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Panel on Transport

Subcommittee on Matters Relating to Railways

Minutes of special meeting on
Wednesday, 18 January 2006, at 9:00 am
in Conference Room A of the Legislative Council Building

Members present	**:**	Hon Miriam LAU Kin-yee, GBS, JP (Chairman) Ir Dr Hon Raymond HO Chung-tai, S.B.St.J., JP Hon Mrs Selina CHOW LIANG Shuk-yee, GBS, JP Hon LAU Kong-wah, JP Hon Andrew CHENG Kar-foo Hon TAM Yiu-chung, GBS, JP Hon Abraham SHEK Lai-him, JP Hon Tommy CHEUNG Yu-yan, JP Hon Albert CHAN Wai-yip Hon WONG Kwok-hing, MH Hon LEE Wing-tat Hon Jeffrey LAM Kin-fung, SBS, JP
Member attending	**:**	Hon James TO Kun-sun
Public Officers attending	**:**	Dr Sarah LIAO Secretary for the Environment, Transport and Works Mr Joshua LAW Permanent Secretary for the Environment, Transport and Works Miss Cathy CHU Deputy Secretary for the Environment, Transport and Works

Mr William SHIU
Principal Assistant Secretary for the Environment, Transport and Works

Mr Alan WONG
Commissioner for Transport

Mr Albert YUEN
Assistant Commissioner for Transport/ Bus and Railway

Mr K H LO
Chief Inspecting Officer (Railways)
Hong Kong Railway Inspectorate Section
Environment, Transport and Works Bureau

Attendance by invitation : Kowloon-Canton Railway Corporation

Mr Michael TIEN
Chairman

Mr Samuel LAI
Acting Chief Executive Officer

Mr Y T LI
Senior Director, Transport

Mrs Grace LAM
General Manager, Corporate Affairs

Mr Tony LEE
Rolling Stock Design & Systems Engineering Manager

Ir Edmund K H LEUNG
Chairman, Independent Review Panel

Ir Professor S L HO
Member, Independent Review Panel

Mr Eric APPERT
Customer Director
ALSTOM Transport Hong Kong Ltd.

Mr Robert DAVIES
Technical Manager - Mechanical
ALSTOM Transport Hong Kong Ltd.

Clerk in attendance	**:**	Mr Andy LAU Chief Council Secretary (1)2
Staff in attendance	**:**	Mrs Mary TANG Senior Council Secretary (1)2
		Miss Winnie CHENG Legislative Assistant (1)5

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I East Rail incident on 21 December 2005 and safety of the railway system

The Chairman said that the purpose of the meeting was to follow up on the East Rail (ER) incident on 21 December 2005 and to discuss the safety aspects of the railway system. She informed that some members of the Subcommittee had paid a site visit to Kowloon Canton Railway Corporation (KCRC)'s Fo Tan Depot on 17 January 2006.

2. The Secretary for the Environment, Transport and Works (SETW) said that the ER underframe equipment mounting problem had aroused much public concern. She said that the first and foremost concern of the Administration was to ensure the safe operation of ER. Efforts had been made to reduce inconvenience to the traveling public. In the light of the fleet-wide problem of ER trains, the Administration had reinforced the seven-member Hong Kong Railway Inspectorate (HKRI) team by seconding eight professional and inspectorate staff from the Electrical and Mechanical Services Department. They were assigned to, inter alia, assess the scale of the problem, examine the effectiveness of the improvement measures, and monitor the subsequent 48-hour regular checks. To ensure that Government could have a thorough assessment, an internationally renowned railway expert would be appointed to help assess the root cause of the problem and examine the robustness of KCRC's present rectification measures and proposed long term improvement measures, following which the Government would also appoint a special investigation committee comprising prominent community personalities and independent non-executive Board members. The committee would expect to carry out an independent investigation into how KCRC had handled the ER incidents, the reporting within the Corporation, the required notification to Government, and the interface between KCRC and HKRI in handling ER incidents.

