

# OPUS2

The Cranston Inquiry

Day 1

March 3, 2025

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Monday, 3 March 2025

(10.00 am)

SIR ROSS CRANSTON: Well, good morning, everyone, those in the room and also those watching on live stream.

This is the first day of the Inquiry's full hearings. As you know, the Inquiry was established last year in January to consider the events of the 23 and 24 November 2021, when many people tragically lost their lives attempting to cross the Channel in a small boat.

The principal purpose of these hearings is for witnesses to give evidence, both as to the events in question, but also other issues which are relevant to the terms of inquiry -- the terms of reference for the Inquiry. The witnesses are going to be questioned by counsel on my behalf. I'm hoping that the evidence they give over the next four weeks will provide valuable assistance to me when I come to prepare the report.

In a moment, I am going to ask Counsel to the Inquiry, Mr Rory Phillips, King's Counsel, to deliver his opening statement. He will outline the issues to be canvassed in the evidence over the next four weeks. But let me just explain that we will have a break at about 11.15/11.30 for the purposes of giving the stenographers a break.

Mr Phillips.

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Opening statement by MR PHILLIPS

MR PHILLIPS: At about 9 o'clock on the evening of 23 November 2021, in the cold and the dark, a group of people gathered on a beach near Dunkirk. They trekked in silence for about two hours to reach their departure point where five smugglers awaited. Men, women and children: they had left their home countries for a variety of different reasons, but they were united in their desperation to reach the United Kingdom.

Some had fled targeted political violence. Some were moving to start a new life, or hoping to join relatives or loved ones. All had made a long journey to Northern France. Some of those journeys were arduous or dangerous. They had all been at the makeshift encampments on the coast of Northern France in the inhospitable November weather. There they had been contacted by representatives of an organised gang of criminals and encouraged to make the crossing. They paid thousands of pounds to people who promised them safe passage. Instead, they were about to embark on a harrowing journey with more than 30 people crammed into a boat with a safe capacity of far fewer than that.

We cannot now be certain how many people boarded the boat that night. One of the smugglers was heard to say, "There are 33 of you", as he lined up the adults on

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the beach. But there may also have been small children on the boat, who may not have been counted and whose names do not appear among the list of the missing.

By about 10 o'clock, the boat had finally been fully inflated and dragged into the water. It had begun to rain. Everyone was quiet and the children seemed nervous. The passengers climbed aboard as the smugglers remained behind on the beach. The women and children were directed to sit on the floor of the boat, while the men perched on the inflated sides.

One of the passengers were nominated by the smugglers to steer the boat. A GPS device was handed to him and he was given brief instructions about how to try to locate Dover. Totally untrained and unfamiliar with the Channel, he was left to steer the boat through one of the busiest shipping lanes in the world.

The passengers were equipped with what the smugglers called a "lifejacket", though the term is hardly appropriate. They were not inflatable devices, but coloured vests stuffed with cotton or other fabric and with strips of reflective material on the sides. Some of the passengers were given hand pumps to top up the inflatable sides of the boat. There was no safety equipment available. They were not given safety advice,

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nor told what to do in the event of an emergency. They were not given an opportunity to ask questions or back out. They were fed misinformation, promised that once they entered British waters, they would be accepted as asylum seekers.

Unseaworthy and overcrowded, the boat set off towards the UK shortly after 10 o'clock. Only two of the passengers would survive the journey. The remains of the boat have not been recovered, but we know that the majority of similar journeys across the Channel are made using poor quality, plastic or rubber inflatable boats which are wholly unsuitable for the crossing. One of the survivors has told the Inquiry that the boat was light brown and around 8 metres long, the engine was small and noisy, and one of the passengers had to keep refilling it from two petrol tanks stashed in the back of the boat.

We cannot now be certain whether the boat failed due to fuel erosion, overcrowding, a failure in the fabric of the boat, the height of the waves, or a combination of all those factors. Whatever the reason, around three hours into the journey the boat began to take on a significant amount of water and became swamped. As soon as the boat started to take on water, the passengers vainly tried to bail out the water and

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1 made panicked calls for help. One called the smuggler  
 2 who had arranged the journey and sent their location,  
 3 but they did nothing to help.  
 4 Just after 1 o'clock in the morning, the UK  
 5 Coastguard was notified of the incident by the French  
 6 authorities. They said that the boat was around half  
 7 a nautical mile from the middle of the Channel with 33  
 8 people on board, including 13 women and eight children.  
 9 The Coastguard labelled the boat as "Incident C" or  
 10 "Incident Charlie". That's the name which you will see  
 11 in the documentation and hear in evidence throughout  
 12 these full hearings. I will set out the history of  
 13 the UK's agencies search and rescue efforts in much  
 14 greater detail later in the opening, but for now it is  
 15 enough to note that the first successful call from  
 16 the boat to the UK authorities came in at about 1.30.  
 17 The caller was in great distress. He told  
 18 the Coastguard that the passengers were "in the water"  
 19 and "everything [was] finished".  
 20 Shortly afterwards, the French authorities  
 21 transferred a call from a 16-year-old on board. He  
 22 spoke to the Coastguard for around 20 minutes. The call  
 23 is harrowing. He said that they had entered the water  
 24 and required immediate assistance. He sent co-ordinates  
 25 from his phone, which showed that the boat was in

1 the Sandettie area of the Channel close to the median  
 2 line, but on the UK side. There were a number of  
 3 subsequent missed calls from the passengers on the boat  
 4 to the Coastguard's phone. At around 2.30,  
 5 the 16-year-old made another desperate plea for help.  
 6 He said to the Coastguard that the passengers were  
 7 "finished" and that they would all die. In response, he  
 8 was told that a rescue boat was on its way. He was also  
 9 asked by the Coastguard to stop calling.  
 10 After receiving an update from the Coastguard,  
 11 a Border Force cutter called the Valiant was tasked to  
 12 respond at about 1.30 am. The Valiant did not leave  
 13 the Port of Dover until 2.22 and took another hour to  
 14 reach the last known location of the boat. A helicopter  
 15 was also tasked by the Coastguard just before 3 am while  
 16 the Valiant was still en route. When the Valiant  
 17 arrived in the Sandettie area at around 3.24, it was  
 18 unable to locate the boat. The co-ordinates had been  
 19 given to Border Force more than an hour and a half  
 20 earlier, so by the time the Valiant arrived, it seems  
 21 likely that the boat had drifted away.  
 22 The Inquiry's expert on survivability,  
 23 Professor Tipton, considers it likely that the majority  
 24 of passengers survived the swamping of the boat and  
 25 the entry into the water. His view is that most of

1 the passengers were still alive at 3.24 when the Valiant  
 2 reached the boat's last known location. Between then  
 3 and 6.10 in the morning, the Valiant searched  
 4 the Sandettie area and located three other small boats,  
 5 rescuing 98 people in all. And to put this in context,  
 6 a total of 367 people were rescued by Border Force in  
 7 the Channel that night, despite it being what one  
 8 Border Force staff member has described as "not a busy  
 9 night in comparison to other nights around that time".  
 10 None of the boats found by Valiant matched  
 11 the description of Charlie, but soon after 5 am,  
 12 the Valiant reported that they had embarked 35 people  
 13 from that boat. In fact, the boat was not Charlie, but  
 14 one which had been identified by the Coastguard as  
 15 "Lima". Again, I will explain the detail of this later,  
 16 but in short, the UK authorities updated their trackers  
 17 to say that Charlie had been embarked and ultimately  
 18 marked the incident as closed.  
 19 As the hours passed and no help arrived, one by one,  
 20 the passengers succumbed to exhaustion and hypothermia.  
 21 Dawn came around 7 am. One of the survivors had  
 22 told the Inquiry that when the sun rose over the water  
 23 there were about 15 people still clinging to the remains  
 24 of the boat. The bodies of their fellow passengers were  
 25 floating around them. He recalled a mother screaming as

1 she searched for her children. By this time,  
 2 the helicopter had been stood down and the Valiant had  
 3 returned to Dover. No one in the UK was looking for  
 4 Charlie, no one came to their rescue.  
 5 Around 12.30 pm that day, on 24 November, a French  
 6 fishing boat sailing approximately nine nautical miles  
 7 off the coast of Calais found the first of the bodies  
 8 floating in the water. By the time they asked  
 9 the French authorities for help in their recovery  
 10 efforts, they had found between 10 and 15 of the dead  
 11 passengers. The UK Coastguard was notified at 1 pm,  
 12 nearly 12 hours after they'd received the first panicked  
 13 calls for help.  
 14 This Inquiry has been able to determine with  
 15 confidence the identities of 26 people who lost their  
 16 lives and of four people who are believed to have been  
 17 on the boat but whose bodies have not been found,  
 18 the missing. One whose body was found has not been  
 19 conclusively identified, but we are able to suggest who  
 20 he was. At this stage, we cannot be certain that there  
 21 were no other people on board, including children, whose  
 22 families may never know their fate. We do know that two  
 23 people survived the sinking of the boat, and of these,  
 24 Issa Mohamed Omar has provided detailed evidence to  
 25 the Inquiry and you will, I hope, hear from him

1 tomorrow. The other survivor provided his account to  
 2 the media, but has not engaged with the Inquiry.  
 3 I will outline the chronology of events that night  
 4 in great detail later, but at the outset it is, you may  
 5 think, clear that some important questions arise. How  
 6 did it come about that the passengers were left in  
 7 the water for more than 12 hours without rescue after  
 8 distress calls were made to the UK authorities? Were  
 9 there further steps which could have been taken to  
 10 prevent this loss of life? And how can we ensure that  
 11 this human tragedy is never repeated?  
 12 And these questions go a long way, of course, sir,  
 13 towards explaining why it was that the Inquiry was set  
 14 up. It may therefore be convenient to turn next to  
 15 the Inquiry itself and to the work which we have done to  
 16 date. I would also like to say a word or two about  
 17 the shape of the full hearings.  
 18 The bodies of those who died were recovered to  
 19 France. Accordingly, as a matter of English law, there  
 20 was no obligation to conduct an inquest here. However,  
 21 following the incident, the Marine Accident and  
 22 Investigation Branch began a safety investigation into  
 23 the incident and I'll refer to them as "MAIB". The MAIB  
 24 report on their investigation was published on  
 25 8 November 2023, and as you know, in your terms of

1 reference you are specifically required to consider  
 2 the MAIB report.  
 3 Of course, the Inquiry has a very different role and  
 4 remit to the MAIB. It was, for example, no part of  
 5 the MAIB's task to answer questions concerning  
 6 the deceased, which, as I will explain, are fundamental  
 7 to your terms of reference. There will no doubt be  
 8 a good deal of reference to the MAIB report over  
 9 the course of the hearing. However, for present  
 10 purposes, let me just say that the Inquiry team have  
 11 examined the MAIB report with great care and drawn on it  
 12 again and again during the course of our investigation.  
 13 Shortly after the MAIB report was published, on  
 14 9 November 2023, the then Secretary of State for  
 15 Transport, the Right Honourable Mark Harper MP,  
 16 announced that an independent non-statutory inquiry  
 17 would be established, and on 11 January 2024, your  
 18 appointment was made public and the terms of reference  
 19 were published. Could we have, please, {INQ010493}  
 20 There are the terms of reference. May I highlight some  
 21 important features.  
 22 First, they focus specifically on the incident on  
 23 24 November 2021. The Inquiry has no wider remit to  
 24 investigate the general and continuing problem of small  
 25 boat crossings, nor to engage with the many politically

1 controversial issues to which it has given rise over  
 2 the years before and since the incident.  
 3 Secondly, the terms of reference require you to  
 4 answer a set of questions at paragraph 2(a) which  
 5 resemble those in inquests. However, the legal  
 6 framework in which those questions fall to be answered  
 7 is obviously different. This is not an inquest and  
 8 you're not bound by the provisions of the Coroners and  
 9 Justice Act 2009 or its related rules and regulations.  
 10 Next, this is a non-statutory inquiry. You're not  
 11 bound by the provisions of the Inquiries Act 2005, nor  
 12 the 2006 rules. All questions as to the conduct of  
 13 the Inquiry and the nature of its processes and  
 14 procedures are for you, as Chair, to determine, subject,  
 15 of course, to applicable principles of law and in  
 16 particular to the overriding duty of fairness.  
 17 And, sir, that serves to underline another key point  
 18 about the Inquiry. It is an independent Inquiry,  
 19 independent of government and of the various public  
 20 bodies whom it has investigated during the course of its  
 21 work.  
 22 The next thing I'd like to stress is that  
 23 the Inquiry's process is inquisitorial and not  
 24 adversarial. Although, as I'll explain in a moment, you  
 25 have accorded some individuals and organisations

1 Full Participant status, there are no parties to  
 2 the Inquiry. Nobody has a claim, or case, or defence to  
 3 advance. Moreover, the Inquiry has no power to  
 4 determine liability, whether civil or criminal.  
 5 The Inquiry's purpose is to find out the truth. It  
 6 is therefore the role of all of those who engage with us  
 7 in our investigation to assist us in getting to  
 8 the truth of what happened that night. And by the same  
 9 token, the overarching question which has guided all of  
 10 your decisions concerning the conduct and procedures of  
 11 the Inquiry is this: what would best and most  
 12 effectively assist the Inquiry in its work and so enable  
 13 you to discharge the task conferred on you by the terms  
 14 of reference.  
 15 To that end, you have designated the following as  
 16 Full Participants and, amongst other things, you've  
 17 permitted them to be represented at this hearing and to  
 18 make opening and closing submissions. And they  
 19 are: a survivor and the families of some of the victims,  
 20 represented today by Sonali Naik King's Counsel,  
 21 instructed by Duncan Lewis Solicitors; the Maritime and  
 22 Coastguard Agency, represented by James Maxwell-Scott  
 23 King's Counsel and instructed by DWF Law LLP,  
 24 the Home Office represented today by George Mallet,  
 25 instructed by the Government Legal Department, and

1 the Department for Transport, represented by  
 2 David Blundell King's Counsel, also instructed by  
 3 the Government Legal Department.  
 4 Before turning to the work which has been done over  
 5 the 14 months since the Inquiry was announced, I would  
 6 like, first, to thank the Full Participants and their  
 7 legal representatives and all those who have engaged  
 8 with us as witnesses, document providers or in any other  
 9 capacity, for the hard work which they have done in  
 10 order to assist us to get to the start of these full  
 11 hearings. The pace has been formidable and it would not  
 12 have been possible to make the progress that we have  
 13 without their cooperation and goodwill.

14 As for the work which we've done, you've given some  
 15 details in the statements you've made at the start of  
 16 our two earlier hearings in March and in October last  
 17 year, the transcripts of which are available on our  
 18 website. The website also features all of the Inquiry's  
 19 protocols which set out in the fine print, so far as  
 20 the Inquiry's processes and procedures are concerned.

21 However, it may help those listening and watching to  
 22 have a high level summary of the work we've done to  
 23 date. We've obtained thousands of pages of material  
 24 relevant to our investigation from a wide range of  
 25 individuals and organisations. We've subjected that

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1 material to close analysis and produced a list of issues  
 2 which shows the topics on which the Inquiry has focused  
 3 its principal attention. We've disclosed material which  
 4 we deem relevant to the Full Participants in accordance  
 5 with our disclosure and redaction protocol. We have  
 6 requested and received witness statements from over 70  
 7 individuals, and wherein appropriate, we have requested  
 8 further witness statements. All of those statements  
 9 have been disclosed to the Full Participants.

10 You have determined, sir, which witnesses you wish  
 11 to hear from in these hearings. We've produced evidence  
 12 proposals for each of them in which the topics to be  
 13 covered by Inquiry Counsel in questioning them, and  
 14 the documents to which reference may be made, have been  
 15 set out. Now, I use the term "questioning" rather  
 16 than "cross-examining" in order to underline again  
 17 the difference between this inquisitorial hearing and  
 18 a civil or criminal trial. Witnesses will be asked  
 19 questions as part of the investigatory work of  
 20 the Inquiry. They have all co-operated with the Inquiry  
 21 voluntarily in preparing their statements and will  
 22 attend to give evidence to you voluntarily. They will  
 23 do so in order to assist you with your work. They will  
 24 be questioned so that you have the clearest picture of  
 25 what happened on the night in question as part of your

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1 quest for the truth.

2 As for the shape of these hearings, I hope to  
 3 complete this opening by lunchtime, we'll have a break  
 4 this morning, as you said, not least for our shorthand  
 5 writers, and another during the afternoon, and that will  
 6 be the pattern on each sitting day. This afternoon, you  
 7 will hear from counsel for the Full Participants and  
 8 we'll begin the evidence tomorrow morning. Our plan is  
 9 to sit four days a week, Monday to Thursday, using  
 10 Fridays only if timetabling difficulties require them.

11 We'll start tomorrow morning with the evidence of  
 12 one of the two survivors of the incident and then begin  
 13 questioning those involved in the rescue effort on  
 14 the UK side on Wednesday morning. At the end of  
 15 the hearings, we will again focus our attention on  
 16 the families of those who died, hearing from them about  
 17 their loved ones over the two final days of evidence and  
 18 before the Full Participants make their closing  
 19 submissions. And in that way I hope we will demonstrate  
 20 another important feature of the way in which  
 21 the Inquiry has gone about its work. We have throughout  
 22 kept very firmly in view the fact that for those who  
 23 lost their lives on 24 November 2021 and for their  
 24 friends and families, this was, above all, a terrible  
 25 human tragedy.

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1 I'd like to mention two further points before  
 2 turning to the issues on which we'll focus our  
 3 attention. The first is to note that the hearings  
 4 represent but one phase, albeit an important one, of  
 5 the Inquiry's work. The investigation has been underway  
 6 for over a year and our work will continue after  
 7 the hearings are over. At that stage, the focus will,  
 8 of course, be on the preparation of your report, which  
 9 will be the culmination of the Inquiry's work.

