation, LandsD is now conducting a comprehensive review of the work priorities and inspection work related to all kinds of non-compliance with the law and lease conditions (including unlawful occupation of government land, unauthorised squatter structures and breaches of land lease conditions). The review involves prioritising the categories of non-compliance cases and the respective enforcement actions, setting time targets for enforcement actions of the priority category, drawing up factors for determining whether a case falls within the priority category, deliberating on the redeployment of resources, and reviewing existing internal guidelines. In the meantime, LandsD will continue to adhere to the pragmatic "risk-based" approach and prioritisation strategy to manage enforcement work for the large number of cases involving unlawful occupation of government land and breaches of lease conditions. After the review, guidelines will be updated, setting out clearly the priority and workflow of different case categories (covering cases involving both priority and non-priority circumstances) for staff to follow. The review is expected to be completed by the fourth quarter this year and the guidelines will be updated accordingly. LandsD will also step up training to ensure

that the Land Enforcement Team in each district carries out enforcement work in accordance with the mechanism established by the headquarters. It will be supplemented by the sharing of real cases of significance to help them clearly understand the enforcement role of the department and take timely action against non-compliance cases. LandsD will continue to review the current manpower to meet the operational demands of daily enforcement work.

Recommendation (g)

746. As for the upgrade of LandsD's internal land enforcement data system currently underway, the department will incorporate a monitoring mechanism and include more relevant data (including the planned use of the land concerned; the number of cases referred by PlanD or other government departments for follow-up action; and records of inter-departmental collaboration or joint enforcement operations), as well as the reviewed priorities and workflows of different types of land enforcement, so as to ensure proper prioritisation of different cases and timely action against non-compliance cases in accordance with the workflow by its staff. The system upgrade is at an advanced stage and is expected to be completed in the fourth quarter of 2025.

Recommendations (j) and (k)

747. PlanD and LandsD have set up a two-tier communication mechanism – the Working Group on Joint Enforcement Operations (the WGJEO) co-led by the Assistant Directors of the two departments to establish and improve the inter-departmental collaboration mechanism for joint enforcement operations; and professional grade staff of both departments have strengthened communication and co-ordination for individual joint operations. The WGJEO will hold regular meeting to strengthen the inter-departmental collaboration. The first two meetings of WGJEO were held in January and August 2025.

Recommendation (l)

748. The Office noted that PlanD had not compiled any statistics on inter-departmental cases referred to LandsD or other departments. PlanD, in response, reviewed and upgraded its internal planning enforcement system to incorporate relevant data of cases referred to other departments as well as records of inter-departmental collaboration or joint operations for monitoring and analysis. The upgraded system can also store data on follow-up actions taken by the departments concerned on cases referred by PlanD. The upgraded planning enforcement system was rolled out on 13 February 2025 for internal use.

749. Separately, as mentioned in Recommendation (g) above, LandsD is working on upgrading its internal land enforcement data system. More relevant data will be included to facilitate the monitoring and analysis of enforcement work. The upgrade is scheduled for completion in the fourth quarter of 2025.

Recommendations (m) to (p)

750. The first meeting of the WGJEO, co-led by the assistant directors of the two departments, was held in January 2025. At the meeting, discussions were held on the proposed screening criteria (e.g. whether the case involves conservation-related zoning, the area of the site and whether the case involves any structures or government land), the updating and reporting mechanism for cases suitable for joint enforcement operations, and the prioritisation of such cases. The WGJEO also agreed to establish a common database for these joint enforcement cases, as recommended by The Ombudsman, to facilitate inter-departmental intelligence sharing and enforcement. After this recommendation was reported at the third joint working group meeting in March 2025, the two departments have finalised the screening criteria and shortlisted suitable cases for further consideration for joint enforcement operations. These shortlisted cases have also been included in the established common database for regular updating and sharing.

751. By adopting a common database and mutually agreed screening criteria, the exchange of intelligence between the two departments and the effectiveness of combating unauthorised developments can be further enhanced.

752. Through the above two-tier meeting mechanism (i.e. joint working group meetings and WGJEO meetings), the enforcement work of the two departments can be strengthened effectively.