3. Mr Michael TIEN, Chairman of KCRC, said that KCRC had maintained much transparency in the handling of ER incidents and had been providing the public with daily reports on the progress of remedial measures. He said that what the public was most interested to know was whether ER was safe and as such the performance of ER in the following two months would be critical in bringing back public confidence on its reliability. Following discussion with rail experts and train manufacturers, it had

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been decided that the mounting of 8 000 underframe components of 23 categories would be re-designed by minimizing the use of welding, relying more on screws instead and installing metal cradles to all compressors as an added safety measure. The re-designing work would expect to be completed in February 2006 and all underframe components would be reinforced with the new design by March 2007. Meanwhile, efforts would be made to identify the root causes of the problem. The inspection work would be conducted according to the following programme –

(a) components without cracks would be inspected once every three months while those with cracks shorter than 14 mm would be inspected every two months;

(b) components with cracks ranging from 14 to 40 mm would be checked once every month and those with cracks from 40 to 50 mm would be checked once a week;

(c) components with cracks ranging from 50 to 68 mm would be checked once every two days and those with cracks longer than 68 mm would be removed for repair; and

(d) non-major components would be examined weekly.

As secondary support, metal cradles would be added to all compressors while industrial-use belts were added on all other major components including those in which no cracks were found. Furthermore, the integrity of major components and belts was examined every 48 hours by visual inspection and hammering tests. In this way, any irregularities and cracks could be promptly identified and replaced/repaired.

4. Mr Samuel LAI, Acting Chief Executive Officer of KCRC (Atg CEO/KCRC) stressed that the series of improvement measures were approved by rail experts and train manufacturers after careful assessment of the situation. He said the non-destructive testing and the hammering test were effective and widely used method for detecting cracks. The proposed inspection programme and regular testing would ensure the safety of ER services and provide the public with the needed confidence on rail services. The size and changes of the cracks would be carefully monitored. It was expected that, with the adoption of the series of improvement measures, the problems associated with the mounting of underframe components could be resolved by early 2007.

5. Mr Andrew CHENG questioned Government's monitoring role in ensuring rail safety. He opined that as evidenced in the present railway incident, there was a need to increase the resources and statutory power of HKRI so that they could effectively assume the regulatory role on railway safety. Indeed, consideration should also be given to setting up a statutory body to perform the work presently undertaken by HKRI in an attempt to step up the monitoring role on the ageing rail systems to ensure passenger safety. SETW said that the role of Government in the monitoring of rail services had been clearly set out in the Railways Ordinance (Cap.519). While there

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were established guidelines on the notification of rail incidents, the provision of a safe and reliable passenger service remained the responsibility of the carrier. Following the present incident, the Administration had strengthened the establishment of HKRI and was prepared to make further improvements to the monitoring system but members would appreciate that this would take time.

Notification requirements

6. Mr Andrew CHENG said that while he acknowledged that the ageing of the rail systems was the cause of most of the ER incidents, what worried him most was the failure in the detection of the problems and the inadequacy in the notification mechanism as evidenced by the present incident. He enquired if KCRC was prepared to review its notification mechanism and management culture. The Chairman of KCRC said that regular examination of the welding of the mounting brackets for underframe components had not been a part of the maintenance and repair programme provided by train manufacturers. It was understood that the welding of the underframe components would last until the end of their serviceable life. While there were regular inspection on the underframe components, cracks in welding were not easily detected but problems were rarely envisaged. On the management culture, the Chairman of KCRC said that he had all along been in close communication with staff on ways to improve the efficiency of rail systems. There were established guidelines on the notification of rail incidents but there would not be a need to notify each and every incident given that there were numerous incidents in the daily operation of rail systems.

7. Mr WONG Kwok-hing recalled that following the last West Rail (WR) incident in July 2005, KCRC had undertaken to provide prompt notification on all rail incidents but he could not understand why it had again failed in its undertaking this time. He was dissatisfied that proper notification was only made upon revelation by the media which was already 20 days after the incident. He questioned whether the senior management was derelict in its duties and whether it should be held responsible for failure in notification. The Chairman of KCRC said that the WR trains collision incident on 21 July 2005 inside the Pat Heung Depot was not a notifiable incident as no injuries nor safety risks were involved. Following the WR incident, KCRC had agreed to take a flexible approach to notify the Administration even though it was not required to do so under the law. As for the present ER incident, KCRC had been providing daily press release with progress reports on the actions taken on cracked equipment found on ER trains. The KCRC management and its staff were committed to ensuring the safety and reliability of rail services and had appointed an Independent Review Panel (IRP) to conduct an in-depth study of the problems and to suggest improvements. The outcome of the IRP study would be reported to members as soon as practicable.