10 Secondly, I should mention that there is a criminal  
 11 investigation arising out of this incident which is  
 12 underway in France and is led by an investigating  
 13 magistrate. French criminal law imposes a strict  
 14 confidentiality obligation on all concerned in such an  
 15 investigation so that the Inquiry has not had access to  
 16 material generated by or for the purposes of that  
 17 investigation. We have, however, kept the French  
 18 prosecutor informed as to the course of our work and  
 19 about these full hearings.

20 So, sir, I turn next to deal briefly with the issues  
 21 on which we'll focus over the coming weeks. And  
 22 the starting point is of course our list of issues which  
 23 I have just mentioned. Could we have that, please.  
 24 That's {INQ010494}. I don't want to spend too much time  
 25 on these now, but the list of issues sets out, in just

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1 over three pages of text, the specific areas within  
 2 the terms of reference on which the Inquiry has and will  
 3 continue to direct its particular attention. It starts,  
 4 as you see, with inquest type questions, issue I, deals  
 5 with the legal framework, issue II, before turning to  
 6 the operational background to the events of the night,  
 7 and that's issue III, going over the page {INQ010494/2}.  
 8 Turning on, please, to issue IV, which is page 3  
 9 {INQ010494/3} of the document, that deals with the key  
 10 questions about the night, and then we focus on lesson  
 11 learning, that's issue V, and end with the question of  
 12 recommendations, over the page at issue VI.

13 There is a good deal to get through in this opening,  
 14 and so to help me and to help the Full Participants,  
 15 the Inquiry legal team has produced and disclosed to  
 16 them some written background material, namely: a very  
 17 detailed chronology of events leading up to the night  
 18 based on the material we've gathered in; three notes on  
 19 the UK organisations who were principally involved in  
 20 what happened, on their operational arrangements and on  
 21 the relevant roles and responsibilities of individuals  
 22 within those organisations; a list of acronyms; and,  
 23 finally, a short note on the legal framework against  
 24 which the events of the night fall to be considered.  
 25 Those documents will appear in due course on our website

1 alongside the transcripts of the days' hearings,  
 2 the witness statements of those who have given evidence  
 3 to us and the documents referred to during the evidence.  
 4 And that written material will allow me to deal briefly,  
 5 I hope, with the background topics and to spend most of  
 6 my time on the events of the night and on the issues and  
 7 questions to which those events give rise. That will be  
 8 the main focus of the evidence during these hearings.

9 So of those background topics, sir, the first I'd  
 10 like to outline at a very high level is the relevant  
 11 legal framework. This is issue II of our list of  
 12 issues. First, the relevant international obligations  
 13 in respect of search and rescue, safety at sea, and in  
 14 particular search and rescue is addressed in a number of  
 15 international treaties, including the 1982 United  
 16 Nations Convention on the Law of the Sea, UNCLOS,  
 17 the 1974 International Convention on the Safety Of Life  
 18 At Sea, SOLAS, and the Search and Rescue Convention,  
 19 1979, SAR. The UK and France are party to all of those  
 20 conventions and are bound by the obligations contained  
 21 in them under international law. The UK and France are  
 22 also Member States of the International Maritime  
 23 Organisation, IMO, which is a specialised agency of  
 24 the United Nations with responsibility for the safety  
 25 and security of shipping. SOLAS and the 1979 SAR were

1 adopted under the auspices of the IMO. The IMO and  
 2 the International Civil Aviation Organisation jointly  
 3 publish and periodically review and update  
 4 the International Aeronautical and Maritime Search and  
 5 Rescue manual, IAMSAR. This is a guide for Member  
 6 States, set out in three volumes, as to the provision  
 7 and organisation of a search and rescue service and as  
 8 to the execution of their responsibilities under  
 9 the applicable aviation and maritime conventions.  
 10 The duty to render assistance to those in peril at sea  
 11 is a long established norm of the law of sea. It finds  
 12 its expression in two specific obligations. First,  
 13 obligations on vessels to render assistance to persons  
 14 in danger or in distress, and secondly, obligations on  
 15 coastal states to establish, operate and maintain  
 16 adequate and effective search and rescue services.

17 So turning to requirements for vessels to render  
 18 assistance. Each of UNCLOS, SOLAS and 1979 SAR contains  
 19 provisions which address the requirements of vessels to  
 20 render assistance to persons in danger or distress.  
 21 Article 98(1) of UNCLOS imposes an obligation on states  
 22 to require that certain action be taken by masters of  
 23 its flag vessels. SOLAS imposes obligations directly on  
 24 masters of a ship to provide assistance in response to  
 25 distress messages. And under both conventions the duty

1 to provide assistance applies regardless of the legal  
 2 status of the person in distress. 1979 SAR expressly  
 3 confirms that assistance is to be provided regardless of  
 4 the nationality or status of the person in distress.

5 The requirement for vessels to render assistance in  
 6 case of distress is incorporated in UK domestic law  
 7 through the Merchant Shipping Act (Safety of Navigation)  
 8 Regulations 2020, and they apply to any UK ships, but  
 9 also to any non-UK ships while they are within UK  
 10 waters.

11 Now turning to the obligations of states, the three  
 12 conventions require states to establish, operate and  
 13 maintain search and rescue services at sea. The most  
 14 detailed provisions concerning search and rescue  
 15 services are found in the 1979 SAR, which establishes  
 16 a comprehensive international system for search and  
 17 rescue operations and provides for states to have  
 18 responsibility for designated search and rescue reasons  
 19 within which search and rescue services are provided.  
 20 It also provides for the rescue of persons in distress  
 21 to be coordinated by a search and rescue organisation  
 22 and, where necessary, cooperation with neighbouring  
 23 search and rescue organisations.

24 In the context of the English Channel, the UK and  
 25 France have concluded the MANCHEPLAN, chapter 2 of which

1 is a regional search and rescue agreement within  
 2 the meaning of the 1979 SAR.  
 3 So my next topic concerns the small boats problem.  
 4 Small boats present particular challenges from a search  
 5 and rescue perspective, and can we please bring up  
 6 {INQ010512}. The Channel is an inherently challenging  
 7 maritime environment. It's a narrow stretch of water  
 8 between the UK and France. At its narrowest point, only  
 9 18 nautical miles wide. The territorial waters of  
 10 France and the UK are separated by what is known as  
 11 the "median line", which we can see on the map marked by  
 12 the crosses. There's a high volume of commercial and  
 13 recreational marine traffic in the Channel. In order to  
 14 manage it, the IMO has approved a traffic separation  
 15 scheme, which again you can see on the map indicated by  
 16 the series of arrows pointing north-east and south-west.  
 17 All shipping is required to follow these lanes and  
 18 a mandatory reporting scheme is in place whereby large  
 19 vessels are required to contact the Coastguard when they  
 20 enter and exit the area.  
 21 Large vessels in the Dover Strait present particular  
 22 risks for small boats. Big ships may struggle to see  
 23 unilluminated small boats, or to detect them by radar.  
 24 Because of their size, large vessels are unable to  
 25 change course quickly to avoid small boats, increasing

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1 the likelihood of collision, particularly if a small  
 2 boat's engine fails and it is left to drift. Big ships  
 3 create large, turbulent wakes as they travel through  
 4 the water, which are quite capable of swamping small  
 5 boats.  
 6 The Channel is also dangerous because it's very dark  
 7 at night, which makes it the more difficult for small  
 8 boats to be found. In winter months especially,  
 9 the weather in the Dover Strait can also make crossings  
 10 more dangerous. Surface temperatures can get very low,  
 11 presenting a risk of hypothermia. If someone also has  
 12 wet clothes on because, for example, they had to board  
 13 the boat in shallow water just off a beach, then this  
 14 risk is increased. The water itself is also very cold.  
 15 If someone enters the water, they could suffer what is  
 16 known as "cold water shock", and I'll return to this  
 17 later. And, of course, misty or foggy conditions can  
 18 make it even harder to see small boats.  
 19 Next, small boats are inherently unseaworthy. They  
 20 are made of inappropriate materials. There have been  
 21 instances of attempted crossings in inflatable paddling  
 22 pools or rowing boats with makeshift paddles. Their  
 23 construction itself can be hazardous, involving parts  
 24 such as sharp wooden or metal floors which can damage  
 25 the inflatable parts of the boat, and they generally

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1 have no communication, location or navigation systems on  
 2 board, save, perhaps, for the occupants' mobile phones.  
 3 They are unable to know precisely where they are in  
 4 the water or what is around them, to communicate their  
 5 position, or to draw attention to themselves.  
 6 Third, people on small boats very often have no  
 7 maritime experience. Additionally, in some instances,  
 8 highly vulnerable people, such as unaccompanied  
 9 children, pregnant women and people with disabilities  
 10 are on board. The boats are often overcrowded. People  
 11 on small boats often have no life-saving equipment, such  
 12 as life jackets, or the equipment they do have is wholly  
 13 inappropriate.  
 14 Finally, unlike other vessels, small boats are not  
 15 named and need to be distinguished on the basis of other  
 16 characteristics, such as their colour or the number of  
 17 occupants.  
 18 Next, a word, if I may, about the small boat  
 19 problem, the number of small boat crossings over time  
 20 and the government's response to it. The small boat  
 21 problem of respect years only began to emerge in  
 22 the second half of 2018. There's a good deal of detail  
 23 on this in the pre-incident chronology which I've  
 24 mentioned, so I'll only highlight the key points this  
 25 morning. If we could bring up on the screen, please,

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1 the native version of {INQ010670}.  
 2 If we can centre it so we can see the whole thing  
 3 that would be excellent.  
 4 This chart shows the number of people arriving in  
 5 the UK by small boat in each month of 2018. As one can  
 6 see, during the first half of that year, the number of  
 7 people who were detected crossing the Channel remained  
 8 very low, but, from August that year, the number of  
 9 crossings began to increase, and in the final two months  
 10 of 2018, there was a surge, whereby some 248 people  
 11 crossed the Channel in small boats.  
 12 As a result of the rise in the number of crossings,  
 13 by mid-December 2018, Border Force vessels were  
 14 frequently being called out to assist with rescues and  
 15 this led the then Home Secretary to declare a major  
 16 incident on 28 December that year. A Gold Command  
 17 structure, or "Gold Group", was established within  
 18 Border Force shortly thereafter, and it was agreed  
 19 between Border Force Maritime Command and His Majesty's  
 20 Coastguard that Border Force assets would be available  
 21 to the Coastguard for search and rescue taskings. This  
 22 arrangement was later formalised on 15 May the next  
 23 year, 2019, under the name "Operation DEVERAN", which  
 24 led Border Force's maritime response to the issue of  
 25 small boats. Thereafter, the Home Office led

24

1 the government's overall policy response to the small  
 2 boats issue, and that remained the position at the time  
 3 of the incident, because it was generally considered  
 4 within government to be an illegal migration issue.  
 5 Next can we have {INQ010669}. Again, I think  
 6 the native version.  
 7 This graph shows the number of people arriving by  
 8 small boat from 2018 to the end of 2021. As we can see  
 9 from the graph, from May to July 2019, the number of  
 10 people arriving continued to rise. In documents from  
 11 July 2019, which the Inquiry has seen, Border Force's  
 12 small boats strategy was described in terms  
 13 as "failing". It was suggested, fleetingly, that  
 14 the issue should perhaps -- and I quote -- "be an  
 15 MCA/RNLI lead rather than Border Force". It was also  
 16 recognised that the risk to life posed by small boat  
 17 crossings was "significant" and that a fatality was  
 18 "highly likely".  
 19 Just a month later, in August 2019, the first  
 20 fatality related to a small boat crossing was recorded.  
 21 In the same month, as we can see from the graph, a new  
 22 record number was reached, with 342 people making  
 23 the crossing. It was also suggested in that month that  
 24 a policy known as "Operation BOWTHORPE" should be  
 25 implemented. That operation had been developed by

25

1 Border Force a few months earlier, and was a policy  
 2 whereby people rescued from small boats would be  
 3 returned to France, rather than taken to the UK. This  
 4 suggestion was made by the then director of the Joint  
 5 Maritime Security Centre, or JMSC, which was  
 6 a cross-government organisation which provided  
 7 intelligence on maritime security issues. The director  
 8 of the JMSC at the time was Dan O'Mahoney who will give  
 9 evidence on the Inquiry in due course.  
 10 So returning to the graph. Over the autumn of 2019  
 11 and the early part of the next year, the crossings  
 12 stayed at a relatively stable level. However, in  
 13 April 2020, the number of people crossing the Channel by  
 14 small boat began to increase substantially, as you can  
 15 see from the graph. Due to movement restrictions  
 16 associated with the pandemic, small boat crossings  
 17 became almost the only method of clandestine entry to  
 18 the United Kingdom.  
 19 On 30 April that year, 2020, the Home Office had  
 20 reiterated its desire to develop a "returns at sea"  
 21 policy. However, this time, the policy went beyond  
 22 returning migrants once rescued and instead involved  
 23 the development of tactics to interdict or turn small  
 24 boats around at sea to prevent them reaching the UK in  
 25 the first place. This was referred to as

26

1 Operation SOMMEN. The development of this policy was  
 2 a focus for the Home Office from this point onwards,  
 3 which is reflected in the volume of communications on  
 4 this issue between the Home Office, the Department for  
 5 Transport and the MCA, which the Inquiry has seen.  
 6 Now, returning to the graph, we can see how, over  
 7 the summer of 2020, the incidents of small boat  
 8 crossings continued to increase. As it was put in  
 9 a document prepared by the MCA's chief executive at the  
 10 time, the number of crossings was "unprecedented".  
 11 As well as developing tactics to interdict small  
 12 boats throughout this period, in August 2020,  
 13 the Home Office established the Clandestine  
 14 Channel Threat Command, CCTC, within its Immigration  
 15 Enforcement department. The CCTC was created to lead  
 16 and unify the government response to small boats  
 17 providing -- and I quote -- "a whole of route, whole of  
 18 government" approach, and ultimately render journeys to  
 19 the UK on small boats -- and I quote -- "unviable".  
 20 Dan O'Mahoney, the former director of JMSC, who I have  
 21 mentioned, was appointed to lead this body.  
 22 As we can see from the chart, September 2020 saw  
 23 a new high in terms of crossings when 1,949 people were  
 24 detected having made the crossing. At the end of that  
 25 year, on 21 December, the CCTC established

27

1 Operation ALTAIR, which covered both the maritime and  
 2 land-based aspects of the Home Office's strategy, such  
 3 as reception facilities, communications campaigns  
 4 upstream in migration routes. And this strategy  
 5 effectively superseded Operation DEVERAN, although, as  
 6 we'll see, that operation retained its name in relation  
 7 to maritime aspects of the CCTC's activity.  
 8 Now, could we have one more chart, please, and this  
 9 is {INQ010671}. Now, this graph shows the total number  
 10 of people detected arriving by small boat each month,  
 11 from the start of 2018 to September last year. And one  
 12 can see how, from the spring of 2021, crossings began to  
 13 increase again, and the speed of that increase, which is  
 14 dramatic, can be seen from the graph.  
 15 In November 2021, 6,971 people crossed in 209 small  
 16 boats. And in fact, as you will see from the graph,  
 17 that total was the third largest monthly total of people  
 18 ever to cross the Channel in small boats.  
 19 One more chart please and this is {INQ010675}. Now,  
 20 this shows not the number of people, but the number of  
 21 small boats, which crossed from 2018, again, to  
 22 September 2024. And in the month with which we're  
 23 concerned, November '21, 209 boats made the crossing,  
 24 which, as you can see, is the largest ever number of  
 25 boats to have crossed in a single month. And we can

28

1 also see, as we all know, looking to the right—hand side  
 2 of the graph, that the problem hasn't gone away.  
 3 Crossings are continuing in large numbers. It's also  
 4 right to note that while the number of boats, as we see  
 5 here, may be fewer, the boats being used are now bigger  
 6 and carry more people.

7 So having set out that context, we can now turn to  
 8 look at some of the organisations and people who were  
 9 involved in responding to the small boats issue and to  
 10 the events of 23 November 2021.

11 So as I have mentioned — I think we can remove  
 12 the chart now, please — we have provided  
 13 Full Participants with three documents on these topics  
 14 which set out far greater detail than time allows me  
 15 this morning, so I'll just deal with some of the key  
 16 points contained within them and take the opportunity to  
 17 introduce some of the witnesses from whom you'll hear in  
 18 the next few weeks.

19 The small boats problem engaged a number of  
 20 organisations and government departments. The primary  
 21 organisations involved in responding to the events with  
 22 which we're concerned were His Majesty's Coastguard  
 23 first, which I'll generally call "the Coastguard", who  
 24 were responsible for coordinating the UK's maritime  
 25 search and rescue response. In other words, and in

1 simple terms, they decided which resources to send to  
 2 help the small boats and when and where to send them.

3 Next, Border Force, who primarily provided the boats  
 4 or vessels which were tasked by the Coastguard to rescue  
 5 people on small boats.

6 Next, some private companies who provided  
 7 aeroplanes, helicopters and drones, to try to help  
 8 the Border Force vessels find the small boats at sea.

9 Next, the RNLI, a charitable organisation which also  
 10 made lifeboats available to the Coastguard for search  
 11 and rescue.

12 And, finally, the French Coastguard, who were  
 13 responsible for coordinating search and rescue incidents  
 14 which took place within French territorial waters, and  
 15 who worked together with the Coastguard pursuant to  
 16 the agreement I've mentioned, the MANCHEPLAN, which set  
 17 out how search and rescue incidents in  
 18 the Channel should be dealt with by the two countries.

19 So turning first to the Coastguard. It, as I've  
 20 said, was responsible for, amongst other things,  
 21 providing a 24—hour emergency search and rescue service  
 22 for incidents in the seas and coastal areas around  
 23 the United Kingdom. It was part of the Maritime and  
 24 Coastguard Agency, the MCA, which was itself an  
 25 executive agency linked to the Department for Transport.