Leisure and Cultural Services Department

Case No. DI/475 – LCSD's handling of obstructions to passageways by bicycles owned by operators of bicycle rental services

Background

753. the Office of The Ombudsman (the Office) received a complaint against Leisure and Cultural Services Department (LCSD). Allegedly, an operator of the bicycle rental services in a certain park under LCSD (the Operator) had been placing a large number of bicycles outside its business area for a protracted period, causing obstruction to a passageway nearby, but LCSD had failed to monitor the Operator effectively such that the irregularities persisted.

754. In the course of investigation, the Office noticed that there were other LCSD recreational venues with bicycle rental services provided by different operators. Operators placing their bicycles outside the permitted areas in violation of regulations not only causes obstruction to passageways and hinders the public's access to and use of recreational facilities, but may also pose safety hazards, which simply cannot be ignored. Against this background, the Office has probed thoroughly LCSD's management arrangements with respect to the display and storage of bicycles by bicycle rental service operators, as well as the Department's enforcement mechanism for tackling related irregularities.

The Ombudsman's observations

(I) Should Strengthen Monitoring of Bicycle Rental Service Operators

755. There are 14 recreational venues under LCSD with bicycle rental services provided by operators engaged by the Department. The business permit for conducting bicycles rental services (Permit) is granted by LCSD through open tender. The contract terms of the Permit explicitly forbid

placing bicycles and articles relating to the bicycle rental services outside the Permit Area.

756. The case study of the Office shows that notwithstanding continued follow-up, LCSD had for years failed to take timely and decisive enforcement actions against the Operator's irregularities in accordance with contract terms. The Office's multiple site inspections also found the same irregularities at other LCSD venues, and this has invited doubts as to whether LCSD had ever reminded the operators of the irregularities or take enforcement action against them in the past.

757. The Office considered it imperative that LCSD strengthened its monitoring of bicycle rental service operators and took decisive enforcement action against violations pursuant to contract terms.

(II) Should Step up Staff Training on Enforcing Permit Contract Terms

758. The case selected for study by the Office shows that during the period when the Operator had violated the contract terms and placed its bicycles outside the Permit Area, LCSD had sought legal advice twice from the Department of Justice on the enforcement of Permit contract terms and related procedures. It subsequently learnt that further enforcement action could not be taken against the Operator's aggravated violations because the reminders LCSD had sent to the Operator earlier did not contain relevant wordings of warning.

759. The Office was of the view that the above might reflect that LCSD frontline staff had failed to fully understand the Permit contract terms and relevant contract management work. LCSD should step up staff training in this aspect.

(III) Unsystematic and Inconsistent Enforcement Mechanism

760. According to the relevant guidelines, LCSD staff issue reminders or warning letters to operators based on the gravity of the irregularities

found. If there is no evident improvement after the third warning letter, LCSD can consider suspending the operator's business or terminating the contract. Nevertheless, the guidelines did not clearly specify how many verbal and written reminders would warrant a warning letter, or whether written reminders and warning letters have a validity period. It is mainly up to individual staff to make decisions depending on the actual circumstances of each case.

761. The Office was of the view that in order to carry out enforcement more efficiently, transparently and fairly, LCSD should enhance the current enforcement regime and the relevant guidelines, for example, by specifying clearly that the Department would issue a warning letter if a cumulative number of verbal or written reminders were given within a certain period of time, and that the criteria for the issuance of a warning letter should be made public. This would facilitate LCSD frontline staff to carry out enforcement work through consistent standards.

(IV) Should Review Operators' Arrangements for Storing and Displaying Bicycles

762. The Office noticed that operators would display bicycles of various models for customers to choose and try so that customers could pick the one they considered suitable, safe and easy to control. Such modus operandi is not unreasonable, and may even have practical need for it. The Office considered that while LCSD had a duty to monitor compliance with Permit contract terms, it should also review whether the current regulatory regime was too restrictive for the operators in the business.

763. LCSD should conduct a comprehensive review on the operation of bicycle rental services at its venues. If it is considered that the space or the geographical location of the bicycle kiosks are found to hamper business operations, the Department should examine whether operators can be allowed to use the space outside the Permit Area for placing their bicycles as long as the relevant regulations are complied with. In the long

run, LCSD should consider including part of the venue as the Permit Area when drafting new contracts for bicycle rental services in the future for better management.