8. Atg CEO/KCRC supplemented that KCRC had informed HKRI of the loosened compressor incident on 22 December 2005, one day after its occurrence. As assessment had to be made on the nature of the incident, i.e., whether it was an isolated case or whether it revealed a systemic failure, it took time for KCRC to carry out the

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necessary investigation. Since the occurrence of the incident on 21 December 2005, KCRC staff had been trying hard to identify the size of the problem. The problem was later found to be fleet-wide and was more serious than what was originally envisaged. The staff concerned had no intention to conceal the incident.

9. Mr Tommy CHEUNG sought the views of the Chairman of KCRC regarding Government's issuance of a warning letter to KCRC on 11 January 2006 condemning it for failure to notify the occurrence of the incident according to statutory requirements. He said that the incident seemed to have suggested that there was some sort of concealment on the part of KCRC which was subsequently revealed by the Administration. The Chairman of KCRC said that according to legal advice obtained by KCRC, it had not contravened notification requirements set out under the KCRC Regulations. He said that KCRC had informed HKRI of the incident on 22 December 2005. He was notified of the incident on 9 January 2006 by the acting CEO/KCRC. He had brought this to the attention of the Administration on 10 January 2006 and had held a meeting with KCRC's board of directors on 11 January 2006 to follow up on the incident. This showed that KCRC had taken the initiative of notification and no effort had been made to conceal the incident.

10. SETW said that the HKRI was notified about the loosening compressor incident on 21 December 2005. It had been told that the affected train had been returned to the depot for further examination, in line with standing practice for trains which needed repair. The Administration had not received further reports on the incident in the days following. However, given the discovery of cracks on many of the underframe components on 22 and 23 December 2005 and the subsequent revelation that such was a fleet-wide problem, KCRC should have made arrangements to further notify the Administration about the gravity of the situation. She pointed out that according to regulation 2 of KCRC Regulations, an accident was notifiable if it occurred on the railway as a result of which any person died or suffered serious injury or that it involved collision which affected the normal operation of a rail line. It was also set out in the Schedule to the Regulations that notifiable occurrences would include occurrences affecting railway premises, plant and equipment which endangered or could endanger the safe operation of the railway.

11. SETW further said that the Administration had to be notified early as it would need time to assess the safety of rail operation. However, further details of the incident were only made available at the KCRC's board meeting on 11 January 2006. The Administration had to decide, based on the information made available at the meeting, on whether ER trains were safe and whether they should be allowed to continue operation. It was based on the provisions of KCRC Regulations that the Administration had issued a warning letter to KCRC, reminding the Corporation that it should report on the incident which was a notifiable occurrence.

12. Mr LEE Wing-tat said that the recent spate of rail incidents and the Administration's condemnation of KCRC's failure of notification had aroused much public concern. It was quite unusual for a Bureau Secretary to condemn an independent public organization. Such had called into question KCRC's ability in

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managing rail services. While he appreciated the efforts of the frontline staff, a lot more needed to be done by the KCRC management to regain public confidence on rail safety. SETW said that KCRC management had been reminded of the notification requirement set out under KCRC Regulations. Since being notified of the incident, the Administration had been cooperating as well as assisting KCRC management and its frontline staff in overcoming the crisis and ensuring the safety of rail services. As rail safety was of primary concern, the Administration would not like to dwell on the contention over who should be held responsible at this stage but a review would be conducted after the incident.