1 The Secretary of State for that department was  
 2 responsible for establishing a search and rescue system  
 3 for the UK pursuant to the international treaties to  
 4 which I've referred. The Coastguard provided the search  
 5 and rescue service on the ground, as it were, and  
 6 the MCA provided the Coastguard with corporate  
 7 leadership and also acted as the link between  
 8 the Coastguard and the Department for Transport.  
 9 The Department for Transport remained responsible for  
 10 the overall policy framework which applied to the MCA  
 11 and the Coastguard.

12 In the executive agency relationship, they were  
 13 known as the agency's "sponsor department". They  
 14 primarily oversaw the activities of the MCA and  
 15 the Coastguard through quarterly sponsorship board  
 16 meetings.

17 At the time of the incident, small boat related  
 18 policy issues which were within the Department for  
 19 Transport's remit were handled by the Maritime Security  
 20 Division. As the Department point out in their written  
 21 submissions, illegal migration policy was not a matter  
 22 falling within this remit. The Maritime Security  
 23 Division was led by James Driver, who will give evidence  
 24 later in the hearings. However, as I have set out, at  
 25 the time of the incident, it was the Home Office which

1 led the government's overall policy response to  
 2 the small boats issue, as it was generally considered by  
 3 government to be an "illegal migration" issue.

4 So then turning in a little more detail to  
 5 the national Coastguard network. To provide its search  
 6 and rescue functions, the Coastguard operated a network  
 7 of Maritime Rescue Coordination Centres, MRCCs, each of  
 8 which had its own area of responsibility, and they were  
 9 located at: Aberdeen, Belfast, Humber, Falmouth,  
 10 Holyhead, Milford Haven, Shetland, Stornoway, Solent and  
 11 Dover. They were all coordinated by the Joint Rescue  
 12 Coordination Centre, or JRCC. Because of the common  
 13 communication systems and procedures the Coastguard  
 14 used, the JRCC was able to allocate resources around  
 15 the network through a process referred to  
 16 as "zone—flexing" or "network flexing". For example, if  
 17 there was a shortage of staff at MRCC Holyhead, any  
 18 search and rescue missions could, if resource allowed,  
 19 be conducted from MRCC Falmouth.

20 As well as this network coordinating function,  
 21 the JRCC contained MRCC Solent, which undertook search  
 22 and rescue missions in its area of responsibility and  
 23 assisted other MRCCs through zone—flexing. In fact,  
 24 the JRCC was the default zone—flexing station for all  
 25 MRCCs.

1 It was also home to the Aeronautical Rescue  
 2 Coordination Centre, or ARCC, which tasked and  
 3 coordinated planes, helicopters and drones for search  
 4 and rescue missions. MRCC Dover was responsible for  
 5 coordinating search and rescue missions in  
 6 the Dover Strait and was therefore the primary station  
 7 for coordinating search and rescue missions in relation  
 8 to small boat crossings. It was also responsible for  
 9 the vessel traffic service which managed the commercial  
 10 maritime traffic in the Dover Strait.

11 So then turning to the provision of search and  
 12 rescue in practice. The Coastguard provided its search  
 13 and rescue service by coordinating assets which were  
 14 declared or contracted to it. It has not had its own  
 15 fleet of rescue boats since the 1970s. The assets  
 16 the Coastguard co-ordinates are either "Declared Search  
 17 And Rescue Facilities" or "Additional Facilities".  
 18 A declared search and rescue facility is a facility  
 19 which has been designated as being available for  
 20 maritime search and rescue according to a specific  
 21 standard or set criteria, whereas an additional facility  
 22 is one which may be available from time to time but  
 23 which is not of a specific standard. The RNLI and  
 24 the private air asset providers I've mentioned were  
 25 declared facilities, whereas Border Force was an

1 additional facility.  
 2 Border Force, and specifically Border Force Maritime  
 3 Command, were in practice responsible for providing  
 4 the assets, by which I mean principally the vessels used  
 5 for the majority of small boat search and rescue  
 6 incidents. As I mentioned earlier, this came to be  
 7 the case through Operation DEVERAN. The Border Force  
 8 Maritime Command was the UK's national maritime law  
 9 enforcement capability and was led by Stephen Whitton,  
 10 who will give evidence in these hearings. In practice,  
 11 tasking was managed day-to-day by Border Force officers  
 12 and higher officers based at the Border Force Maritime  
 13 Command Centre in Portsmouth. On the night of  
 14 the incident, these roles were undertaken by Tom Willows  
 15 and Karen Whitehouse respectively, both of whom will  
 16 also give evidence.

17 Border Force Maritime Command Centre would receive  
 18 asset tasking requests by phone from the Coastguard and  
 19 contact the commander of the relevant vessel.

20 In terms of the assets which were available on  
 21 the night, His Majesty's Cutter HMC Valiant was the only  
 22 boat tasked to rescue people in small boat. Her  
 23 commander, Kevin Toy, who was in charge of the vessel  
 24 that night, is also due to give evidence.

25 Turning briefly to the private providers, as I've

1 said, the Coastguard also used aeroplanes, helicopters  
 2 and drones to try to obtain a recognised maritime  
 3 picture, in other words to inform them how many small  
 4 boats were in the water and where, so that rescue boats  
 5 could be directed more effectively. The Inquiry expects  
 6 to hear evidence from those involved in providing these  
 7 services and they include: Christopher Norton, who's  
 8 company, 2Excel Limited, provided the Coastguard with  
 9 two types of fixed wing aircraft, however, on the night,  
 10 they were unable to fly due to bad weather;  
 11 Graham Hamilton, is a director of Bristow Helicopters  
 12 Limited, who I will refer to as "Bristow", they provided  
 13 helicopters to the Coastguard for search and rescue, and  
 14 on the night, one of their helicopters was deployed,  
 15 call sign R163; and finally, the Inquiry expects to hear  
 16 from the Captain of R163, Christopher Trubshaw, later in  
 17 these hearings.

18 Now, then turning to the individuals involved from  
 19 the Coastguard. Please may we bring up {INQ010677}.  
 20 This document shows the line management structure within  
 21 the Coastguard and the MCA at the time of the incident.  
 22 And the Inquiry expects to hear evidence, first, from  
 23 David Jones, who is at the top of the box,  
 24 labelled "MRCC Solent", further down the document,  
 25 please, bottom left, do you see? Yes, thank you. He

1 was the JRCC Tactical Commander and his role was to  
 2 oversee the entire Coastguard network. To do this he'd  
 3 review active search and rescue missions to make sure  
 4 there were sufficient resources available and that there  
 5 was a plan in place.

6 Next, Dominic Golden, just opposite in the circle on  
 7 the right, under "ARCC". He was the Aviation  
 8 Tactical Commander, which meant he was responsible for  
 9 tasking aerial search and rescue assets.

10 Then, looking at the right-hand side of the graph,  
 11 we see on MRCC Dover, to the right, at the top,  
 12 the Small Boat Tactical Commander, George Papadopoulos.  
 13 This was a role unique to MRCC Dover which had been  
 14 created to provide leadership in relation to small  
 15 boats. However, over time, the role developed so that  
 16 when was on station, the Small Boat Tactical Commander  
 17 could review ongoing small boat search and rescue  
 18 missions at Dover, instead of  
 19 the JRCC Tactical Commander. He could also play a more  
 20 hands on role, undertaking search and rescue tasks in  
 21 the operations room, and we'll hear more about this in  
 22 due course. George Papadopoulos reported to Mike Bill,  
 23 the Division 2 Commander, whose name appears higher up  
 24 the chart there, MRCC Humber. He had overall  
 25 responsibility for both MRCC Dover and MRCC Humber, and

1 as we can see from the graph, this was a senior  
 2 non-operational role, reporting directly, up to the top  
 3 of the chart, to the head of Coastguard operations.  
 4 Now, if we can go back to the bottom left,  
 5 "MRCC Dover" — sorry, bottom right, we'll see there,  
 6 towards the middle of the diagram, Neal Gibson and  
 7 James Crane listed as team leaders. They were the team  
 8 leaders at MRCC Dover, so far as we're concerned. They  
 9 were also qualified search and rescue mission  
 10 controllers, SMCs, which meant they were able to  
 11 coordinate and lead search and rescue missions, and  
 12 the MCA has helpfully set out some of the features of  
 13 their role in their opening submissions.  
 14 Staying at this level, but moving back to the left,  
 15 to the yellow "MRCC Solent" box, we can see  
 16 Christopher "Tom" Barnett and Richard Cockerill, who  
 17 were, similarly, team leaders and qualified SMCs at  
 18 the JRCC. As I've mentioned earlier, SMCs there, at  
 19 the JRCC, could assist other MRCCs to conduct search and  
 20 rescue missions remotely. They were also able to act as  
 21 maritime coordinators, who, the Inquiry understands,  
 22 performed the same functions as a Maritime Operations  
 23 Officer within the operations room.  
 24 Then turning to that role and back to the bottom  
 25 left-hand corner of the green box, please, we see

1 the name Stuart Downs. He was the Maritime Operations  
 2 Officer there, MOO. They performed search and rescue  
 3 tasks in the operations room under the direction of  
 4 the SMC, as you can see from the chart. And again, in  
 5 relation to their role, the MCA have provided some  
 6 helpful additional detail in their opening submissions.  
 7 So could we clear the chart, please.  
 8 So the next and most important topic for this  
 9 morning is the question of the night's events and  
 10 the issue how those who died came by their deaths. That  
 11 really is the key issue for the Inquiry and for these  
 12 hearings, issue 1c and IV of the list of issues.  
 13 In terms of the immediate background to that night,  
 14 as we have seen, the events that the Inquiry is  
 15 investigating took place against a background of  
 16 unprecedented numbers of small boat crossings. I've  
 17 touched on the question of how the various UK bodies and  
 18 agencies responded to the problem.  
 19 In November 2021, approximately 90% of small boat  
 20 rescues were undertaken by Border Force. However, its  
 21 vessels were not designed or equipped for search and  
 22 rescue. By November '21, at a meeting attended by  
 23 Coastguard and Border Force, amongst others, it was  
 24 acknowledged that the situation for Border Force  
 25 Maritime was critical and non-sustainable without an

1 increase in asset numbers. The remainder of the rescues  
 2 were undertaken by the RNLI, the principal provider of  
 3 lifeboats to the Coastguard. Their volunteer crews were  
 4 also facing significant pressure from small boat call  
 5 outs in November '21.  
 6 Despite Border Force's major role in small boat  
 7 search and rescue that month, the Inquiry understands  
 8 that there was no written agreement or memorandum of  
 9 understanding which addressed the respective roles and  
 10 responsibilities of Border Force and the Coastguard.  
 11 Rather, it appears that working arrangements developed  
 12 and adapted over time. We will explore the consequences  
 13 of this in relation to small boat search and rescue,  
 14 including with regard to Border Force's enforcement role  
 15 in the coming days.  
 16 The sharp rise in small boat activity in 2021 also  
 17 had inevitable impacts on Dover Coastguard, but the  
 18 concerns there were long-standing. Coastguard  
 19 recognised, no later than 2020, that Dover was under  
 20 strain because of the increase in incident numbers and  
 21 low staffing levels. Staff welfare concerns were  
 22 acknowledged again in the summer of 2021, when a debrief  
 23 on migrant activities noted that the Dover operations  
 24 team and others were effectively firefighting, unable to  
 25 take effective breaks, which the debrief said — and

1 I quote — "compounded human factor and welfare risks".  
 2 In November 2021, the MCA's Corporate Risk Register  
 3 was amended to include the risk that HM Coastguard may  
 4 become overwhelmed resulting in loss of life. So  
 5 Coastguard was fully on notice of the impact of  
 6 the long-standing resourcing problems facing Dover,  
 7 combined with the significant increase in numbers of  
 8 small boat crossings and also that there were serious  
 9 risks related to this. Its recruitment exercises had  
 10 failed to cover the deficit by November '21. On  
 11 the 19th of that month, it was decided that the maritime  
 12 zones covered by Dover would be reduced to one, zone 14,  
 13 the Dover Strait, which is where small boat activity  
 14 principally took place, and that staff shortages would  
 15 be dealt with by way of remote coverage from the Joint  
 16 Rescue Coordination Centre, the JRCC.  
 17 Coastguard also altered shift patterns at Dover,  
 18 requested that staff do overtime and also asked that  
 19 competent staff from other stations went to Dover for  
 20 periods of duty. The search and rescue mission  
 21 controller, the SMC, at Dover, who worked during  
 22 the night watch of 23 to 24 November, has told  
 23 the Inquiry that in the weeks leading up to that shift,  
 24 he had frequently worked six on, two off, instead of  
 25 the usual two day, two night, four off, shift pattern,

1 due to lack of staff .  
 2 On 22 November, the day before the events in  
 3 question, it was recognised within Coastguard that  
 4 staffing at Dover was insufficient for the upcoming  
 5 night watches. There was a request for volunteers, but  
 6 this request did not bear fruit , save that one  
 7 Coastguard officer agreed to go to Dover and start his  
 8 shift at 5 am on 24 November.  
 9 So I now turn to focus specifically on this question  
 10 of staffing .  
 11 As was anticipated, the staffing of the search and  
 12 rescue team at Dover was one person below its suggested  
 13 seasonal level during the night shift or "watch" from  
 14 23 to 24 November. The watch ran for 12 hours from 7.30  
 15 in the evening until 7.30 in the morning. That night,  
 16 there were two coastguards working on search and rescue.  
 17 There was also a trainee present. The search and rescue  
 18 team, as I've said, was led by an SMC. He was in  
 19 control of the search and rescue activity from Dover  
 20 that night and he was also the team leader. He  
 21 supervised a Maritime Operations Officer, who had joined  
 22 the Coastguard in March '21, and a trainee. And  
 23 additionally, the team was joined at 5 o'clock in  
 24 the morning by an SMC from another station, who, as I've  
 25 said, had agreed to work that day in Dover as a Maritime

1 Operations Officer.  
 2 The Dover Coastguard also ran a maritime traffic  
 3 monitoring service for the Dover Strait and, due to  
 4 staffing shortages, the SMC on the night watch also had  
 5 to provide cover for that team during the early part of  
 6 the night. He returned to the operations room in  
 7 the early hours of the morning of 24 November, shortly  
 8 after the first calls from what became known  
 9 as "Incident Charlie" were received.  
 10 Whilst he was absent, an SMC in the JRCC in  
 11 Hampshire took over control of search and rescue  
 12 operations remotely. However, due to the low staffing  
 13 levels at Dover and the amount of activity during  
 14 the night, the JRCC remained involved after the Dover  
 15 SMC had returned.  
 16 Also based at the JRCC on the night in question were  
 17 the Maritime and Aviation Tactical Commanders.  
 18 The Maritime Tactical Commander was not contacted for  
 19 any tactical oversight or advice on the night in  
 20 question and nor did he review any of the distress  
 21 incidents at Dover.  
 22 Additionally, there was a duty Strategic Commander  
 23 on call during the night in question, but he too was not  
 24 contacted and so was unaware of the events of the night  
 25 and took no part in them.

1 The Small Boats Tactical Commander was not working  
 2 during the night watch of 23 to 24 November 2021. He  
 3 did work on the day watch the next day, beginning, as  
 4 I've said, at 7.30 in the morning, however, due to  
 5 the volume of work and pressure on MRCC Dover, he  
 6 undertook an operational role equivalent to an MOO,  
 7 rather than acting in the tactical role of his job  
 8 description. He worked under the SMC and team leader on  
 9 the day watch.  
 10 During the night watch, 23 to 24 November,  
 11 the absence of the Small Boat Tactical Commander and  
 12 the absence of any input from the Maritime  
 13 Tactical Commander and the duty Strategic Commander  
 14 meant that there was no tactical or strategic oversight  
 15 of the operational search and rescue decisions taken by  
 16 the SMC at Dover.  
 17 Turning then to the question of the assets.  
 18 Turning to this question and dealing first with  
 19 the air assets, throughout the night in question,  
 20 the Aviation Tactical Commander liaised with the various  
 21 companies providing air assets to the Coastguard.  
 22 Primarily, this was through calls with 2Excel, who, as  
 23 I've said, provided fixed wing assets, and Bristow, who  
 24 provided the helicopters. He also spoke with  
 25 the company RVL, who, on the night in question, were

1 contracted to fly at a high altitude for the Home Office  
 2 and with Tekever, who were contracted to fly drones for  
 3 the Coastguard. But that night, it was only 2Excel and  
 4 Bristow who were anticipated to fly for the Coastguard.  
 5 When contacting Bristow, the Aviation Tactical Commander  
 6 spoke primarily to the Captain of the helicopter known  
 7 as R163, and he later received updated instructions from  
 8 the SMC at Dover.  
 9 The Coastguard in Dover also liaised with  
 10 the Border Force Maritime Command Centre throughout  
 11 the night. A Border Force Higher Officer was based in  
 12 the office in Portsmouth and an Immigration Officer was  
 13 working remotely. They were primarily responsible for  
 14 managing and deploying Border Force Maritime assets. As  
 15 I have said, the Border Force vessel that was identified  
 16 as the primary responder for the night in question was  
 17 the cutter, the Valiant.  
 18 By contrast with the level of contact that  
 19 the Coastguard had with Border Force, during the night  
 20 in question, the SMC at Dover did not task or  
 21 otherwise liaise with the RNLI. The adequacy of  
 22 the search and rescue assets tasked on the night is  
 23 a question that the Inquiry will address.  
 24 Next, systems.  
 25 In terms of the systems that were used in