764. The Ombudsman recommended LCSD to –

(a) keep monitoring the Operator closely. Should it continue to occupy the space outside the Permit Area in violation of contract terms, decisive enforcement action must be taken;

(b) strengthen monitoring of bicycle rental service operators and take decisive enforcement actions against irregularities pursuant to contract terms;

(c) step up staff training on the enforcement of Permit contract terms and relevant procedures to ensure that enforcement actions are taken rigorously, accurately and effectively;

(d) examine how to enhance the current enforcement regime and relevant guidelines, so as to carry out enforcement work in a more efficient and fairer manner in accordance with consistent standards;

(e) conduct a comprehensive review on the operation of bicycle rental services at venues under its purview, and to examine the feasibility of allowing operators to use the space outside the Permit Area for placing their bicycles through management arrangements or measures, subject to compliance with the relevant requirements;

(f) consider revising the terms of future Permit contracts to suitably include a certain area outside the bicycle kiosks as part of the Permit Area for better management;

(g) collect information on the performance of operators (especially irregularities and their approach to complying with reminders and warning letters, etc.) and include such information into the LCSD database as reference in approving new Permits in the future; and

(h) step up publicity to encourage members of the public to monitor operators' performance and report irregularities to LCSD at once.

Government's response

765. LCSD accepted The Ombudsman's recommendations and has taken the following follow-up actions.

Recommendations (a) and (b)

766. LCSD continued to follow up on the issues closely, including daily inspections of the bicycle kiosks to rigorously monitor the Operator's business operation. Monthly meetings were held with the Operator to review its performance, during which it was clearly stated that the department would consider terminating the rental contract of bicycle kiosks should there be repeated violations. As a result, the situation improved significantly. LCSD also worked in close collaboration with the district's Task Force on Illegal Parking Bicycle and took part in joint enforcement actions on 18 December 2024 and 21 March 2025 to crack down on violations. By the end of the kiosk contract on 31 March 2025, the Operator had not committed further violations. Following the contract's expiry, LCSD has arranged for the kiosks to be relocated to an area within its park that is entirely under its management to enable more effective supervision.

767. LCSD has always been rigorous in monitoring the operations of all bicycle kiosk operators, ensuring compliance and taking appropriate actions in accordance with relevant contract terms when necessary. If irregularities like illegal parking of bicycles are identified, LCSD will promptly issue verbal reminders and request immediate rectification.

Further actions, including issuing written reminders or warning letters, will be taken as needed to remind operators that violations would lead to contract termination.

Recommendations (c) and (d)

768. To strengthen monitoring efforts, LCSD has enhanced the "Guidelines on Monitoring of Catering and Other Revenue Contracts" and introduced a new set of "Guidelines on Monitoring of Performance of Bicycle Kiosk Permit Holders" with examples of violations. These serve as clear and practical references for enforcement personnel to understand the procedures for handling violations, apply appropriate contractual clauses, and make use of regulatory documents (including reminders, warning letters and termination notices) for more effective handling of the issues.

769. In terms of strengthening staff training, LCSD has enhanced its training courses by incorporating the above-mentioned guidelines and using this case as a practical example in the contract management curriculum, with a view to enhancing staff's knowledge and skills in monitoring operators, including the criteria and considerations for issuing verbal reminders, written reminders and warning letters, to ensure that enforcement actions are taken more rigorously, accurately and effectively. LCSD has also made the course content available on its intranet for easy access by all personnel.

Recommendations (e) and (f)

770. Recognising the unique geographical challenges posed by the kiosks in this case, which is located between public pedestrian pathways and bicycle lanes outside LCSD's jurisdiction, LCSD has reviewed the locations of other bicycle kiosks. If a kiosk is located within its venue, LCSD has designated bicycle display / storage areas for the operators to cope with their operational needs. The department has also reminded district management to ensure that future bicycle rental service contracts

should include provisions for designated bicycle display / storage areas to facilitate operators' business operation and LCSD's supervision.

771. Given the unique geographical location of the kiosks concerned, LCSD has arranged for its relocation to an area within the park that is entirely under LCSD management, which allows inclusion of bicycle display / storage areas in the Permit Area of its future contracts.