13. Mrs Selina CHOW said that what the public was most concerned was passenger safety and it was hoped that Government and KCRC would be united in their efforts to provide a safe rail service. She said that KCRC, being a major mass transport service provider, had all along been providing an efficient rail service to the satisfaction of the public. The staff of KCRC had been working hard to maintain the quality of service and there was a need to keep up their morale and give them the needed support. While there was a time gap in notification, it should be noted that KCRC would also need time to perform preliminary investigation into the incident before reporting to the Administration. As an independent IRP had been appointed to investigate into the causes of the incident, it would not serve any useful purpose to resort to finger-pointing and fault-finding at this stage, particularly when there might not be any human error involved.

14. Ir Edmund K H LEUNG, Chairman, Independent Review Panel (Chairman of IRP) said that it would not be responsible on his part to speculate on the causes of incident when investigation had yet to complete. As far as he understood, the incident was the first of its kind in the history of KCRC and was an atypical occurrence. There could be a number of possible factors leading to the cracks in the underframe components and safety measures would be introduced to prevent future recurrences. The IRP would try to complete investigation as soon as possible, hopefully by the end of the January 2006 as requested by the Chairman of KCRC. Ir Professor S L HO, member, IRP said that as there were discrepancies in the outcome of the tests performed on different trains, more time was needed to analyze the results. It was hoped that some preliminary findings could be made available by the end of January 2006.

15. Mr WONG Kwok-hing sought further clarification about the circumstances under which an incident should be reported as there appeared grey areas in the requirement for notification. SETW said that Part II of the Schedule to the KCRC Regulations had set out the 12 types of occurrences affecting railway premises, plant and equipment which required notification. While such requirements had been clearly set out, there could however be different interpretations on which level of occurrences should be notified. Log books containing entries of all occurrences would be kept for HKRI's inspection and decision as to whether further follow-up actions were necessary. She understood that these entries were in great detail if the occurrences affected the safety of passengers. However, these would tend to be brief if the occurrences were within depots and did not involve any injuries. Such were the

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grey areas which would need to be further looked into so that staff would know exactly the circumstances under which an occurrence should be reported. The Chairman of KCRC clarified that KCRC staff had been instructed to abide by the requirements set out in the Regulations and only in circumstances which were not covered by the statutory provisions would staff be allowed to take actions appropriate to the situation.

16. Mr Andrew CHENG said that it would appear that Government and KCRC had different interpretations of the notification requirements since Government had issued a warning letter to KCRC condemning it for failure to notify the occurrence while legal advice obtained by KCRC was that it had not contravened notification requirements. He sought SETW's views on the present situation as the difference in interpretation had given the public an impression that Government was unable to exercise control over the management of KCRC. The situation might have been attributed to the lack of resources and manpower of HKRI, as a result of which proactive monitoring actions could not be taken. He considered it necessary that the statutory power as well as the resources to be given to HKRI should be reviewed. He also enquired if the Administration would prefer to resolve the KCRC's management problems before the proposed merger between MTR Corporation Limited (MTRCL) and KCRC, or it would try to expedite the proposed merger in an attempt to resolve all rail problems in one go.

17. SETW said that Government had been very clear about the enforcement of notification requirements and as such it had issued a warning letter to KCRC on the Corporation's failure to notify the incident. She said that legal opinions were often conflicting and she would not like to argue over whose legal opinion was correct. Under the additional requirement, KCRC would need to submit certification on the safety of all ER trains. This would ensure that all incidents affecting safety would be notified. While a comprehensive review would be conducted, she hoped that this would not increase the workload of KCRC staff who were already under great pressure to ensure the safe operation of ER since the incident happened. There was a need for cooperation between Government and KCRC to ensure the safety and efficiency of rail service. She also agreed that the resources and power to be vested on HKRI could be reviewed. As regard the proposed merger between MTRCL and KCRC, she said that it was not up to the Administration alone to decide on its progress. She agreed that if the progress could be expedited, it would cause less uncertainty to the staff. The Chairman said that the grey areas in the notification requirements would be further followed up by the Subcommittee.