1 November '21 by the Coastguard to record and share  
 2 information received about small boats, its primary  
 3 information management was software called "ViSION".  
 4 The ViSION system enabled the Coastguard to maintain  
 5 logs for each small boat incident opened. Each incident  
 6 was attributed a unique alpha numeric reference composed  
 7 of a number and a phonetic alphabet reference which  
 8 refreshed to "Alpha" at the start of each watch.  
 9 The ViSION system facilitated network or  
 10 zone—flexing, which, as I've said, is the Coastguard's  
 11 practice of providing remote coverage from other  
 12 stations of the JRCC, because the information contained  
 13 in the logs could be viewed remotely on ViSION.  
 14 However, at the time of the events in question,  
 15 the ViSION systems used by the aviation and maritime  
 16 sections of Coastguard were incompatible.  
 17 In addition to the ViSION system, the Coastguard  
 18 also used an operational support spreadsheet to record  
 19 and monitor information about small boats known as  
 20 a "tracker". Border Force and the French Coastguard  
 21 also had their own trackers, and by the time of these  
 22 events, the Coastguard had recognised that  
 23 the multiplicity of trackers was problematic. In  
 24 August 2021, the absence of — and I quote — "a single  
 25 version of the truth", due to the existence of multiple

1 trackers owned by difference stakeholders, had been  
 2 raised as a concern at a high level within  
 3 the Coastguard. A proposed solution was the creation of  
 4 a single UK tracker with live access for both  
 5 the Coastguard and Border Force, and shortly before  
 6 23 November, Border Force gained live access to  
 7 the Coastguard tracker, which was known as the "shared  
 8 tracker" for this reason.  
 9 However, they also — that's Border Force —  
 10 maintained their own separate tracker. This was emailed  
 11 at early intervals to a large distribution list of  
 12 Home Office recipients for the most part, but including  
 13 the Coastguard. The shared tracker and the Border Force  
 14 tracker recorded much the same information. This  
 15 included a row for each incident opened by  
 16 the Coastguard, a series of columns for relevant  
 17 information about each incident, including position  
 18 information, the number of persons on board and  
 19 a description. Importantly, there was also a column for  
 20 a Border Force reference also known as an "M" number,  
 21 because it was prefaced by the letter "M". This  
 22 reference was given to a small boat once it had  
 23 encountered a UK asset. The M number would be sprayed  
 24 on the boat itself and recorded by the Coastguard and  
 25 Border Force. Those M numbers reset each year on

1 January and ran sequentially. On the night in  
 2 question, the first small boat to be encountered by  
 3 the Valiant was given the M number 957, the second 958,  
 4 the third 959. As I've mentioned, the French Coastguard  
 5 also had its own tracker, similar in style and content  
 6 to the Coastguard and Border Force trackers.  
 7 It's important to note here that in November '21,  
 8 neither the Coastguard nor Border Force had live access  
 9 to the French tracker and they relied upon the French  
 10 sending it across by email. And as we'll see, at the  
 11 time of and prior to the events with which the Inquiry  
 12 is concerned, the Coastguard were aware, both that  
 13 the French sometimes delayed in sending their tracker  
 14 and also that this impacted negatively on situational  
 15 awareness.  
 16 SIR ROSS CRANSTON: Mr Phillips, I'm wondering if it's  
 17 appropriate to have a break.  
 18 MR PHILLIPS: It's a very convenient moment, sir.  
 19 SIR ROSS CRANSTON: Because you're about to start on  
 20 the narrative, I know, yes.  
 21 So we'll have a break for ten or so minutes.  
 22 (11.16 am)  
 23 (A short break)  
 24 (11.29 am)  
 25 SIR ROSS CRANSTON: Yes, Mr Phillips.

1 MR PHILLIPS: Sir, returning to the narrative, on Monday,  
 2 22 November, the weather forecast used by Border Force  
 3 and Coastguard to predict the likelihood of small boat  
 4 crossings, known as the "Operation DEVERAN Weather  
 5 Assessment", was amber, meaning crossings were likely on  
 6 23 November, and red, meaning crossings were highly  
 7 likely, on the 24th.  
 8 On the 22nd, a "red days meeting" took place. These  
 9 were held between the Coastguard, Border Force, RNLI and  
 10 other stakeholders involved in small boat rescue work,  
 11 in which the forecast and risks to an effective response  
 12 were discussed. At that meeting, it was said that  
 13 Border Force intended to provide good coverage.  
 14 Staffing shortages at MRCC Dover were discussed.  
 15 Following the meeting, the representative who had  
 16 been present on behalf of 2Excel sent an email  
 17 internally identifying the significant risk for  
 18 the period, including the night of 23 to 24 November,  
 19 and advising them to — and I quote — "try and cover as  
 20 much as [they] can". Had the flights taken place as  
 21 planned, 2Excel would have launched at half past  
 22 midnight on the 23rd and flown two planes without gaps  
 23 in coverage until the next morning. However, in  
 24 the event, they didn't fly their pre—planned  
 25 surveillance missions due to concerns over poor

1 visibility and insufficient diversion air fields. As  
2 a result, the Coastguard had no situational awareness of  
3 small boats crossing the Dover Strait.

4 By around half past midnight in the very early hours  
5 of the 24th, the Aviation and Maritime  
6 Tactical Commanders had recorded their significant  
7 concern about the dangers of the situation in the ViSION  
8 system. They referred to being "effectively blind" in  
9 the absence of a surveillance flight and said that "this  
10 has the potential to be very dangerous". They cautioned  
11 against relaxing and expecting a normal night.

12 The extent to which this message was understood  
13 operationally is a question to be explored in the coming  
14 days.

15 No alternative assets were tasked between half past  
16 midnight, which is when the Coastguard was put on notice  
17 that 2Excel had postponed its flight, until after  
18 2 o'clock in the morning. The reasons for the delay and  
19 its potential significance are also questions to be  
20 explored.

21 Ultimately, the search and rescue helicopter R163  
22 was tasked to undertake a surveillance flight by  
23 the Aviation Tactical Commander.

24 At just before 1 o'clock in the morning, Dover  
25 Coastguard received the French tracker for the first

1 time that night. As a result, for the first time that  
2 night, the Coastguard obtained some intelligence as to  
3 small boats crossing the Dover Strait. The French  
4 tracker recorded four small boats heading towards UK  
5 waters. Then, just after 1 o'clock, Dover received its  
6 first notification in a telephone call with French  
7 Coastguard about the small boat that is the subject of  
8 this Inquiry. The French Coastguard told Dover that  
9 although the small boat, known by the French as "small  
10 boat 7", was not shown on the French tracker, it was in  
11 fact closer to UK waters than the other small boats that  
12 had been recorded on the tracker. Location co-ordinates  
13 and two telephone numbers were provided to Dover  
14 Coastguard. The French said that there were 33 people  
15 on board, including 13 women and eight children. It was  
16 said that 14 of those on board were wearing life  
17 jackets.

18 Around 15 minutes after this call, the MOO at Dover  
19 opened a new incident in ViSION, Incident Charlie, to  
20 record the information about French boat 7.

21 The information that was entered contained an error,  
22 however. Whereas the French had given no information  
23 about the state of the small boat 7, it was erroneously  
24 recorded in the ViSION logs as being in good condition.  
25 This was the first error made in the recording of

1 information about Incident Charlie, but as we will see,  
2 it was not the last.

3 Around the same time that Incident Charlie was  
4 opened, the MOO at Dover called Border Force to let them  
5 know about Incident Charlie, which was calculated to be  
6 in UK waters by that point. Following this call,  
7 shortly before 1.30 in the morning, the Border Force  
8 cutter, the Valiant, was tasked. At the point that it  
9 was tasked, the Coastguard and Border Force had no  
10 knowledge that Incident Charlie was in distress.

11 The MOO at Dover had erroneously recorded it as being in  
12 good condition and had told Border Force the same, but  
13 in truth, the Coastguard had been provided with no  
14 information from the French about the condition of small  
15 boat Charlie.

16 It is likely, in fact, that the small boat was  
17 already in distress at this time. Reports in the French  
18 media refer to the French Coastguard's failure to inform  
19 Dover Coastguard that Charlie was in distress when it  
20 first relayed information about small boat 7. And in  
21 a call just after 1.30 in the morning, which is likely  
22 to be the first connected call between the boat and  
23 the Coastguard, the caller told the Coastguard that  
24 those on board were "in the water" and that "everything  
25 [was] finished".

1 Around ten minutes after the first likely call from  
2 Incident Charlie, at 01:48, the French Coastguard  
3 transferred a call which lasted around 20 minutes.  
4 The caller was a 16-year-old Iraqi Kurdish boy, Mubin  
5 Rizghar Hussein, who has been identified among  
6 the victims. He spoke to the SMC at Dover. He repeated  
7 that they were "in the water" and were "finished".

8 During this call, he managed to obtain the Coastguard's  
9 mobile phone number, and at 2.01, geolocation  
10 information was sent to the Coastguard from the mobile  
11 phone of another of the victims, Shakar Ali Pirot. An  
12 updated position was sent from his mobile phone at 2.21,  
13 and at 2.20, from a Turkish mobile phone number that  
14 belonged to another of the victims. However,  
15 the Coastguard did not see these updated positions until  
16 over an hour after they were sent, and the reasons for  
17 this will be explored in the hearing.

18 In the course of the long call with Mubin, it became  
19 apparent that those on board the small boat could see  
20 another vessel. The SMC believed that this could be  
21 a tanker called the Gaschem Shinano, and the Coastguard  
22 contacted that vessel. However, the Gaschem Shinano  
23 reported that they could see nothing and they were  
24 permitted to continue on their way.

25 Shortly after this call, however, the SMC at Dover

1 decided to broadcast a Mayday relay. He has told  
 2 the Inquiry that he had an initial gut feeling after  
 3 the call that this was a real emergency. Mayday relays  
 4 are reserved for severe distress situations where there  
 5 is an imminent and grave risk to life. The Mayday  
 6 relay, broadcast initially at 2.26, said that the small  
 7 boat was "taking water and requiring immediate  
 8 assistance". This was repeated at around 2.45,  
 9 3 o'clock and 3.19. The position sent by the mobile  
 10 phone number I've mentioned at 2.01 was provided, which  
 11 was near to the Sandettie light vessel, in UK waters on  
 12 the Sandettie sandbank in the Dover Strait. The Inquiry  
 13 understands that the Mayday relay broadcast for small  
 14 boat activity was a highly unusual step.

15 The SMC at Dover told Border Force on the night in  
 16 question that he decided to broadcast the Mayday relay  
 17 in order to get a French vessel used by the French  
 18 Coastguard, the Flamant, to respond. This was because  
 19 the Flamant was approximately three nautical miles away  
 20 from the sinking small boat whereas the Valiant was nine  
 21 nautical miles away. The SMC has told the Inquiry,  
 22 however, that he believes he still would have broadcast  
 23 the Mayday relay had the Flamant not been nearby.

24 In the event, the Flamant did not respond to  
 25 the Mayday relay. On the face of it, it appears that by

1 failing to respond, the Flamant would have breached its  
 2 obligation to render assistance to persons in distress  
 3 at sea under the International Convention for the Safety  
 4 of Life at Sea. However, as I've noted, the response of  
 5 the Flamant, and indeed the French Coastguard, to this  
 6 incident is the subject of ongoing criminal proceedings  
 7 in France, and as I've said, French law on investigative  
 8 secrecy has prohibited the Inquiry from gaining access  
 9 to any material from those proceedings.

10 Whilst the SMC at Dover spoke to the French Guard  
 11 about the sinking small boat and the Mayday relay, he  
 12 never directly requested the French to task the Flamant  
 13 to go to Incident Charlie. That said, it's unclear what  
 14 the result would have been had he done so, since the UK  
 15 Coastguard had no power to task or direct the French  
 16 vessel. We'll investigate this further in the coming  
 17 days.

18 Few commercial vessels responded to the Mayday  
 19 relay. The first three broadcasts of the relay failed  
 20 to use the correct digital selective calling alert for  
 21 a distress situation. The MCA's internal review into  
 22 Incident Charlie concluded that the error made no  
 23 difference because the substantive content of  
 24 the message would still have gone to every vessel.  
 25 This, again, will be explored with the witnesses.

1 So I now turn back to the Valiant, which, you  
 2 remember, was tasked shortly after 1.30 in the morning.  
 3 She took around two hours from tasking to arrive on  
 4 the scene. Took about 30 minutes to leave her berth,  
 5 including waiting for an embedded enforcement officer to  
 6 embark, and then a further 20 minutes to clear the Port  
 7 of Dover. After leaving the port, the journey to  
 8 the Mayday relay position took another full hour.  
 9 The Valiant's commander has told the Inquiry that she  
 10 travelled at best speed. The adequacy of the overall  
 11 response time will be examined at the hearings.

12 On the night in question, Dover Coastguard and  
 13 Border Force did in fact discuss the sufficiency of  
 14 the Valiant's tasking. In an important call, at 3.11,  
 15 they discussed the French tracker which showed four  
 16 small boats, including Charlie, all in the same area  
 17 around the Sandettie light vessel.

18 Could we have, please, the map {INQ010512}.

19 You can see, I think, there, the Sandettie bank,  
 20 which is, again, just on the median line between French  
 21 and UK waters.

22 Thank you, if that could be removed.

23 On the call between them, the SMC at Dover  
 24 calculated that the total numbers of persons on board  
 25 the vessels would be 110 and acknowledged that this

1 would be "pushing [their] luck for Valiant", given its  
 2 maximum survivor capacity was 100 people. But, despite  
 3 this, he and the Border Force officer decided not to  
 4 task any further assets. Indeed, the SMC said that he  
 5 hoped the French couldn't count. They both agreed that  
 6 this was "the dream" only to task one asset. The views  
 7 expressed on this call will be explored further during  
 8 the hearings.

9 In addition to the Valiant, the search and rescue  
 10 helicopter R163 was also in the same area from shortly  
 11 before 4 o'clock in the morning. As I've said, it was  
 12 initially tasked by the Aviation Tactical Commander  
 13 shortly before 3 o'clock, with a mission to locate  
 14 "migrant vessels". When the Aviation Tactical Commander  
 15 tasked the helicopter, he contrasted what he said he  
 16 called a "true SAR incident", search and rescue, with  
 17 the telephone calls that had been coming in that night  
 18 of, in his words, "sharks with lasers surrounding  
 19 the boats and were all dying type of thing". Both this  
 20 language and the dichotomy he set up between a "true"  
 21 search and rescue incident and a "legal" or theoretical  
 22 one will be examined with the witnesses.

23 R163's tasking was later amended by the SMC and  
 24 search parameters were given. However, he made no  
 25 reference to the sinking boat Charlie or to

1 the possibility that there were people in the water.  
 2 Around an hour after its initial tasking, the helicopter  
 3 was airborne, but it didn't find the sinking small boat  
 4 and it was not re-tasked to continue searching after its  
 5 initial sortie. Questions around the search parameters,  
 6 the information provided to the helicopter and  
 7 the reasons for its failure to find the small boat and  
 8 indeed the decision not to re-task it will all be  
 9 examined in the hearings.

10 Returning to the narrative then. There was  
 11 a further call from the French Coastguard about  
 12 Incident Charlie at 2.42. The French Coastguard told  
 13 the SMC at Dover that those on board had said, "Help me,  
 14 help me, help me. We are in the water". The French  
 15 Coastguard asked whether the UK was sending a rescue  
 16 boat, and audibly gasped on being told that the Valiant  
 17 was still 40 minutes away. Despite this, however,  
 18 the call ended without a workable solution to  
 19 the problem having been agreed.

20 The message relayed to Dover by the French at 2.42,  
 21 that the people on board the small boat were in  
 22 the water and needed help, was consistent with the other  
 23 calls taken by MRCC Dover from those on board. After  
 24 the long call with Mubin, which I have mentioned, and  
 25 which had taken place around an hour earlier, there were

1 a number of further calls. At 2.25, the MOO at Dover  
 2 took a call which was identified by the Coastguard as  
 3 being from Charlie and which was consistent with other  
 4 calls from the sinking small boat. Despite lasting  
 5 almost five minutes, neither the phone number of  
 6 the caller nor any updated geolocation information was  
 7 obtained.

8 Around five minutes later, at 02:31, the SMC  
 9 answered a further call from Mubin. Mubin repeated that  
 10 they were "finished" and that they would "all die".  
 11 The SMC responded by telling Mubin to stop calling and  
 12 to await a rescue boat, which he said would arrive in  
 13 less than half an hour. In the event, the Valiant did  
 14 not arrive in the Mayday relay position until around an  
 15 hour after this call. Despite the call lasting around  
 16 seven minutes, there was no attempt by the SMC to obtain  
 17 updated geolocation information about the position of  
 18 the small boat from Mubin. The MOO at Dover has told  
 19 the Inquiry that he recalls the SMC raising his voice on  
 20 this call and that, at the time, he told somebody at  
 21 the JRCC that his supervisor was "having a row with  
 22 someone called Moomin".

23 There were also four missed calls to  
 24 the Coastguard's mobile phone from numbers linked to  
 25 Incident Charlie. There was also a three-minute call

1 between the Coastguard mobile phone and a number linked  
 2 to Charlie, however the Coastguard's mobile was not  
 3 integrated into the information management system and  
 4 there is no record of what was said.

5 Then, finally, at 3.06 and 3.11, there were two  
 6 calls taken by the MOO at Dover. Both calls were  
 7 consistent with originating from Incident Charlie in  
 8 terms of the similar narrative and the high level of  
 9 distress.

10 One of the two survivors, Issa Mohamed Omar, says in  
 11 his statement to the Inquiry that he believes that  
 12 the last calls before the boat capsized were made by one  
 13 of the Afghans on board and that "desperate calls were  
 14 being made right up to the moment [they] capsized".  
 15 The caller at 3.06 said that the boat was sinking and  
 16 that "part of [their] body [was] in the sea" before  
 17 the call cut out. The caller at 3.11, which may be  
 18 the last call from Incident Charlie, repeatedly said,  
 19 "help me", and that those on board were "finished".  
 20 The MOO at Dover asked the question, "Where are you", of  
 21 the caller some 17 times, despite the caller's clear  
 22 inability to answer beyond saying that they were in UK  
 23 waters. The futility of this question is striking, you  
 24 may think. No attempt was made by the MOO to obtain an  
 25 updated position. He ended the call by suggesting that

1 the boat was in French waters if the caller's phone was  
 2 not able to make a 999 call.