Recommendation (g)

772. LCSD has optimised its existing database and procedures for collecting operator performance data. All performance evaluation reports for operators are now uploaded to a central database on the LCSD's intranet for consolidation. Briefings have been conducted to familiarise staff with the new arrangements and system operation processes, so that relevant personnel could check the database for past performance records for reference when handling tendering exercises in the future.

Recommendation (h)

773. To facilitate the collection of public feedback, LCSD has installed notice boards at its venues, clearly displaying venue information and contact numbers of venue managers. Similar notices will be posted at bicycle kiosks to facilitate public access to such information. Members of the public can also reach out via the 1823 hotline or email, or contact LCSD directly via email.

Transport Department

Case No. DI/469 – Transport Department's Arrangements for Driving Test

Background

774. In recent years, there is a growing public demand for driving tests (especially road tests) and the average waiting time of driving tests is very long. However, the number of road test provided by the Transport Department (TD) is affected by various factors, including the objective conditions of the venues of the test centers, the traffic conditions in the vicinity, the demand for road tests for different types of vehicles, as well as the manpower of the TD, etc., resulting in an insufficient number of driving tests to satisfy the public demand over the years. Furthermore, driving test services had been suspended intermittently by TD six times between 2020 and 2022 in response to the Government's anti-epidemic and social distancing measures during the COVID-19 outbreak. As a result, the waiting time for taking the more popular driving test for non-commercial vehicles had once been as long as nearly a year.

775. In addition, the number of appeals against road test results also shows a rising trend in recent years, reflecting an increase in the public's discontent with TD's road test arrangements. the Office of The Ombudsman (the Office) has also received public complaints and queries about TD's decision of and justification for prohibiting video recording of road tests with the dashboard cameras in test vehicles.

776. Against this background, the Office has examined TD's administrative arrangements for and management of driving test services, its mechanisms for evaluating candidates' performance in road tests and handling appeals, as well as explored the feasibility for TD to record driving tests more objectively with the help of technology.

The Ombudsman's observations

(I) Proactively explore ways to improve driving test services and shorten waiting time for road tests

Explore Ways to Increase Road Test Output by Putting in More Manpower Resources and Designating New Test Venues

777. During the last 12 years, both the number of applications for road tests and the road test output of TD had increased, but the road test services still failed to meet the demand. Put simply, the waiting time for road tests would remain excessively long unless there is a sustained and substantial decrease in the demand for the tests. In other words, the waiting would only be prolonged again if more and more people apply for the road tests in the future. The Office considers the situation is undesirable. TD should, therefore, make every effort to increase road test output to ensure a shorter waiting time of candidates.

778. The Office noticed that since the end of the epidemic, TD has arranged for Driving Examiners (DEs) to work extra hours in a bid to increase road test output, and indicated that it will look for suitable sites to set up new driving test centres. The Office agreed to the above measures and recommended that TD should explore how to increase road test output by putting in more manpower resources and designating new test venues. For instance, it can arrange for DEs to take up additional work on weekends so that more road tests can be arranged. Besides, the Department should consider setting up additional driving test centres at locations with lower traffic flows in various parts of Hong Kong (e.g. at locations in the New Territories or outlying islands which are farther away from the city centre or residential areas). If designating new driving test centres proves to be effective in shortening the candidates' waiting time for road tests, TD should, in the long run, consider replacing those driving test centres currently located in busy districts with the newly set up centres, where feasible.

Continue to Review and Enhance the "Duty Reporting Arrangement" to Increase Road Test Output

779. Under the "Duty Reporting Arrangement", DEs must first arrive at the TD Headquarters in Ho Man Tin, Kowloon by 8 am every working day for computer ballot-drawing, then proceed to the various driving test centres to discharge their testing duties. Such arrangement results in extra travel time by the staff involved and would in effect reduce the time available to DEs for conducting road tests each day.

780. The Office is glad to learn that in response to the investigation, TD had completed another review on the "Duty Reporting Arrangement" at the end of 2023, and has since mid-June 2024 adopted the "Direct Reporting Arrangement" (DEs should be allowed to travel directly from residence premises to driving test centres assigned by balloting to discharge testing duties) on a trial basis at four of the non-commercial vehicles driving test centres. The Office recommended that TD should review the "Direct Reporting Arrangement" after a certain period into the trial run at the four test centres. If the trial is effective and staff's feedback is positive, TD should proactively study the feasibility of implementing the "Direct Reporting Arrangement" at other driving test centres so as to increase its road test output.