18. Mr James TO requested KCRC to provide members with the information paper which was made available to KCRC's board of directors at its meeting on 11 January 2006 as well as the advice given by IRP on 14 January 2006. Noting that an additional requirement was imposed on KCRC requesting it to submit certification on the safety of all ER trains for passengers' service each day before the commencement of passengers' service, he enquired about the existing certification mechanism and how such was managed. SETW said that the board of directors had received a power point presentation from KCRC regarding the incident and if the board of directors did

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not object, this could be provided to members to facilitate their understanding of the problem. She said that KCRC would be required to provide a safety clearance certificate each day to HKRI before the commencement of passengers' service and KCRC had accepted the additional requirement. HKRI would be monitoring the operation of rail services round the clock and would be working closely with KCRC and IRP. At Mr TO's request, Atg CEO/KCRC agreed to provide members with the information received by KCRC from IRP on 11 January 2006.

19. Mr LAU Kong-wah was aware that there was another incident occurring the day before in which a train wire was wrongly connected. He enquired if the said incident had been notified. SETW confirmed that the said incident had been notified. Responding further to Mr LAU as to why the incident had not been reported in the press, SETW said that as the incident occurred within the depot and was rectified soon after, it was not considered necessary to inform the press. Mr LAU however pointed out that the collision incident which took place in July 2005 also occurred within the depot but as such incidents might have serious implications, the public should have the right to know. Mr Y T LI, Senior Director, Transport, KCRC (SDT/KCRC) said that the incident which occurred on 17 January 2006 concerning a wrong wire connection occurred during the testing of trains inside the maintenance depot. The problem was immediately rectified and as there were no safety implications, the incident had not been reported to the press. He assured members that all trains were certified safe before being allowed to carry passengers.

Investigation

20. Mr LAU Kong-wah said that the site visit to Fo Tan depot on 17 January 2006 had been very useful in understanding the extent of the problem. Members were able to see for themselves how the underframe components were loosened and how these were now mounted with industrial-use belts and metal cradles which had secured them in position. He said that under the present circumstances, assurance of safety was first and foremost and apportioning of blame would be secondary. KCRC had imposed a number of safety measures and it had also undertaken that it would not operate ER trains unless it was safe to do so. Given the wide public concern, he enquired whether the Administration was confident about the safety of ER trains and if so, the basis upon which its confidence was built.

21. SETW said that in deciding on the safety of the rail systems, the Administration would need to rely on expert advice which had to be analyzed and assessed by HKRI. Detailed analyses had been performed on the incident which had turned out to be a fleet-wide problem. The cracks had been studied carefully and reinforcements had been applied as necessary. The safety implications were assessed by experts using modelling studies. As pointed out by the Chairman of KCRC, components with cracks longer than 68 mm would be removed for repair. These strict standards were derived on a scientific basis for ensuring the safety of trains. The round-the-clock maintenance inspection by KCRC staff together with the enhanced monitoring by HKRI had provided the needed safety assurance. Based on the report from HKRI, ER trains were considered safe and were allowed to operate. She assured members

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that ER service would be stopped if the trains were found to be unsafe.

22. Ir Dr Raymond HO declared interest that he was involved with the civil works of ER in 1977. He noted that the KCRC maintenance staff had been under immense pressure to rectify the rail systems following the incident and he was pleased to note that they had had the full support from the rest of the staff. He appreciated KCRC's efforts in the remedial works which had been both effective and efficient. He however criticized the use of the term "nylon strings" to describe the belts used in securing the underframe components which had given the public a wrong impression on the safety of the system. The belts used were in effect industrial-use belts which were able to fasten the components securely in place. Noting the loosening of the underframe components was due to cracks in the welding of the mounting brackets, he enquired whether the last refurbishment of ER trains in 1999 was performed in Hong Kong or in the United Kingdom, where the trains were manufactured.

23. Mr Robert DAVIES, Technical Manager- Mechanical, ALSTOM Transport Hong Kong Ltd.(TMM ALSTOM) advised that the refurbishment was done in Hong Kong. The underframe components were not a part of the refurbishment which mainly involved the body shells and the additional doors, and no re-welding was done. Atg CEO/KCRC further explained in response to Mr TAM Yiu-chung that the last refurbishment of ER trains in 1999 was performed in Hong Kong using the services provided by the train manufacturers, the ALSTOM Transport Hong Kong Ltd. The refurbishment was performed as the trains had already been in operation for 15 years. The main refurbishment works involved the conversion of compartments from three-door to five-door, the widening of gangways between train compartments and the upgrading of some electronic systems. There had not been any refurbishment works for the underframe components.