3 The call lasted just over four minutes, ending  
 4 around 3.15. Based on all of the evidence which the  
 5 Inquiry has considered, it seems likely that within  
 6 about 15 minutes of the end of that last desperate call,  
 7 all of those on board the sinking small boat fully  
 8 entered the water.

9 At 03:33, a message sent from the Coastguard mobile  
 10 phone to Shakar Ali Pirot's phone did not reach  
 11 the recipient and another call to his phone failed at  
 12 4.16.

13 The Valiant arrived in the Mayday relay position,  
 14 that is the 2.01 geolocation position, at around 3.24,  
 15 before the helicopter was on the scene and during  
 16 the period in which those on board the sinking small  
 17 boat likely fully entered the water. The temperature of  
 18 the seawater was 13 degrees Celsius and it was dark.

19 Under its terms of reference, the Inquiry must  
 20 investigate what happened after those on board entered  
 21 the water, including how those who died came by their  
 22 deaths. And to this end, we have obtained evidence from  
 23 Professor Michael Tipton, Professor of Human & Applied  
 24 Physiology at the University of Portsmouth, who is an  
 25 expert in cold water survival. The report makes for

1 difficult reading.  
 2 Professor Tipton concludes that whilst some of those  
 3 on board may have drowned immediately upon entering  
 4 the water due to cold shock, this was unlikely to be  
 5 the cause of death for the majority, since they would  
 6 have been pre-cooled by exposure to an air temperature  
 7 of between 2 to 5 degrees Celsius and by the cold  
 8 seawater that had been filling the boat for some time.  
 9 It is likely, therefore, that the majority died over  
 10 a longer period.  
 11 Professor Tipton considers that some will have died  
 12 by sunrise at around 7 am and others between sunrise and  
 13 rescue in the early afternoon of the next day. He  
 14 concludes that most drowned when they could no longer  
 15 hold on to the buoyant remains of the small boat as  
 16 a result of either physical incapacitation due to  
 17 cooling of their hands, arms and legs, or loss of  
 18 consciousness, or cardiac arrest due to hypothermia.  
 19 Professor Tipton considers that it is likely  
 20 the majority were still alive when, at around 3.24,  
 21 the Valiant arrived at the Mayday relay position. Given  
 22 that the position had been sent at 2.01, however, it was  
 23 perhaps unsurprising that the Valiant found nothing and  
 24 continued north because she considered that, if  
 25 the small boat's engine had failed and it had stopped,

1 it may have drifted in that direction.  
 2 Then, at around 3.34, the Valiant located two small  
 3 boats, one stopped and one underway. She went towards  
 4 the stopped vessel and was alongside it at 3.48.  
 5 The Valiant had embarked the 35 people on board  
 6 the first small boat by around 4.34. Whilst this was  
 7 happening, the Valiant was in touch with both Dover  
 8 Coastguard and Border Force. Border Force provided  
 9 the M number of M957 for this first boat. And just  
 10 after 4.20, after obtaining information about  
 11 the numbers on board, colour, location and any calls  
 12 made, the SMC at Dover identified M957 as incident  
 13 "Lima". However, at that time, information about  
 14 the first small boat continued to be recorded on  
 15 the Charlie log.  
 16 Around an hour later, the SMC at Dover committed his  
 17 decision that the first small boat found was  
 18 Incident Lima to writing. He recorded that the small  
 19 boat Lima had been embarked by the Valiant on the Lima  
 20 incident log in ViSION and on the Lima row in the shared  
 21 tracker. However, there was by then an error on  
 22 the shared tracker which the SMC at Dover did not  
 23 correct when he entered the information about Lima. At  
 24 3.57, the SMC at the JRCC in Hampshire had allocated  
 25 M957, the M number allocated to Incident Lima, to

1 Incident Charlie in the shared tracker. The reasons for  
 2 and impact of this error will be explored in  
 3 the hearings.  
 4 After embarking the 35 people on board the first  
 5 small boat, the Valiant was tasked by MRCC Dover to go  
 6 to vessels located by R163. As you will recall, R163  
 7 had arrived in the same area as the Valiant shortly  
 8 after 4 o'clock in the morning, when the Valiant was  
 9 alongside the first small boat, M957.  
 10 By around 5.20, the Valiant was alongside the second  
 11 small boat and R163 had already informed MRCC Dover that  
 12 the second small boat was underway and not in distress  
 13 or in need of immediate assistance. Border Force  
 14 attributed the number M958 to the second boat.  
 15 A headcount from this boat was called in by Valiant of  
 16 31 adult men. Dover Coastguard asked the Valiant if it  
 17 had any names for the English speakers, to which Valiant  
 18 responded negatively, but said that one of them did say  
 19 that they saw someone make a call.  
 20 As with the information for M957, the information  
 21 about M958 was all entered in the Incident Charlie  
 22 ViSION log. However, M958 bore no resemblance to what  
 23 the Coastguard knew of Charlie. Charlie was sinking, in  
 24 distress and in need of immediate assistance, M958 was  
 25 not. Charlie was stopped, M958 was underway. Charlie

1 had men, women and children on board, M958 only had  
 2 adult men. And those on board Charlie had made multiple  
 3 distress calls, whereas on M958, one person saw another  
 4 person making one call.  
 5 There is no contemporaneous record that  
 6 the Coastguard linked M958 to Charlie, but it is the SMC  
 7 at Dover's evidence to the Inquiry that, consciously or  
 8 unconsciously, he believed on the night that M958 was  
 9 Charlie. This will need to be explored at the hearings.  
 10 After embarking the second small boat, Dover  
 11 Coastguard told the Valiant that there was another  
 12 tasking to the third small boat which was "in  
 13 the vicinity of 'Southwest Goodwin'". This is  
 14 a completely different area of the Channel to  
 15 the Sandettie. The Valiant then left the Sandettie area  
 16 and was tasked to a different incident, "November",  
 17 which was the third vessel to be identified by  
 18 the helicopter R163.  
 19 Again, all of the information about the third small  
 20 boat embarked by the Valiant was recorded in the Charlie  
 21 ViSION log. It was also recorded in the November ViSION  
 22 log, and this third boat was given the number M959.  
 23 The Valiant engaged with November, or M959, at around  
 24 6.30, and after embarking a further 32 people, she  
 25 returned to Dover at capacity. To recap, she had 66

1 people already on board, 35 from the first boat, 31 from  
 2 the second boat, to add to the third boat's 32,  
 3 producing a total of 98. Her capacity, as I've said,  
 4 was 100.

5 In the Charlie ViSION log, there are two entries  
 6 from the MOO at Dover at 06:46 simultaneously tasking  
 7 Valiant to Incident November and clearing the Valiant  
 8 from Incident Charlie. By around 6.45 on 24 November,  
 9 therefore, Dover Coastguard had effectively terminated  
 10 the search and rescue operation for the sinking small  
 11 boat Charlie without recording any reasons for this  
 12 decision.

13 As I have mentioned, dawn broke at around 7 o'clock  
 14 on the morning of the 24th. The survivor,  
 15 Issa Mohamed Omar, has told the Inquiry that when  
 16 the sun came up, there were around 15 or fewer people  
 17 left holding on to the deflated boat. He recalls seeing  
 18 bodies floating all around them. He recalls seeing  
 19 a Kurdish woman, who was screaming, desperately  
 20 searching for her children. The horror of what he saw  
 21 is almost unimaginable. He started swimming after dawn.  
 22 He says that he swam for many hours before he was  
 23 rescued. Throughout this time, the Coastguard did not  
 24 actively search for those people in the water who had  
 25 been on board Charlie.

1 When considering the actions of those working on  
 2 the day watch on 24 November, the extent to which there  
 3 was any meaningful oversight of the decision—making of  
 4 the SMC at Dover on the night watch in relation to  
 5 Incident Charlie will be an important question for  
 6 the Inquiry to explore. As we've seen, his  
 7 decision—making was not reviewed on the night watch.  
 8 And, significantly, particularly so far as the following  
 9 day watch was concerned, he left no written record of  
 10 key decisions made in relation to Incident Charlie. It  
 11 will be for the Inquiry to understand how far  
 12 the absence of a written record meant that the incoming  
 13 day watch were unable properly to understand and  
 14 potentially challenge these decisions and any reasoning  
 15 that lay behind them.

16 Moreover, the Inquiry will need to explore  
 17 the extent to which any challenges faced by the day  
 18 watch in understanding what had happened in  
 19 Incident Charlie the previous night were compounded by  
 20 the existence of misleading or wrong information  
 21 insofar as information had been recorded in writing.  
 22 The shared tracker and the Border Force tracker wrongly  
 23 identified M957 as Charlie, whereas M957 was in fact  
 24 Lima. The Border Force tracker wrongly identified  
 25 Charlie as having been embarked by the Valiant, and

1 the Charlie ViSION log contained information about each  
 2 small boat encountered by the Valiant during the night  
 3 watch without actually attributing any of them to  
 4 Incident Charlie itself.

5 Was the result that the decision—making from  
 6 the night watch on Incident Charlie became effectively  
 7 impenetrable and was thereby insulated from any  
 8 meaningful oversight? And if so, how was it that  
 9 the Coastguard systems did not prevent such an outcome?

10 At just before 1 o'clock on the day watch in  
 11 the afternoon of 24 November, some nine and a half hours  
 12 after the likely time that people on board the boat fell  
 13 into the water, Dover Coastguard received a call from  
 14 the French Coastguard who reported that a French fishing  
 15 vessel had encountered around 10 to 15 people in  
 16 the water who were unconscious, and requested that  
 17 the Coastguard send an aircraft. The location was in  
 18 French waters, but close to the median line. This  
 19 incident was identified in the ViSION logs as "Xray 2"  
 20 and no connection was made by the day watch to  
 21 Incident Charlie, which, as we know, was closed a few  
 22 hours later. The search and rescue response was  
 23 significant. Three French vessels, the Flamant, and two  
 24 others, were tasked, as well as a French helicopter.  
 25 The UK Coastguard sent R163 and an RNLI lifeboat was

1 also tasked.

2 As I've said, Issa Mohamed Omar swam for many hours  
 3 before he was rescued by a French fishing boat and then  
 4 transferred to the French authorities and hospital in  
 5 France. There was one other survivor, an Iraqi Kurd.  
 6 He has not engaged with the Inquiry, but some of  
 7 the family's statements refer to their contact with him  
 8 and the information he gave about their loved ones who  
 9 died. It is said that one of the victims died just half  
 10 an hour before rescue. The question of whether the loss  
 11 of life was avoidable is not an academic one in this  
 12 case.

13 So then, sir, I would like to turn to identify some  
 14 of the themes and questions which arise from that  
 15 narrative. By its terms of reference and in part IV of  
 16 the list of issues, a central area of investigation for  
 17 the Inquiry is the adequacy of the search and rescue  
 18 operation and the extent to which the loss of life was  
 19 avoidable. This will require exploration of the reasons  
 20 why the sinking small boat was never found and  
 21 the foreseeability of the tragic loss of life which  
 22 ensued.

23 In respect of the search and rescue response,  
 24 a number of key themes and questions emerge from  
 25 the narrative and they will be the subject of our

1 particular focus with witnesses in the coming days.  
 2 First, resources. As I've said, the Coastguard were  
 3 on notice from at least 2020 that Dover was under  
 4 significant strain. There was a chronic understaffing  
 5 problem. Whilst they had put in place a number of  
 6 measures in response, including a recruitment drive, by  
 7 November 2021, they had not been able to recruit  
 8 the numbers required to make up the shortfall. Altered  
 9 shift patterns for Dover employees and remote coverage  
 10 from other stations were therefore routinely relied  
 11 upon.

12 By November 2021, with the unprecedented numbers of  
 13 small boat crossings, the risk of overwhelm was real.  
 14 Staff at Dover were working long hours and some, such as  
 15 the SMC at Dover on the night watch, were routinely  
 16 working altered shift patterns, which reduced their time  
 17 off by a third. The persistent problem of  
 18 understaffing, in combination with the spike in numbers  
 19 of small boat crossings in 2021, placed immense pressure  
 20 on staff at Dover and the evidence shows that  
 21 the Coastguard were fully on notice.

22 Additionally, as some of the witnesses have told  
 23 the Inquiry, calls from those on board small boats were  
 24 often extremely distressing. The callers were often  
 25 scared, desperate, panicked, fatigued and they struggled

1 to communicate. They will often have been at sea in  
 2 terrible and dangerous conditions for many hours.  
 3 Responding to such calls, particularly in the working  
 4 conditions of 2021 which I have described, inevitably  
 5 took its toll on those at the frontline, who were doing  
 6 it day in, day out.

7 Sir, the Inquiry's investigation will focus on  
 8 the identification, monitoring and assessment of risk by  
 9 Coastguard and others, including whether the mitigating  
 10 actions taken were sufficient in terms of the urgency  
 11 and scale of the response and considering any decision  
 12 not to declare a major incident. A key question to be  
 13 explored during the hearings is how, if at all,  
 14 the resourcing problems which I have mentioned impacted  
 15 on the search and rescue response to Incident Charlie.

16 In relation to the impact of remote coverage from  
 17 the JRCC, Coastguard were alive to certain problems  
 18 relating to this in the summer of 2021, including  
 19 challenges to situational awareness. The Inquiry will  
 20 investigate whether remote coverage from the JRCC  
 21 impacted on the effectiveness of the search and rescue  
 22 operation.

23 In relation to resourcing concerns at Dover, we will  
 24 also investigate the adequacy of the search and rescue  
 25 assets that responded to small boat crossings in

1 November '21. As I have mentioned, around 90% of  
 2 rescues at that time were undertaken by Border Force,  
 3 none of whose vessels were designed or equipped for  
 4 search and rescue. By that month, it was acknowledged  
 5 that the situation for Border Force Maritime was  
 6 critical and non-sustainable without an increase in  
 7 asset numbers. Additionally, RNLI, as I've mentioned,  
 8 were also facing significant pressure from small boat  
 9 call outs.

10 It will be important for the Inquiry to investigate  
 11 how far, if at all, this situation impacted on  
 12 the tasking and deployment of maritime assets on  
 13 the night. In particular, why did the Valiant take  
 14 two hours from tasking to reach the Mayday relay  
 15 location? Was this a reasonable response time for  
 16 a search and rescue mission? Why did the SMC at Dover  
 17 not task another asset capable of arriving more quickly?  
 18 Why was the Valiant considered sufficient by  
 19 Border Force and Dover Coastguard when they had  
 20 calculated that there were persons in the small boats in  
 21 excess of Valiant's survivor capacity? Did Border Force  
 22 make sufficient assets available? And why was RNLI not  
 23 tasked? And more generally, and perhaps more  
 24 fundamentally, were the Valiant and the other  
 25 Border Force assets suited to search and rescue at all?

1 Secondly and relatedly, cooperation and information  
 2 sharing with other stakeholders. Border Force, as I've  
 3 explained, became increasingly involved in search and  
 4 rescue in the absence of any memorandum of understanding  
 5 or other written agreement setting out respective roles  
 6 and responsibilities. Did this create a grey area,  
 7 a lack of clarity as to Border Force's role? And how  
 8 did its enforcement role interact with its search and  
 9 rescue function? Did any of this have an impact on  
 10 the night in question, noting, for example, that on that  
 11 night, the Valiant did not depart Dover until an  
 12 enforcement officer had embarked? And did the  
 13 Home Office share all the intelligence that it has to  
 14 likely small boat crossings with the Coastguard? These  
 15 are questions which the Inquiry will investigate.

16 And we will also consider the relationship between  
 17 the Coastguard and its other key partner in small boat  
 18 search and rescue, the French Coastguard, and  
 19 the effectiveness of systems for search and rescue  
 20 coordination and information sharing.

21 Third, situational awareness and preparedness.  
 22 There was a failure to obtain a recognised maritime  
 23 picture on the night in question, both due to a delay in  
 24 the Coastguard obtaining the French tracker and a result  
 25 of 2Excel's failure to fly its planned surveillance

1 mission. Delays in obtaining the French tracker were  
 2 recognised by the Coastguard as a problem well in  
 3 advance of the events in question. The frequent delays  
 4 were raised in meetings between the UK and French  
 5 Coastguards in late 2020 and again in the summer of  
 6 2021. The Inquiry will investigate whether the UK  
 7 Coastguard did enough to mitigate the effect of these  
 8 delays, including on the night in question.

9 And was the fixed wing flight provided by 2Excel  
 10 a reliable means of obtaining situational awareness in  
 11 November 2021? What was the plan B for when fixed wing  
 12 could not fly?

13 Fourth, communication between the Coastguard and  
 14 small boats. The Coastguard had a contract with  
 15 a company providing remote interpretation services, but  
 16 it was not used on the night and it appears it was  
 17 rarely used and unsuited to communications with small  
 18 boats. The Inquiry will investigate the communication  
 19 problems on the night, and more fundamentally, it will  
 20 consider whether the interpretation service was fit for  
 21 purpose when communicating with small boats.

22 The Inquiry will also need to consider the extent to  
 23 which Standard Operating Procedures were followed, and  
 24 if not, to ascertain why. In particular, why was  
 25 updated geolocation information not sought on calls

1 identified as being repeats of the same incident? Why  
 2 were callers from the sinking boat repeatedly asked  
 3 the question, "Where are you", when it was clear that  
 4 they could not give a precise report? Why did  
 5 the Coastguard tell the callers to stop calling? And,  
 6 finally, why was Mubin told that a rescue boat would be  
 7 with him within half an hour when, in fact, it was still  
 8 approximately an hour away from the Mayday relay  
 9 position?

10 More generally, were there adequate systems and  
 11 procedures for identifying repeat calls and providing  
 12 relevant information, including advice on survivability?  
 13 And to what extent were the responses of the Coastguard  
 14 and Border Force officers on the night explicable by  
 15 reference to what the Inquiry understands to be  
 16 a widely-held belief that callers from small boats might  
 17 exaggerate their level of peril in order to accelerate  
 18 rescue? How widespread was the belief that small boat  
 19 incidents were not, to use the term employed by  
 20 the Aviation Tactical Commander, "true" search and  
 21 rescue incidents?