Reinstate the Target Waiting time and Achievement Rates on Conducting Road Tests for Non-Commercial Vehicles

781. Previously, TD had set performance pledge at within 82 days and a 95% achievement target regarding the waiting time for road tests for non-commercial vehicles. This is a demonstration of good public administration. Nevertheless, the Department abolished the performance pledge and no longer projected the achievement rate in 2016 due to changes in supply and demand for the tests. The Office considers that waiting time is not only a significant statistical indicator, but also an important yardstick with which TD can assess and enhance its operations, optimise its resource deployment and allocation, as well as a criterion for

the Department and the public to monitor TD's work efficiency. The Office recommended that TD should resume the practice of setting service standards in respect of road tests for non-commercial vehicles and state clearly the target of arranging a road test for candidate within certain number of days upon receiving an application for the test.

(II) Enhance arrangements for recording road test assessments

Provide Guidelines to DEs on Making Instant Remarks

782. Both TD and the Transport Tribunal have been handling more and more appeal and review cases in recent years. Currently, the handling procedures rely heavily on the instant remarks and records made by the DEs in the course of the road tests. Nevertheless, when the Office scrutinised the instant records made by various DEs during road tests, the Office noticed obvious differences in how the DEs had made the records and what they had written down. The Office considered it imperative that TD should promulgate guidelines on the making of instant remarks by DEs during road tests to enable DEs to record driving road test assessments more efficiently and more accurately by means of standardized criteria.

Installing Video Recording Equipment in Test Vehicles

783. At present, TD prohibits the installation of video recording equipment in test vehicles. As such, appeals and review requests can only be processed based on the reports written by DEs immediately after the road tests. Having examined the administrative arrangements for road tests in the Mainland and other regions, the Office found that video recording equipment are already being used in the Mainland and some other countries to record the course of road tests and candidates can request to review the recorded footages in order to file appeals. In some countries, electronic systems have already been or are going to be adopted to evaluate road test performance.

784. With the growing popularity of dashboard cameras and the rapid development of reliable technology, installing video recording equipment in test vehicles is in line with the prevailing trend in society, and it actually has certain practical benefits. The Office opines that TD should seriously review its current practice of prohibiting video recording of road tests and consider whether introducing video recording systems or equipment specifically for road tests is adequate and reasonable. This arrangement would facilitate collection of data and video images during the tests by TD and the candidates and make it easier for DEs to explain their professional assessment of candidates' performance, as well as raise the Department's efficiency in handling candidates' appeals and requests for review. The Office agreed that protecting personal privacy is of paramount importance. So, in addition to making video-recording arrangement, TD should also examine ways to properly manage and maintain the personal data contained in the footages. It should communicate with the stakeholders continuously and respond to their different concerns. The Office is pleased to note that TD has already conducted a feasibility study on the installation of video recording equipment in test vehicles. In the long run, the Department should further consider whether advanced technology (such as electronic assessment systems) should be employed to help DEs evaluate candidates' performance in driving tests.

(III) Enhance arrangements relating to driving tests

Extend Validity Period of Learner's Driving Licence and Driving Test Form

785. Recent years saw a growing demand for road tests and a lengthening waiting time for taking the tests. Currently, candidates usually have to wait around 7 to 8 months. The waiting had once been as long as about a year during the epidemic. Under such circumstances, it is not pragmatic for TD to set a validity period of 12 and 18 months respectively for the learner's driving licence and the driving test form. Candidates who have failed the road test and are allotted an end-of-list test appointment date for retest would probably have to apply for a learner's driving licence

again because the original licence would have expired by then. Similarly, the driving test forms of candidates who have applied for postponing the road test may also have expired before the candidates can actually take the road tests, given the growing demand and the already long waiting time for the tests.