24. Mr TAM Yiu-chung enquired if the cause of the incident was a lack of maintenance of the underframe components. The Chairman of IRP said that while no firm conclusion could be drawn at this stage, it would appear that refurbishment of underframe component was in general not necessary in the first 15 years.

25. Ir Dr Raymond HO enquired about the cause of the cracks and how these could be prevented. The Chairman of IRP said that the incident on 21 December 2005 involved an atypical fault, the causes of which had yet to be identified. He said that metal fatigue was usually caused by cyclic and stress levels exceeding the designed capacity.

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26. Ir Dr Raymond HO noted that the base of the mounting bracket was a narrow strip measuring only 10 centimetres (4 inches) long and part of it was trimmed off with a flat surface leaving only one weld which was functioning. He queried why such trimming was allowed as this would expose the only weld to excessive stress. He said that it was the responsibility of the manufacturer to ensure that the design was proper and that the mounting bracket was able to carry the heavy weight of the underframe components. TMM ALSTOM explained that the equipment used was a standard design on a standard piece of equipment and had been used in other trains. At this stage, he was not able to tell whether the type of weld used was the cause of the incident. Clearance had to be obtained from the manufacturers on the mounting of the underframe components and further investigation would be performed on this aspect in the next few weeks.

27. Ir Dr Raymond HO enquired whether other non-destructive testing, apart from the hammering test and the magnetic particles inspection (MPI), would be essential in the present case. TMM ALSTOM said that the train manufacturers, the ALSTOM Transport Hong Kong Ltd., would consult KCRC on the tests which would be performed. He said that while the hammering test would identify cracks on the surface, MPI would be the standard technique in identifying cracks above a few millimetres.

28. Ir Dr Raymond HO enquired whether the welding in Hong Kong was up to the standard required in the United Kingdom. TMM ALSTOM said that the trains were designed in accordance with the British standards in the 1970s. The present standards were equivalent in terms of technical requirements. He understood that KCRC staff responsible for welding would need to go through an accreditation similar to the requirement in the United Kingdom.

29. Mr TAM Yiu-chung enquired about the service lives of the trains and whether there was any overseas experience in dealing with cracks in the welding of components. TMM ALSTOM explained that the normal service lives of trains were about 30 years but could be extended by additional maintenance. The design of ER trains were similar to the "Class 317" trains running out of London and a check on their database had revealed no such cracking incidents although they had been in operation for 25 years. As the cracking problems only occurred in Hong Kong, Mr TAM was concerned if such were due to over-usage and/or over-speeding of the trains. In this connection, he enquired if there were any speed limits or restrictions on the operation of the trains and if so, whether KCRC had been forewarned by the train manufacturers. TMM ALSTOM advised that the trains were operating within their specifications in terms of speed, acceleration and deceleration, both under manual driving and the Automatic Train Operation (ATO) system. Atg CEO/KCRC supplemented that there had been close liaison with the train manufacturers in the operation of ER trains under ATO or Automatic Train Protection (ATP) systems. All the operative procedures were tried out in accordance with design specifications before being implemented.

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30. Mr Jeffrey LAM said that he was pleased to note that joint efforts had been made by Government and KCRC to resolve the problems. As cracks in the mounting brackets were quite unusual given that welding was supposed to last for 30 years, he considered it necessary that further investigation should be carried out to see if there were any inherent quality defects associated with the manufacturing or maintenance process. Atg CEO/KCRC said that KCRC and IRP were trying hard to identify the causes of the incident and hopefully the preliminary findings could be completed by January 2006. TMM ALSTOM advised that train manufacturers would be supporting the investigation and advising KCRC on the interim and long term solutions. While the train manufacturing company was not aware of any inherent quality defects, it would be keeping an open mind in the investigation.