22 And what of the Coastguard mobile phone? Why was it  
 23 not integrated into the information management systems?  
 24 Why was one call taken, of whose content there is no  
 25 record, but many others missed? Why was updated

1 geolocation information missed by the Coastguard for  
 2 over an hour?

3 Fifthly, the adequacy of the search and rescue  
 4 operation itself. A central question for the Inquiry is  
 5 why the Valiant and the helicopter R163 did not find  
 6 the sinking small boat. In considering this question,  
 7 we will need to examine whether they were tasked with  
 8 the correct search parameters and provided with  
 9 sufficient information to enable them to conduct an  
 10 effective search.

11 And then the Mayday relay. We'll consider  
 12 the reasons for making the decision to broadcast  
 13 the relay and the circumstances in which it was  
 14 terminated. We'll investigate how commonly were Mayday  
 15 relays used in small boat search and rescue and examine  
 16 whether Standard Operating Procedures were followed on  
 17 the night, why the wrong DSC alert was used, and whether  
 18 this had any effect on the responses of other vessels.

19 Sixthly, systems, and in particular information  
 20 management and record keeping. At the time of  
 21 the events in question, the Coastguard was on notice  
 22 that there were problems in relation to the recording of  
 23 information in the ViSION system for a small boat search  
 24 and rescue. In August 2020, an internal Coastguard  
 25 review of a small boat incident recognised that there

1 was insufficient record keeping in the ViSION system.  
 2 A similar criticism was made in another review in  
 3 July 2021. How, if at all, had these criticisms been  
 4 addressed by November '21? The Inquiry will explore  
 5 the circumstances in which mistakes were made in  
 6 the recording of information in relation to  
 7 Incident Charlie. It will seek to understand how this  
 8 might have impacted on the ability of the incoming day  
 9 watch to understand the operational detail of the search  
 10 and rescue response from the previous night. Did any  
 11 such problems impact the search and rescue response in  
 12 this incident?

13 The Coastguard were similarly aware that there were  
 14 problems surrounding the use of trackers. They were on  
 15 notice before November 2021 that the existence of  
 16 numerous trackers used by different stakeholders  
 17 challenged a "single version of the truth". Whilst it  
 18 appears that Border Force had obtained live access by  
 19 the night of 23 November, there is no evidence that any  
 20 guidance as to its effective use had been created or  
 21 delivered by that time. The Inquiry will investigate  
 22 how far, if at all, this contributed to the errors made  
 23 on the trackers that night. We'll also explore why  
 24 the shared tracker was not consistently updated during  
 25 the night watch. And, conversely, why was

1 the Border Force tracker updated when the shared tracker  
 2 was not?  
 3 The question of the circumstances in which  
 4 the shared tracker contained errors will also be  
 5 explored, including entries made by staff in the JRCC  
 6 and by non-operational staff, and why these errors went  
 7 uncorrected, including any systems, or the absence of  
 8 such systems, for quality assurance. The Inquiry will  
 9 also examine the question of what, if anything,  
 10 the Border Force tracker added to the Coastguard's  
 11 understanding of the status of Incident Charlie. Could  
 12 this have been relevant to the entry marking Charlie as  
 13 resolved in the shared tracker or to the later entry in  
 14 the ViSION log that the tracker showed that Charlie had  
 15 been resolved? Or, if not, what were the reasons for  
 16 those entries?  
 17 And finally, the cessation of the search and rescue  
 18 response for Incident Charlie. This area of  
 19 investigation will cover many of the themes addressed so  
 20 far. When the Coastguard was a notice that the small  
 21 boat Charlie was sinking and in indeed of immediate  
 22 assistance, and had broadcast a Mayday relay to that  
 23 effect, why did the search and rescue response cease  
 24 after the Valiant had embarked three vessels, none of  
 25 which was positively identified as Charlie in

1 the written records from the night?  
 2 Of these three small boats, the first and third were  
 3 identified by Dover Coastguard as "Lima" and "November"  
 4 respectively. The other, the second boat, was known to  
 5 Dover Coastguard to be underway and in good condition,  
 6 contrary to the information the Coastguard had of  
 7 the sinking small boat Charlie. However, the night  
 8 watch SMC at Dover has told the Inquiry that he believed  
 9 that this second small boat, M958, was Charlie.  
 10 The MCA's internal review into the incident concluded  
 11 that the decision-making was reasonable.  
 12 The Inquiry will need to consider the grounds for  
 13 and implications of this stated belief that M958 was  
 14 Charlie. It must investigate why the search and rescue  
 15 response was effectively terminated on the night shift  
 16 when the Valiant was re-tasked to Incident November.  
 17 The Inquiry will question why there was no written  
 18 record of key decisions that were apparently made on  
 19 the night watch and it will consider the actions of  
 20 those present on the incoming day watch. And in the  
 21 end, the Inquiry must draw its own conclusions as to  
 22 the reasonableness of the decision to terminate search  
 23 and rescue for the sinking small boat and of the systems  
 24 that permitted it.  
 25 But, throughout this hearing, and indeed this

1 Inquiry, what we will and must always keep at  
 2 the forefront of our minds is, at the time when  
 3 the Valiant was "cleared" from Incident Charlie, when  
 4 she returned to Dover and when the helicopter returned  
 5 to base, when the incident was marked as resolved and  
 6 closed, at all those times, the human beings who had  
 7 been on board the sinking small boat were in the water  
 8 and the vast majority of them were drowning.  
 9 So, sir, the final section of my opening concerns  
 10 post-event lesson learning and the question of  
 11 recommendations.  
 12 Issue VI of the Inquiry's list of issues addresses  
 13 the theme of recommendations, and that requires us both  
 14 to look back at the actions that have been taken since  
 15 November 2021 to prevent or reduce the risk of a similar  
 16 incident occurring, and also to look forward so as to  
 17 identify what, if any, other recommendations may be  
 18 appropriate.  
 19 So looking back first, there have been three  
 20 investigations or reviews of the incident which are of  
 21 relevance to understanding what steps have already been  
 22 taken by the organisations involved in search and rescue  
 23 operations.  
 24 First, as I've mentioned, the MAIB report, which  
 25 came out in November 2023. They made two formal

1 recommendations.  
 2 First, they recommended that the MCA, and I quote:  
 3 "[B]uild on existing liaison with French authorities  
 4 to devise a tracking and identification system that, to  
 5 the greatest extent possible, removes the possibility of  
 6 confusion and error when compiling an overview of small  
 7 boats attempting the crossing."  
 8 And, secondly, it recommended that the MCA and  
 9 Border Force, and I quote:  
 10 "[D]evelop procedures for achieving, as far as is  
 11 practicable, an overview picture of migrant boat  
 12 activity during periods when aerial surveillance is  
 13 limited to rotary wing aircraft or is unavailable."  
 14 Now, the MCA and the Home Office's responses to  
 15 the MAIB report outline the measures that have been  
 16 taken to implement the recommendations and they  
 17 include: the development of a live internet-based  
 18 tracker for small boats, the provision of additional  
 19 surface vessels and additional aerial surveillance  
 20 platforms, combined with more flying hours. Having  
 21 considered their responses, the MAIB closed  
 22 the recommendations as complete.  
 23 Secondly, the United States Coastguard were  
 24 commissioned by the Coastguard to conduct a Search and  
 25 Rescue Case Study Review into the sinking of small boat

1 Charlie, and the Case Study Review was submitted on  
 2 14 July 2023 and described itself as "akin to a peer  
 3 review for system improvement". The US Coastguard made  
 4 14 recommendations which were directed at  
 5 the Coastguard's working relationship with the French  
 6 authorities, organisational processes, resource  
 7 management and communications.

8 The MCA provided its response to the Case Study  
 9 Review on 28 May the next year, 2024. The MCA accepted,  
 10 in part or in full, and implemented seven of the 14  
 11 recommendations. As to the other seven, it either took  
 12 no action or did not accept the recommendations, because  
 13 it considered that the recommended actions were already  
 14 part of the Coastguard's policies and/or procedures  
 15 before 24 November 2021 or that existing arrangements  
 16 were adequate.

17 The third review was the Coastguard's own internal  
 18 review into the incident, a version of which dated  
 19 May 2024 and marked as being in draft form, has been  
 20 provided to the Inquiry. Now, this review made 21  
 21 recommendations covering information gathering; ViSION  
 22 and Coastguard communication; Coastguard procedures;  
 23 the role of the SMC and Tactical Commander; stakeholder  
 24 liaison; search planning; post-incident actions; and  
 25 training and exercise. The MCA has stated that it

1 accepted the recommendations and has implemented  
 2 the majority of them.

3 The picture that emerges from the outcome of these  
 4 investigations and reviews, as well as from  
 5 the responses provided to the recommendations that have  
 6 already been made, is that a significant number of  
 7 actions have already been taken by the agencies involved  
 8 with a view to preventing or reducing the risk of an  
 9 incident similar to the sinking of small boat Charlie  
 10 from occurring, and it is right and important to  
 11 acknowledge the progress that has already been made  
 12 before we look forward.

13 Looking forward, you'll remember that I identified  
 14 seven key themes and questions arising from the search  
 15 and rescue response, which will be the subject of  
 16 further exploration with witnesses in the coming days.  
 17 I'd like briefly to return to those themes, this time  
 18 with a view to analysing the actions that have been  
 19 taken in each area and to highlight areas of interest to  
 20 the Inquiry where there may be scope for further  
 21 recommendations.

22 So, first, resources. I have already referred to  
 23 the human resourcing issues at MRCC Dover in  
 24 November '21 and the below minimum staffing levels on  
 25 the night watch. The MAIB found the effect of this to

1 be twofold. First, the SMC was unable effectively to  
 2 perform his role of managing the overall search effort  
 3 because of the high volume of calls, the ongoing  
 4 management of multiple issues, and because staff became  
 5 involved in other tasks, such as taking emergency calls  
 6 from small boats. And, secondly, there were  
 7 insufficient resources to correlate information from  
 8 emergency calls, from the French, at Gris-Nez, and other  
 9 sources in real-time, and that's section 2.6.2 of  
 10 the MAIB report. The Inquiry will welcome evidence  
 11 about the current position in relation to staffing,  
 12 including an update as to whether the plan for a migrant  
 13 operational cell involving an increase of 24 staff at  
 14 MRCC Dover has been realised.

15 As to the resourcing of surface and aerial assets,  
 16 as I've already noted, both the MCA and the Home Office,  
 17 in their responses to the MAIB recommendations, referred  
 18 to additional aerial and surface asset capabilities.  
 19 I note that additional aerial asset capability was  
 20 achieved in 2022 through Project Caesar, comprising  
 21 Schiebel S100 drones and a DA62 fixed wing aircraft,  
 22 which provided increased flying time of up to 16 hours  
 23 a day and live video imagery to MRCC Dover.  
 24 Furthermore, additional surface assets, including four  
 25 Crew Transfer Vessels, were brought into service by

1 the Home Office as part of Operation Isotrope between  
 2 2022 and 2023. A further three Fast Reconnaissance  
 3 Vessels were due to be operational from the third  
 4 quarter of last year.

5 This increase in aerial and surface assets is of  
 6 course to be welcomed. Whether those assets are now  
 7 sufficient in number and have adequate capabilities to  
 8 perform search and rescue operations is a matter for  
 9 further exploration with witnesses. In particular,  
 10 there is a question as to whether the available aerial  
 11 assets now provide adequate mitigation in circumstances  
 12 where fixed wing aircraft cannot operate.

13 In relation to surface assets, the issues to be  
 14 explored include whether Crew Transfer Vessels are an  
 15 appropriate type of vessel to conduct search and rescue  
 16 taskings, in the light of the evidence the Inquiry has  
 17 received about the restrictions on their safe deployment  
 18 as the wave height approaches or exceeds 1 metre;  
 19 whether it would be feasible or practicable for  
 20 the Coastguard to acquire its own surface assets; and  
 21 whether vessels could be placed on stand by to undertake  
 22 search and rescue activities.

23 Secondly, inter-departmental cooperation.  
 24 The Inquiry will explore whether there is a need to  
 25 formalise existing arrangements between the Department

1 for Transport or the Coastguard on the one hand, and  
 2 the Home Office/Border Force on the other, as to their  
 3 respective roles and responsibilities when carrying out  
 4 search and rescue taskings.  
 5 And a related topic is cooperation between all  
 6 organisations involved in the response to small boat  
 7 crossings in the Dover Strait and whether cooperation  
 8 may be improved through more joint training exercises  
 9 involving all stakeholders. It's right to say that  
 10 there have been a number of training exercises, and  
 11 I can give two examples.  
 12 First, a multi-agency table-top exercise was held on  
 13 2 December '21 in Dover and attended by representatives  
 14 of the RNLI, the Home Office, Bristow and the MCA.  
 15 The purpose of the exercise was said to be, amongst  
 16 other things, to improve pre-planning for small boats  
 17 crossings and to improve cooperation between responders.  
 18 Secondly, a multi-agency workshop was held on  
 19 2 December '22 on board the HMC Severn to discuss mass  
 20 rescue tactics with participation from the RNLI,  
 21 the Coastguard and maritime operators.  
 22 However, the Inquiry understands that there has  
 23 been, to date, no formal joint exercise between  
 24 the Coastguard, Border Force and the RNLI.  
 25 Improving cooperative working between

1 the organisations involved in search and rescue in  
 2 the Dover Strait may also require formalisation of  
 3 the position in relation to on-scene command. For  
 4 example, a search and rescue operation may involve  
 5 the attendance of both Border Force and RNLI assets,  
 6 which can give rise to uncertainty or confusion  
 7 regarding where and with whom on-scene command and  
 8 coordination lies.  
 9 There are a number of potential models that might be  
 10 drawn on from different contexts. In marine emergencies  
 11 where there is a significant risk of pollution, for  
 12 example, the representative of the Secretary of State  
 13 for the Department for Transport exercises ultimate  
 14 command and is tasked to oversee, control and if  
 15 necessary intervene in the command of the salvage  
 16 operation. The Joint Emergency Services  
 17 Interoperability Principles, reflected, for example, in  
 18 the Kent Police's Maritime Incident Emergency Plan,  
 19 which has been disclosed to the Inquiry, provide a set  
 20 of principals for joint working that are designed to  
 21 enhance multi-agency command, control and coordination  
 22 in responding to major incidents. So the Inquiry wishes  
 23 to understand whether some version of these, or other  
 24 models, would be of assistance in unifying on-scene  
 25 command in the multi-agency responses required by search

1 and rescue operations.  
 2 Third, situational awareness. The delays  
 3 experienced by the Coastguard in November 2021 in  
 4 obtaining the French tracker have been addressed through  
 5 the implementation of a live internet-based tracking and  
 6 identification system prepared by the French Coastguard  
 7 but made accessible to the UK Coastguard.  
 8 The practicality of using this live tracker will be  
 9 the subject of further consideration.  
 10 Fourth, communication between the Coastguard and  
 11 small boats. The Inquiry understands that a new system,  
 12 known as the ICU system, was introduced in April 2023 to  
 13 enable better communication between the Coastguard and  
 14 people on small boats. The system enables text messages  
 15 sent in English from the Coastguard to be automatically  
 16 translated to the language used by persons on the small  
 17 boat once selected, and vice versa. The ICU system has  
 18 the further benefit of providing positional data  
 19 automatically for the mobile phone being used.  
 20 The Inquiry will explore the extent to which  
 21 the operation of the ICU system has alleviated some of  
 22 the difficulties in communicating with small boats.  
 23 The Inquiry will also be interested in an update on  
 24 the planned roll-out of the Artemis mobile phone system  
 25 to search and rescue aircraft operating in the Channel,

1 which will enable communications between the Coastguard  
 2 and small boats in the UK Search and Rescue Region, even  
 3 in the absence of a mobile phone signal.  
 4 The Inquiry acknowledges that steps have already  
 5 been taken to update the Standard Operating Procedures,  
 6 in particular the Standard Operating Procedure on Small  
 7 Boat Information Gathering, to provide officers with  
 8 a list of information they should try to obtain when on  
 9 the telephone with people on small boats and  
 10 the creation of a new operating procedure relating to  
 11 the use of WhatsApp when responding to small boat  
 12 incidents. For example, staff are now instructed to  
 13 provide the alphanumeric reference number for the small  
 14 boat incident at the end of every call and ask  
 15 the caller why use it if they call the emergency  
 16 services again. As with all new processes and  
 17 procedures, however, their introduction is only one part  
 18 of the story. The Inquiry wishes to ascertain  
 19 the extent to which these new processes and procedures  
 20 have been embedded through appropriate training and/or  
 21 exercises.  
 22 Fifth, the adequacy of the search and rescue  
 23 operation. Insofar as the Mayday relay is concerned,  
 24 the Inquiry notes that the Coastguard had accepted and  
 25 implemented the recommendation of the US Coastguard in

1 its Case Study Review by reminding staff to use  
 2 the appropriate distress alert when making a Mayday  
 3 broadcast through a "hot topic" notification of existing  
 4 procedure.  
 5 Sixth, information management and record keeping.  
 6 In the light of the inadequate recording of information  
 7 in relation to Incident Charlie, the question arises  
 8 how, if at all, criticisms of insufficient record  
 9 keeping in ViSION have been addressed.  
 10 Seventh, the cessation of the search and rescue  
 11 response for Incident Charlie, which gives rise to  
 12 consideration of the procedures for the suspension and  
 13 termination of search and rescue operations, and record  
 14 keeping of the rationales for those decisions.  
 15 The Inquiry notes that the Coastguard did not accept  
 16 the US Coastguard's recommendation to develop an  
 17 affirmative criteria for closing or correlating cases,  
 18 on the basis that it was already part of existing  
 19 procedures in November '21.  
 20 Sir, in addition to the areas which I've identified,  
 21 the Inquiry wishes to hear from witnesses about other  
 22 matters which may be material to the efficacy of search  
 23 and rescue arrangements in the UK, and therefore  
 24 potentially capable of reducing the risk of a similar  
 25 event occurring. These are matters which have emerged

1 from the evidence gathered, or which have been drawn to  
 2 the Inquiry's attention, and the list is not exhaustive.  
 3 First, diversion airfields. One of the reasons  
 4 given for the cancellation of 2Excel's flights was  
 5 the lack of a suitable diversion airfield. 2Excel have  
 6 explained to the Inquiry that because its diversion  
 7 airfields requests on the night in question were to  
 8 support a routine patrol tasking, referred to as  
 9 a "Category B" tasking, airfields were not compelled to  
 10 accept it. The Inquiry understands that responding to  
 11 an emergency would have been a Category A. And so  
 12 the Inquiry wishes to understand whether it is desirable  
 13 or necessary for UK airfields that are open to be  
 14 compelled to accept Category A and Category B search and  
 15 rescue aircraft diversion airfield requests, if they can  
 16 safely do so.  
 17 Next, Mass Rescue Protocol. The Inquiry will be  
 18 interested to hear from witnesses about whether there is  
 19 a need for a mass rescue/mass person in the water rescue  
 20 policy or protocol, which sets out the procedure  
 21 for triage, rescue and immediate casualty care. I note  
 22 that the development of a Mass Rescue Plan was one of  
 23 the recommendations of the US Coastguard Case Study  
 24 Review which was not accepted by Coastguard on  
 25 the grounds that there are already plans in place to

1 respond to multiple small boat incidents and multiple  
 2 persons in the water from small boats.  
 3 Finally, the question of independent oversight.  
 4 The Coastguard is an emergency service but, unlike other  
 5 emergency services, it is not subject to inspectorate  
 6 oversight. The Inquiry will explore with witnesses  
 7 whether such independent oversight is required.  
 8 The Inquiry does not pre-judge the question whether,  
 9 and which, further recommendations might be required to  
 10 be made. What I've sought to do this morning is simply  
 11 to signpost those areas in which the Inquiry will be  
 12 assisted by further information and evidence, to enable  
 13 it to reach informed conclusions in relation to  
 14 recommendations.