786. The Office is of the opinion that unless TD can, within a short period, shrink the waiting time for road tests to around 82 days, just as it had been ten years ago, otherwise, with the current long waiting time for the tests, the short validity period of the learner's driving licence and the driving test form would indirectly cost road test candidates more time and money. Besides, TD would also need to spend resources accordingly to handle applications for renewing the learner's driving licence and the driving test form. This would in effect increase its administrative cost. In this light, the Office recommended that TD should review the validity period of the learner's driving licence and the driving test form.

Registration of Test Vehicles

787. Some candidates indicated that despite having arrived at the driving test centres on time, they still could not sit for the road test because their driving instructors, together with the test vehicles, failed to show up for the tests. Since private driving instructors can have a number of students simultaneously, they may have to shuttle between different driving test centres within a short period of time on the same day so that their students can use the vehicle for the driving tests scheduled for the day. At present, TD only requires the candidates to provide the registration numbers of the test vehicles and information about the driving instructors when they attend the road test. If the same test vehicle is found to have been registered for several road tests to be held at the same test session, only the first candidate who registers the vehicle would be allowed to sit for the test. The other candidates whose tests are scheduled for a later time would have to look for another eligible vehicle on the spot at once.

788. When candidates fail to sit for road tests because their test vehicles are engaged in road tests held elsewhere at a similar time and cannot arrive at the test centres, it would not only affect the candidates (who would have to queue up for the road test again as a result), it would also waste the precious test sessions. The Office considered that the above situation can be avoided with administrative measures, such that test resources can be better utilised, different candidates would not register the same test vehicle for road tests scheduled for the same time slot, and those candidates given a later test slot would not miss the road test for not having a test vehicle, thereby wasting the test sessions.

<u>"Venue Assistants" near Driving Test Centres</u>

789. With respect to the "venue assistants" hired by the different Driving Instructors Associations, TD considered that they have not affected the road tests process and the Department has communicated with the relevant sector regarding the issue. The Office's observations found that the "venue assistants" had in fact rendered the candidates a lot of help in the course of the road tests. As TD confirmed that it had received complaints about some assistants asking for money at test venues, the Office considered that it should step up venue management at driving test centres and keep communicating with the driving instructor sector to help monitor the operations of "venue assistants" so as to ensure that the road tests are conducted in a fair and orderly manner.

790. The Office has the following recommendations to TD –

(a) to proactively explore ways to further increase road test output through flexible manpower deployment. For instance, it can consider arranging for the DEs to work extra hours on weekends;

(b) to study proactively the feasibility of increasing road test output by designating more driving test centres at locations with lower traffic flows in various parts of Hong Kong (e.g. at locations farther away from the city centre or residential areas);

(c) to conscientiously review the trial run of the "Direct Reporting Arrangement" at the four driving test centres;

(d) if the above trial arrangement is positively received, TD should proactively examine the possibility of extending the Arrangement to other driving test centres;

(e) to resume the practice of setting service standards and achievement targets in terms of waiting time for road tests for non-commercial vehicles;

(f) to promulgate guidelines as soon as possible on the making of instant remarks by DEs during road tests;

(g) to review its practice of prohibiting video recording of road tests;

(h) if video recording is feasible upon review, TD should examine measures to protect personal privacy and communicate with the stakeholders continuously in the course of introducing video recording equipment specifically for road tests;

(i) in the long run, to consider whether advanced technology (such as electronic assessment systems) should be employed to help DEs evaluate candidates' performance in driving tests;

(j) to seriously review the validity periods of the learner's driving licence and driving test form;

(k) to implement suitable measures as soon as possible to prevent the situation where more than one candidate registers the same test vehicle for their road tests during the same time slot because the private driving instructor has to provide his/her vehicle for use by several candidates under a tight road test schedule; and

(l) step up management at driving test centres and keep in constant communication with the driving instructor sector with respect to the monitoring the operations of their staff so as to ensure that road tests are conducted in a fair and orderly manner.

Government's response

791. TD accepted the Office's recommendations and has taken the following follow-up actions.

Recommendation (a)

792. TD has been striving to secure additional resources to create posts of Driving Examiners (DEs) and redeploy resources to increase road test output. The most recent recruitment exercise for DEs was completed in 2024 in order to fill the vacancies. All newly-recruited DEs have completed training and commenced conducting driving tests.