31. Mr Jeffrey LAM was concerned that the full introduction of the ATO to the ER system in 2003 might have added stress to the underframe components and created interface problems, which could be aggravated by the acceleration and deceleration of trains. The Chairman of IRP said that pending the outcome of investigation, the speed of ER trains had been reduced as a safety measure. Initial assessment had indicated that the rate of change of acceleration and deceleration resulting from ATO driving had added stress to the rail systems but the train manufacturers had maintained that such was not the case.

32. Mr Jeffrey LAM noted that on the day of the incident on 21 December 2005, the driver of a southbound ER train was alerted by a red warning light inside the driving cab, denoting the failure of train equipment. The Control Centre was immediately informed and arrangements were made to alight all passengers at Fo Tan Station. This was followed by an on-site examination which had revealed that one of the underframe components was partially loose. Since the red warning light was a useful detector, he enquired if this was in place to alert the driver and the Control Centre of any failure of the rail system. SDT/KCRC affirmed that the red warning light would be lit in case of any failure of train equipment, thereby alerting the driver and the Control Centre of the problem. He further explained in response to Mr LAM that the new design in the mounting brackets would minimize welding and rely on screws. Where welding could not be avoided, reinforcement in the form of metal cradles would be used. The detailed design of the mounting brackets would expect to be finalized by February 2006.

KCRC management

33. Mr Albert CHAN said that the discovery of cracks in the 202 underframe components was a cause for concern to the traveling public and had revealed flaws in the maintenance of rail systems. The series of rail incidents had called into question the quality of KCRC management and had raised public concerns about the ability of KCRC in managing rail services. The public was also concerned that there would be more serious rail incidents in future. He noted that many of the more senior posts of KCRC were acting appointments, possibly owing to the uncertainties associated with the proposed merger of MTRCL and KCRC. Such might have adversely impacted on the management and structure of KCRC. He asked the Chairman of KCRC whether

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the proposed merger had prevented him from making positive changes to the re-organization of KCRC. He was also concerned that the crux of problem might have been attributed to the management culture of KCRC which had adversely affected the implementation of policies.

34. The Chairman of KCRC said that he had been holding management meetings with the board of directors of KCRC every month. Following the last rail incident, a series of improvement measures had been implemented while a number of committees had been set up under the chairmanship of board directors. As a result, close liaison had been maintained between management and staff through which mutual confidence had been established. With the departure of the last CEO in 2003, KCRC management had once planned to launch a global hunt for a new CEO. However, with the proposed merger, the management had decided to appoint Mr Samuel LAI as the acting CEO during the interim period, on grounds of his competence for the job.

35. Atg CEO/KCRC said that he had been the acting CEO for over two years; and this had imposed some constraints on him because the acting appointment gave an impression that the post was a temporary one. The staff of KCRC would expect the CEO to demonstrate leadership and lay out a roadmap for the Corporation's future development. Even if he devised a five-year plan, the staff would question where it would lead to. It was not easy to change a company's culture because it took many years to do it. Any change in culture should be from bottom up and buy-in from all levels of staff was required.

36. Mr Abraham SHEK declared interest that he was one of the directors of KCRC. He said that the views put forward by members were very constructive and he agreed to have them reflected to the KCRC management. He hoped that the present incident would not give the public the impression that KCRC trains were not safe. He assured members about the safety of KCRC's rail service as it had all along been providing a very safe and efficient service to the public. At the board meeting on 11 January 2006, the IRP and the train manufacturers had assured the board of directors about the safety of ER trains. As regard the criticism about KCRC's culture, he said that the crisis management of the incident and the remedial measures promptly undertaken by staff round-the-clock had demonstrated the quality of KCRC management and its united efforts in the provision of a safe and reliable service to the public.

37. The Chairman said that the progress of investigation into the present incident as well as the remedial measures taken by KCRC to ensure the safety of trains would be followed up as an additional agenda item at the next meeting of the Subcommittee scheduled for 3 February 2006. Separate meetings would be held later to discuss the management culture of KCRC and the grey areas in the notification requirements.

(*Post meeting note*: At the request of the Administration and with the concurrence of the Chairman, the meeting was rescheduled for 17 February 2006 at 10:45 am.)

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II Any other business

38. There being no other business, the meeting ended at 10:45 am.

Council Business Division 1
Legislative Council Secretariat
22 February 2006