15 That, sir, concludes all I wish to say in opening.  
 16 SIR ROSS CRANSTON: Well, Mr Phillips, thank you very much  
 17 for that comprehensive opening. I understand you're now  
 18 going to read the names of the victims, and as a mark of  
 19 respect, I would ask everyone to stand when Mr Phillips  
 20 does this.

21 MR PHILLIPS: Sir, I'm going to start by reading out  
 22 the names of the dead, first reading out the names of  
 23 those 26 people, men, women and children, whose  
 24 identities have been established to the satisfaction of  
 25 the Inquiry: Kazhal Ahmed Khidir Al-Jamoor; Hadiya

1 Rizghar Hussain; Mubin Rizghar Hussein; Hasti Rizghar  
 2 Hussein; Rezhwan Yassin Hassan; Mohammed Qader Abdullahi  
 3 Awla; Shakar Ali Piro; Serkawt Piro; Mohammed; Bryar  
 4 Hamad Abdulrahman; Muslim Ismael Hamad; Afrasia Ahmed  
 5 Mohamed Akoi; Hasam Mohamed Ali; Bilind Shakir Baker;  
 6 Maryam Noori Mohammedameen; Mhabad Ali Ahmed;  
 7 Mohammed Hussein Mohammedie; Sirwan Alipour; Fikiru  
 8 Shiferaw Tekalegn; Niyat Ferede Yeshiwendim; Meron Hailu  
 9 Gebrehiwet; Halima Mohammed Shikh; Husain Tanha;  
 10 Mohammed Naeem Mayar; Shahwali Kochy; Ahmad Didar;  
 11 Mohamed Ali Mohamed Hassam Elsaey.

12 And there was, as I've said, another person on  
 13 the boat whose body was found and whom we believe to  
 14 have been Le Van Hau.

15 Then I shall read out the names of the missing,  
 16 those four men who we believe were on the boat but whose  
 17 bodies have not been found: Pshtiwan Rasul Farkha  
 18 Hussein; Twana Mamand Mohammed; Zanyar Mustafa Mina.  
 19 Gomaa Gaber Mohamed Ahmed Nada.

20 SIR ROSS CRANSTON: Well, thank you very much.

21 Well, we'll resume at 2 o'clock with opening  
 22 statements from the Full Participants. So thank you  
 23 very much.

24 (12.45 pm)

25 (The short adjournment)

1 (2.00 pm)  
 2 SIR ROSS CRANSTON: Yes, well, good afternoon, everyone.  
 3 We're now going to have opening statements from  
 4 the Full Participants and I'm going to call, first of  
 5 all, on Sonali Naik King's Counsel, who is representing  
 6 the family and instructed by Duncan Lewis.  
 7 Opening statement by MS NAIK  
 8 MS NAIK: Thank you very much, sir.  
 9 I appear today with Mr Robottom of my counsel team,  
 10 instructed by Maria Thomas of Duncan Lewis Solicitors on  
 11 behalf of the bereaved families and one of the two  
 12 survivors of the fatal incident in late November 2021.  
 13 We set out the central concerns of those bereaved  
 14 families and the survivor arising from the tragedy and  
 15 the issues that they invite the Inquiry to investigate  
 16 over the coming weeks.  
 17 Sir, as you know, the families and the survivor have  
 18 fought hard to instigate this Inquiry and have waited  
 19 for over three years for it to begin and they're  
 20 sincerely grateful to the chair and the team for your  
 21 industry and dedication in bringing it into fruition.  
 22 In the room today, and I know you've just met them,  
 23 there are Emebet Kefyalew, the wife of the victim  
 24 Fikiru Shiferaw, and Freweyni Hayiemariam Gitet and  
 25 Morris Sleshi Tewelde, the mother and brother of

1 the victim Niyat Ferede Yeshiwendim. Both victims were  
 2 from Ethiopia. They fled as a result of the brutal war  
 3 in Tigray, resulting in a full scale humanitarian crisis  
 4 which killed thousands and displaced millions. And  
 5 the other family members are of course participating,  
 6 watching this online from Iraqi Kurdistan, Ethiopia,  
 7 Somalia and elsewhere in the United Kingdom. And  
 8 the survivor Issa Mohamed Omar, from whom the Inquiry  
 9 will hear tomorrow via video-link, is watching from  
 10 France, and they are all very grateful for  
 11 the arrangements that the Inquiry was able to put in  
 12 place to facilitate their participation.  
 13 At the outset, we hope that the Inquiry will not  
 14 only provide some of the answers that the victims'  
 15 families have been seeking since that tragic night, but  
 16 also that, Chair, you can make some meaningful  
 17 recommendations to put right some of the wrongs in the  
 18 system that enabled it to happen.  
 19 Thank you very much to Counsel to the Inquiry  
 20 Mr Phillips KC, who's just powerfully outlined  
 21 the incident in his opening that at least 31 people lost  
 22 their lives, 26 or 27 bodies were later recovered, and  
 23 it's important to note that three of our clients' family  
 24 members, Twana, Zanyar and Pshtiwan, were never found.  
 25 They were all Kurdish. They were from Iraq. All young

1 people, two just 18 years old, one aged 20.  
 2 The evidence of the survivor indicates that the official  
 3 list of the dead and missing may well be an  
 4 underestimate. The incident that night were men, women  
 5 and children crammed on to a small boat, there were  
 6 fathers, mothers, sons, daughters, brothers and sisters,  
 7 people's loved ones, people's friends and they all made  
 8 the journey in hope for the future. And the Inquiry  
 9 will hear directly from our clients, the bereaved of  
 10 the — by the events that night, of the profound impact  
 11 of their loss, and it will also hear from our client,  
 12 who survived the other deal and suffered over 14 hours  
 13 in the bitter, freezing waters of the Dover Strait.  
 14 As we've heard just a few hours into that journey in  
 15 the early hours of 24 November 2021, the small boat  
 16 became swamped, and everyone, the men, women and  
 17 children, entered the water. They were the clearest  
 18 indications throughout that the boat was sinking and  
 19 that lives were in imminent danger. Those on board, as  
 20 we've heard, made urgent distress calls to the emergency  
 21 services in the UK, pleading, "They're in the water ...  
 22 We are dying, where is the [rescue] boat". A Mayday  
 23 relay was issued, but a nearby French Navy vessel failed  
 24 to assist. A Border Force cutter was sent to rescue  
 25 the boat, but abandoned its search having recovered

1 three other boats, none of which matched the level of  
 2 distress or desperation heard on the calls made by those  
 3 on board.  
 4 So despite this, we say the UK authorities failed to  
 5 act with the urgency and coordination required to save  
 6 lives. Systems were overwhelmed, calls were missed, and  
 7 assumptions made, and ultimately the search for those  
 8 people in distress was terminated. How many of those on  
 9 the boat that had perished by the time of search was  
 10 abandoned and how many remained alive can never be  
 11 known, but strikingly, as the expert report from  
 12 Professor Michael Tipton on survivability suggests that,  
 13 had they been located, even at that time, some could  
 14 have been rescued. Such uncertainty magnifies the grief  
 15 suffered by the bereaved families and the survivor. In  
 16 the words of from the words of Mohammed Hussein  
 17 Mohammedie, a 19-year old — the father of Mohammed  
 18 Hussein Mohammedie, who's a 19-year-old Kurdish Iraqi:  
 19 "Imagine your child gets into trouble in the water,  
 20 and you are not there and cannot help him. Imagine he  
 21 stays in the water for 12 hours, and no one comes to his  
 22 rescue. This is what we are always thinking about. It  
 23 ... stays in the front of your mind; the effect is  
 24 always there."  
 25 So in the context of this Inquiry, the bereaved

1 families and the survivor make three overarching  
 2 submissions. First, that the purpose of the Inquiry  
 3 should guide the approach taken to the -- to these  
 4 proceedings and the lessons learned and recommendations  
 5 to prevent future deaths.

6 Second, that the evidence shows that prior to  
 7 the tragedy, it was entirely predictable that  
 8 a catastrophic event involving mass casualties in  
 9 the English Channel would occur, and there was a well  
 10 recognised risk of authorities with responsibility for  
 11 protecting life at sea being overwhelmed and  
 12 ill equipped to respond.

13 And, third, that the litany of systemic and  
 14 operational failings -- state failings, which  
 15 contributed to the disaster on the night of  
 16 the November 2021 and which emerges from the evidence  
 17 before the Inquiry, leads to the inexorable and crushing  
 18 conclusion that this tragedy was also preventable.

19 So, first, as to the purpose of the Inquiry, of  
 20 course, at its most fundamental, this Inquiry is about  
 21 giving the deceased and the bereaved families and  
 22 the survivor a voice. The Inquiry has and will hear  
 23 repeated reference to Incident Charlie, but this was  
 24 a search to find and a failure to find people, victims,  
 25 and of course the Inquiry will not and must not lose

1 sight of that reality. Our clients enter this process  
 2 in grief, but with resilience and hope for the truth and  
 3 justice. In the words of one of the survivors,  
 4 Issa Mohamed Omar:

5 "I feel a lot of responsibility to the families of  
 6 the victims who lost their lives ... I believe that  
 7 I survived partly to be the voice of these people and to  
 8 fight to make sure that refugees are not neglected in  
 9 this way again."

10 The voices of our clients and the memories of those  
 11 they loved and lost that night must form the heart of  
 12 this Inquiry.

13 Second, this Inquiry has been established to  
 14 distinguish the UK's duty to investigate the duty --  
 15 UK's duty to protect those -- the lives of all those  
 16 within its jurisdiction. The duty to save life at sea  
 17 is centuries old, reflective of customary international  
 18 law. The UK Government has long recognised that it's  
 19 a moral, as well as legal obligation, and  
 20 the Human Rights Act refers -- further requires  
 21 the state to fulfil its obligation to protect life at  
 22 sea. The right to life under Article 2 requires  
 23 the Inquiry to undertake the vital task of investigating  
 24 the circumstances of the victims' deaths, identifying  
 25 what went wrong and ensuring that lessons are learned

1 from this tragedy for the future. And those --  
 2 the duties which are -- which must be fulfilled without  
 3 discrimination as to nationality, race or immigration  
 4 status. Indeed, it's central to the duty to ensure  
 5 assistance under the Search and Rescue Convention, as  
 6 Mr Phillips outlined, that it applies to any person in  
 7 distress at sea. The convention was aimed at developing  
 8 a procedure so that no matter where an accident  
 9 occurred, the rescue of persons in distress would be  
 10 coordinated by a SAR organisation, and, where necessary,  
 11 with cooperation between neighbouring SAR organisations,  
 12 regardless of the nationality or status of such a person  
 13 or the circumstances in which that person was found.  
 14 It's an obligation to ensure that assistance be  
 15 provided, it's a duty of result to effect assistance.

16 The Inquiry lists as one of the issues as to why  
 17 the -- those who lost their lives undertook such  
 18 dangerous journeys. Importantly, the witness statement  
 19 from Nikolai Posner, from Utopia 56, sets out that  
 20 the conditions in the encampments both in Calais and  
 21 Dunkirk are dire, there's a lack of adequate food and  
 22 drinking water, sanitation and healthcare. And since  
 23 October 2016, there's been a state policy in France of  
 24 a no settlements point, that is to prevent  
 25 the development of large encampments. Violent evictions

1 occur almost daily, and we know that several of  
 2 the victims were caught up in the major eviction of  
 3 a camp in Dunkirk on 16 November 2021, just a week  
 4 before the disaster. So in the absence of safe routes  
 5 to the UK and given such increasingly hostile and  
 6 desperate conditions for migrants in Northern France,  
 7 people continue to undertake potentially deadly journeys  
 8 across the Channel in their thousands and in  
 9 increasingly overloaded boats. And people continue to  
 10 die. The International Organisation for Migration  
 11 estimates that at least 82 people have died attempting  
 12 to cross the Channel in 2024. Hence, of course,  
 13 the Inquiry's mandate to prevent future deaths is of  
 14 fundamental importance.

15 Second, we say that the disaster was predictable and  
 16 the Inquiry will hear that the month of 2020 --  
 17 November 2021 saw unprecedented numbers of people  
 18 crossing the Channel in small boats. But, when viewed  
 19 in context, it's clear that a catastrophic event, as  
 20 I said, involving mass casualties was predictable at the  
 21 time.

22 First of all, the number of people crossing on  
 23 23 November 2021 was not especially high for the period.  
 24 What had become -- begun in 2018, as we've heard, in  
 25 response to UK-French increase in securitisation

1 measures, which started as small self-organised  
 2 crossings quickly became operations organised by  
 3 smugglers with 30 or 40 people on board flimsy vessels.  
 4 From 2021, in the middle of 2021, there was  
 5 a particularly steep general increase in numbers of  
 6 individuals arriving in the UK and a pattern had emerged  
 7 where there was intense crossing activity periods during  
 8 times of good weather and low wave height, either  
 9 the frequency of migrant crossings was closely related  
 10 to the sea state rather than the seasons. And indeed  
 11 that there had been a spike in numbers in November 2020,  
 12 when 567 people crossed in six days, and between August  
 13 and -- 2021 and 23 November 2021, there were 18  
 14 occasions when more than 400 people crossed in a single  
 15 day.

16 So the evidence shows that the number of people who  
 17 crossed the Channel on the night of 23/24 November, 757,  
 18 was not particularly high for the period. And moreover,  
 19 the trends in crossing made it predictable at that time,  
 20 and not just with the benefit of hindsight, that  
 21 the UK's search and rescue function, whose capacity did  
 22 not substantially change during 2020 and 2021, would be  
 23 overwhelmed.

24 Secondly, the risk of overwhelms had been recognised  
 25 by the relevant public authorities. As early as

1 December 2018, the Home Secretary declared small boat  
 2 crossings a major incident. But Her Majesty's  
 3 Coastguard didn't do so, despite the fact that its major  
 4 incident plan, published a year before the tragedy, in  
 5 October 2020, identified the search for or rescue of  
 6 large numbers of people from small craft in distress  
 7 simultaneously in the geographic region as a risk type  
 8 with the potential to constitute a major incident under  
 9 the Civil Contingencies Act 2004.

10 As early as September 2020, in a meeting between  
 11 HM Coastguard and their French counterparts, both had  
 12 recorded they had insufficient assets to deal with heavy  
 13 days. By June 2021, a representative of Border Force  
 14 Maritime Command wrote, given the increasing number of  
 15 migrant boat crossings across the Channel, "it was only  
 16 a matter of time" before the authorities would have to  
 17 deal with what they describe as so-called  
 18 "non-survivors" and they ask for guidance on matters  
 19 such as the transfer of bodies ashore given that there  
 20 was "a lot of public surveillance" of operations in  
 21 Dover.

22 By July 2021, officials recorded they were facing  
 23 a "humanitarian crisis waiting to happen", and that it  
 24 was "amazing that more people [hadn't] lost their lives  
 25 already".

1 By August 2021, senior management within  
 2 HM Coastguard had decided that the MRCC in Dover needed  
 3 24 additional Coastguard officers and a dedicated team  
 4 to oversee small boat activity. But the recruitment  
 5 drive had not achieved that objective by November of  
 6 that year. Despite these concerns and obvious risks  
 7 involved, it wasn't until November 2021 that  
 8 the Maritime Coastguard Agency added a new risk to its  
 9 Corporate Risk Register that HMCG might "become  
 10 overwhelmed" and that the consequence would be "loss of  
 11 life".

12 So these known risks were not failed -- these known  
 13 risks were failed to be acknowledged or acted upon,  
 14 major incident planning was not conducted, training was  
 15 not undertaken, and the reasons for those failings are  
 16 matters which the Inquiry will be required to examine in  
 17 oral evidence, ascertaining the causes and impacts of  
 18 those failings central to the Inquiry fulfilling its  
 19 terms of reference and the Article 2 requirement.