793. On the other hand, TD has already arranged for DEs to take up additional work on weekends since late March 2023. Additional 12 400 and 4 000 driving tests were held in 2024 and 2025 (as at June) respectively. The waiting time for driving tests of non-commercial vehicles (combined tests) of non-designated driving schools substantially decreased from 257 days in January 2024 to 151 days in June 2025. TD will timely review the need to continue the relevant measures in the light of public demand for driving test services and manpower of the Department.

Recommendation (b)

794. To cope with the demand for driving test services, TD has been making efforts to identify suitable sites in the territory for setting up additional and more widely-distributed driving test centres (DTCs), with a view to increasing the road test output. Such sites have to be well suited for conducting driving tests, including being suitably located for testing

whether the candidates have mastered all necessary driving skills to complete various driving tests required by legislation and having normal traffic flow for the observation of the candidates' abilities in handling different traffic conditions. TD will maintain close liaison with the Planning Department to identify suitable sites for setting up additional and more widely-distributed DTCs.

Recommendations (c) and (d)

795. TD has reviewed the duty reporting arrangements for DEs and DTC Officers. Taking into account various factors, such as the different operational needs of the DTCs, the traffic conditions in the vicinity and the practical arrangements, the "Direct Reporting Arrangement" for DEs and DTC Officers to travel directly to DTCs to report duty has been implemented at the four designated DTCs starting from June 2024.

796. Taking into account factors such as operational needs, nearby traffic conditions and actual arrangements of various driving test centres, TD considers that the Direct Reporting Arrangement cannot be implemented at other driving test centres at present. Hence, there is no plan to extend the arrangement to other driving test centres for the time being.

Recommendation (e)

797. TD is conducting review on the setting of performance pledge for road tests for non-commercial vehicles and will make an announcement as soon as possible.

Recommendation (f)

798. TD updated the "Guidelines on Making Instant Remarks During Road Tests" and published them for all DEs in January 2025.

Recommendations (g) to (i)

799. TD has taken reference from the practices of video recording the course of road tests in various regions (including the Mainland), whereby the practices vary in different places. In the Mainland, driving test venues are provided by the Government and the test vehicles are government-owned. However, most of the road tests in Hong Kong are conducted on public roads while the test vehicles are privately owned.

800. TD needs to carefully consider the implementation details and the use of resources, as well as consult stakeholders' views before the introduction of new technologies, maintaining a balance among factors such as legal requirements, privacy of candidates and cost-effectiveness. TD will continue to keep in view the developments in different places in this regard and consider the relevant measures at an appropriate juncture.

Recommendation (j)

801. Regarding learner's driving licence, applicants of driving tests, except for motorcycle driving tests, are not required to apply for learner's driving licences in conjunction with the application of driving tests. Applicants can apply for a Road Test (Part B Test and Part C Test) upon completion of the Written Test (Part A Test), and then apply for a learner's driving licence and make arrangements for their driving learning schedule based on their actual needs as the road test date approaches.

802. Regarding the validity period of driving test form, the current 18-month (about 540 days) validity period can adequately address most situations (including the waiting time of about 500 days during the epidemic). For example, as at end-June 2025, the longest waiting time for road tests of non-commercial vehicles of non-designated driving schools is about 154 days. In such case, the 18-month validity period is sufficient to allow applicants to apply for postponement of road tests twice.

803. Upon review, TD considers that the prevailing arrangements have provided sufficient flexibility for learner drivers, and there is no need to extend the validity period of learner's driving licence and driving test form.

Recommendation (k)

804. TD held a meeting with the driving instructor trade in September 2024, reminding the private driving instructors to prevent the situation where more than one candidate register the same test vehicle for their tests during the same time slot because the instructor has to provide his/her vehicle for use by candidates under a tight road test schedule. TD noted that the situation has improved and will continue to closely monitor the situation and maintain liaison with the trade.

Recommendation (l)

805. TD held a meeting with the driving instructor trade in September 2024, requiring proper management and monitoring of the staff hired by the Driving Instructors Associations to ensure that they abide by the laws and do not interfere with moving vehicles on the road, so as not to endanger their own safety and that of other road users. Meanwhile, TD also replaced the banners at DTCs in the fourth quarter of 2024 to remind everyone not to interfere with the tests, disturb the candidates or obstruct other road users.