20 Third, the Home Office's prioritisation of border  
 21 and securitisation distracted from the importance of  
 22 protection of life at sea and materially increased  
 23 the risk to life in the English Channel. UK  
 24 Border Force was charged with both carrying out search  
 25 and rescue functions under HMCG's direction and with

1 enforcement of immigration at sea, known  
 2 as Operation DEVERAN. This identified that the safety  
 3 of life at sea was an overarching priority, but training  
 4 and resources were directed at enforcement tactics and  
 5 not search and rescue. The then Home Secretary,  
 6 Priti Patel, developed a policy of "pushbacks", termed  
 7 Operation SOMMEN, which was intended that Border Force  
 8 officers on jet skis would physically force small boats  
 9 back across the median line and into French waters.  
 10 The pushback's Standard Operating Procedure of July 2021  
 11 itself recognised that the use of the policy "increases  
 12 the risk to life at sea", and, more importantly,  
 13 the Maritime Coastguard Agency and HMCG objected on  
 14 the basis that the policy would endanger life. In their  
 15 1 May briefing, the MCA defined all boats crossing  
 16 the median line to be in distress until assessed as  
 17 otherwise due to the inherently unsafe nature of  
 18 the crossings.

19 In May 2020, as Mr Leat noted in his first witness  
 20 statement, the Pushbacks Policy was recorded on  
 21 the Corporate Risk Register as potentially resulting in  
 22 "very significant" risk to safety of life at sea. The  
 23 MCA briefing note of the same month concerns the tactics  
 24 conflicted -- that the tactics conflicted with the UK's  
 25 legal obligations under the Safety Of Life At Sea and

1 identified the risks involved with having more than one  
2 tasking authority overseeing the response to small  
3 boats.

4 Notwithstanding these concerns, the Home Office  
5 continued to pursue the pushback agenda and sought to  
6 enlist the MCA's assistance to do so. The then  
7 Home Secretary told MCA officials that they needed to do  
8 "all ... [they] could to support the Home Office being  
9 able to turnaround migrants to France".

10 Importantly, the Pushbacks Policy had a detrimental  
11 impact on the maritime relationship with France at  
12 a time when it was obvious that any reduction in French  
13 cooperation could manifestly increase the number of  
14 migrants making it to the UK. The Pushbacks Policy was  
15 due to be rolled out in November 2021, and it was  
16 unceremoniously dropped by the previous government  
17 following legal challenges by the Public Commercial  
18 Services Union, the tactics never having been deployed.  
19 Valuable time and resources were wasted on a dangerous  
20 plan when they should have been focused on saving lives.  
21 The bereaved families and the survivor are heartened by  
22 the Inquiry's intention to explore how the Pushbacks  
23 Policy impacted the development of plans and  
24 the deployment of resources in response to small boat  
25 crossings at the time.

1 Third, we say that the disaster was preventable. So  
2 following on from the high level policy failure to focus  
3 time and resources on improving search and rescue  
4 function in the Dover Strait, there was a chain of  
5 systemic and operational failures that contributed to  
6 the disaster on 23 and 24 November. And of course  
7 the investigation of those failures is central to this  
8 Inquiry's task. We have ten key concerns which are  
9 highlighted by the bereaved families and the survivors  
10 prior to the commencement of the witness evidence. But,  
11 in summary, they are, first, that the staffing levels of  
12 suitably qualified staff at the MRCC in Dover were  
13 patently inadequate. The rescue coordination centres  
14 were required to be operational on a 24-hour basis and  
15 constantly staffed by trained personnel. Yet, as we've  
16 heard, the staffing levels were a constant issue and  
17 there was high turnover leading to shortage of  
18 personnel. There was a clearly identified need for more  
19 fully qualified operators, and operational and senior  
20 personnel recognised the insufficiency of qualified  
21 staff and the need to increase staffing levels in order  
22 to manage the increase in small boat crossings. Indeed,  
23 there was evidence of fatal and near fatal incidents  
24 that took place in 2021, in circumstances where there  
25 was no search and rescue mission coordinator, NSMC,

1 present at the MRCC in Dover.

2 In the days prior to 23 and 24 November, there were  
3 repeated concerns that amber days were becoming as busy  
4 as red days, but resourcing and staff planning did not  
5 reflect that concern, including on the night itself. As  
6 a result of the low staff levels, operational processes  
7 and incident oversight that was faltering, and  
8 the "Review, Assess, Guidance" procedure, a key  
9 component of the search and rescue oversight and indeed  
10 the only mechanism for the contemporaneous review of  
11 search and rescue mission coordinators' decision—making  
12 was rendered "not practicable", in the words of  
13 David Jones, the former MTC at HM Coastguard.

14 Secondly, the issue of the provision of training for  
15 staff was seriously lacking. There was no formal  
16 training for HMCG staff on small boat crossings on  
17 coordinating multiple distress incidents and managing  
18 multi-agency assets. Despite the witnesses referring to  
19 unique challenges posed by such operations, staff were  
20 not provided with the training needed to help them cope  
21 under those considerable pressures of dealing with small  
22 boat incidents, and, tragically, that lack of specific  
23 training came to the fore on the night.

24 Third, when turning to surveillance, MRCC was short  
25 on eyes, as well as hands. Despite recognition that

1 aerial surveillance was essential to generating  
2 a maritime picture to enable informed decision—making  
3 and reconciliation of incidents, contingencies were not  
4 put in place for when surveillance aircraft could not  
5 fly, which of course occurred on the night due to bad  
6 weather.

7 The SAR convention obliges the "closest practicable  
8 co-ordination between maritime and aeronautical services  
9 so as to provide the most efficient and effective search  
10 and rescue services". But the interests of border  
11 enforcement appear to have taken precedence over human  
12 safety. As James Crane, the SMC, observed in  
13 the aftermath:

14 " ... [t]he lack of air cover proved to be  
15 a significant deficit to us as we were not able to  
16 maintain an overwatch of targets, nor have a running  
17 commentary from ... aircraft."

18 Fourthly, as to call handling, despite  
19 the Coastguard being obliged to ensure it was capable of  
20 a 24-hour basis of promptly and reliably receiving  
21 distress alerts, crucially, they had no adequate system  
22 to identify whether boats had made repeat calls. There  
23 was no system for providing practical advice during  
24 phone calls to improve survivability in the event of  
25 cold water immersion. And despite the obligation to

1 receive distress alerts, both promptly and reliably,  
 2 the MRCC Dover missed several calls to the standalone  
 3 mobile phone number associated with Incident Charlie.  
 4 The upshot is that crucial opportunities to communicate  
 5 with and ascertain the position of those on board  
 6 Charlie were missed. And moreover, as we've heard,  
 7 the call handler repeatedly asked the desperate caller  
 8 where he was and the location of the boat, all of which  
 9 were futile.

10 Fifth, the SAR convention requires the Coastguard to  
 11 actively "use its search and rescue units and other  
 12 available facilities" to provide assistance to persons  
 13 in distress in the UK Search and Rescue Region by  
 14 tasking declared assets — declared facilities, for  
 15 example, RNLI assets, and additional facilities, for  
 16 example, Border Force assets. Once in the UK Search and  
 17 Rescue Region, all small boats were considered in  
 18 distress — to be in the distress phase and hence they  
 19 were, by definition, considered to be in grave and  
 20 imminent danger, requiring immediate assistance. HMCG  
 21 were aware that small boats were routinely left  
 22 unattended by French vessels at the median line and that  
 23 most would have taken on water by the time they were  
 24 rescued by HMCG.

25 Concerns were raised prior to November 2021 about

1 the availability and suitability of the Border Force  
 2 vessels and crew and, critically, the Border Force  
 3 vessels were not declared as SAR assets.  
 4 On 23 and 24 November, tasking decisions were  
 5 impacted by the limited assets available. And at  
 6 the start of Operation DEVERAN, there were two UK  
 7 Border Force assets on standby, both of which had  
 8 a reactive deployment strategy, which, during periods of  
 9 high activity, were simply not sustainable.  
 10 The reactive posture adopted by the HMCG meant there was  
 11 little prospect of SAR assets reaching small boats as  
 12 they crossed into the UK Search and Rescue Region,  
 13 despite being classified as being in distress once in UK  
 14 waters.

15 And there was an unwillingness even to task a boat  
 16 prior to — to task, even prior to a boat entering UK  
 17 waters, so when the French tracker received details of  
 18 the five small boat incidents on course to reach  
 19 the median line, no assets were tasked, as was the case  
 20 with Incident Charlie and with the tasking of  
 21 the Valiant.

22 As to information sharing and cooperation, the SAR  
 23 convention requires neighbouring states to cooperate and  
 24 enter into agreements for that purpose, and we've heard  
 25 about the MANCHEPLAN that had been agreed in 2018

1 between the UK and France with the intention to  
 2 strengthen search and rescue coordination covering any  
 3 maritime event "liable to occur" in the English Channel.  
 4 Yet the system for information sharing and SAR  
 5 coordination between the Coastguard and the French was  
 6 skeletal with limited intelligence being shared. It was  
 7 practically ineffective because of the failure to use  
 8 a single message format when communicating, and this,  
 9 unsurprisingly, led to misunderstandings over which  
 10 state was allocated responsibility for SAR missions.

11 HMCG's reactive posture of awaiting the French  
 12 tracker to share — awaiting the French to share its  
 13 tracker led to known issues of delay which meant that  
 14 crucial times were waiting, and the adequate  
 15 coordination of UK and French assets on the scene was an  
 16 issue that had been raised in the months prior to  
 17 November 2021. Indeed, there's evidence from  
 18 the NGO Alarm Phone that the French and UK authorities  
 19 were passing responsibility for conducting search and  
 20 rescue operations back and forth between them which led  
 21 them to shirking their respective duties. On the night  
 22 in November 2021, there were no direct attempts to —  
 23 made to secure French assistance for Charlie, even when  
 24 the French vessel Flamant was closest to its last known  
 25 position.

1 There were failures in information sharing and  
 2 recording with HMCG. Failures to record in person  
 3 discussions had been recognised as an issue within HMCG  
 4 prior to November 2021, and on the night, there were  
 5 examples of poor information sharing throughout  
 6 the night shift. Mr Gibson didn't inform Mr Downs of  
 7 the Mayday relay or the basis for it. Mr Downs didn't  
 8 link the calls he answered to the Incident Charlie.  
 9 The additional calls from Charlie were not assigned to  
 10 any incident. When the day shift began, MRCC had  
 11 limited or no awareness of the Incident Charlie or  
 12 the possibility that it had not been rescued. These  
 13 failures were compounded by the inability to adequately  
 14 record information on the ViSION system, and the result  
 15 was that HMCG simply had no idea that Charlie had not  
 16 been rescued.

17 Turning to the Mayday relay, there were multiple  
 18 failures relating to the Mayday relay in respect of  
 19 Charlie. It was broadcast with an urgency alert, which  
 20 is used when there's no imminent danger or loss of life  
 21 and immediate assistance is not required or justified.  
 22 But, most fundamentally, it was terminated prematurely.  
 23 HMCG was aware, or ought to have been, that  
 24 the immediate danger and risk to life for the occupants  
 25 of Incident Charlie persisted long after the final

1 Mayday relay at 3.20.  
 2 As to the Home Office intelligence sharing,  
 3 the priority of border enforcement over search and  
 4 rescue functions meant that crucial opportunities to  
 5 share intelligence were missed by the Home Office.  
 6 The Home Office's Clandestine Channel Threat Command was  
 7 established to make small boat crossings unviable  
 8 through intelligence gathering, detection and  
 9 deterrence. There was an intelligence report on  
 10 the afternoon of 23 November that estimated that 120 to  
 11 130 people were expected to cross the Channel between  
 12 2000 hours and 0600 hours on the 23 and 24 November.  
 13 This information was circulated internally earlier that  
 14 evening, but there's no indication that HMCG were made  
 15 aware of the possibility that up to 130 people may be in  
 16 grave danger and imminent danger within the UK Search  
 17 and Rescue Region requiring immediate assistance.  
 18 Instead HMCG were entirely reliant on the incomplete and  
 19 delayed information from the French, which wasn't  
 20 received until many hours later.  
 21 So against that background, the poor sharing of even  
 22 the most basic information between HMCG and UK  
 23 Border Force fatally hindered the authorities' response.  
 24 Mr Gibson took a decision to broadcast a Mayday relay  
 25 due to the "elevated level of shouting and panic"

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1 exhibited by the occupants of Incident Charlie during  
 2 a phone call. The commander of the Valiant was aware  
 3 that Incident Charlie was believed to be "taking water",  
 4 but understood that this was "common" and "did not  
 5 necessarily mean that a given vessel is sinking".  
 6 Mr Gibson, having directly spoken with and heard  
 7 the level of distress of those on board Charlie, had a  
 8 "gut feeling that this was not a routine call [or] an  
 9 exaggerated case". But crucially, he didn't relay that  
 10 information to the Border Force Maritime Command Centre,  
 11 nor the Valiant. Mr Gibson was made aware that  
 12 the occupants of Incident Charlie were reportedly "in  
 13 the water". And, again, this crucial information,  
 14 likely to impact the on scene search and rescue  
 15 operation and its urgency, including whether RNLI  
 16 support was required for a potential mass casualty event  
 17 with multiple people in the water. But again,  
 18 the evidence indicates that vital information wasn't  
 19 relayed to Border Force MCC or the Valiant,  
 20 notwithstanding they had been tasked to assist  
 21 the vessel carrying victims of the disaster.  
 22 HMCG failed to seek basic identifying information  
 23 about that vessel. As Mr Toy, a commander in  
 24 the Border Force explains in his evidence, the Valiant  
 25 had "no way of determining whether a particular migrant

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1 vessel did or did not correspond to a particular event".  
 2 This resulted in sheer guesswork to reconcile each  
 3 rescued vessel with the incidents recorded via  
 4 the classification system used by HMCG. This was  
 5 a tragically misplaced assumption that Charlie had been  
 6 located and migrants embarked which led to the search  
 7 and rescue operation being terminated prematurely.  
 8 The convention requires or obliges HMCG to continue  
 9 search and rescue operations, where practicable, "until  
 10 all reasonable hope of rescuing survivors had passed".  
 11 Terminating a search requires "reliable information"  
 12 either that an operation has been successful or that  
 13 the emergency no longer exists. That wasn't  
 14 the evidence available at the time had it been properly  
 15 assessed and evaluated.  
 16 So, in conclusion, Chair, sir, the bereaved families  
 17 and the survivors would like to take this opportunity to  
 18 thank the Inquiry team for their hard work and  
 19 dedication to date. They've waited over three years to  
 20 have their voices heard and to hear and understand  
 21 the truth of what happened on the night of 23 and  
 22 24 November. As people continue to make perilous  
 23 journeys across the English Channel, it's their  
 24 collective hope that, over the coming weeks, this  
 25 Inquiry will make findings and recommendations that both

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1 vindicate the memories of those that lost their lives  
 2 and prevent similar tragedies in the future.  
 3 Thank you.  
 4 SIR ROSS CRANSTON: Well, thank you very much, Ms Naik. I'm  
 5 grateful.  
 6 I'll now call on Mr Maxwell—Scott King's Counsel who  
 7 represents the Maritime and Coastguard Agency.  
 8 Opening statement by MR MAXWELL—SCOTT  
 9 MR MAXWELL—SCOTT: Mr Chairman, I, together with  
 10 Jack Murphy, represent the Maritime and Coastguard  
 11 Agency instructed by DWF Solicitors.  
 12 As you know, we have submitted a written opening  
 13 which I anticipate the Inquiry will make public later  
 14 today. I do not intend in this oral statement to repeat  
 15 everything we have said in our written opening. Rather,  
 16 I wish to identify some points which I would encourage  
 17 you to keep in mind over the next four weeks.  
 18 Before doing so, may I take this opportunity to say  
 19 how important it is that the families and the survivors  
 20 are kept at the centre of this investigation.  
 21 The thoughts of those who work and volunteer at  
 22 the Maritime and Coastguard Agency are with them. It is  
 23 committed to assisting the Inquiry in its investigation  
 24 of this tragic incident.  
 25 There are five topics which I will address you on in

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1 this opening. My first topic is: the nature and role of  
2 the Maritime and Coastguard Agency, which I shall refer  
3 to as "the MCA", and His Majesty's Coastguard, which  
4 I shall call "HM Coastguard".

5 HM Coastguard forms part of the MCA, which is an  
6 executive agency of the Department for Transport.  
7 HM Coastguard's role was laid down in Parliament in  
8 the 1992 HM Coastguard Responsibility Statement. It  
9 sets out HM Coastguard's responsibilities in relation to  
10 events at sea, on the shoreline and on cliffs.  
11 Everything which I say in this statement will relate to  
12 events at sea.

13 In relation to such events, there are four points  
14 which I wish to make. One, HM Coastguard is an  
15 emergency service, the UK's only national emergency  
16 service. It works 24 hours a day, 365 days a year.

17 Two, like other emergency services, it is  
18 a responsive service.

19 Three, its role is to respond to emergencies within  
20 a defined area, the UK Search and Rescue Region. This is  
21 a large area covering approximately 2 million square  
22 miles. To the north, it reaches the same latitude as  
23 the Faroe Islands. To the west, it stretches far into  
24 the north Atlantic, where its boundary is with Canada's  
25 Search and Rescue Region. It also covers approximately

1 half of the English Channel.

2 Four, unlike most emergency services, it is not  
3 HM Coastguard's staff and volunteers who attend  
4 emergencies at sea. HM Coastguard initiates and  
5 co-ordinates search and rescue by mobilising, organising  
6 and tasking assets operated and staffed by other  
7 organisations. HM Coastguard has rescue coordination  
8 centres across the UK. The officers who work in them,  
9 who I will refer to as coastguards, are connected with  
10 each other by a national network. Coastguards receive  
11 emergency calls from and about people who are in  
12 difficulty at sea. They have the ability to task --

13 SIR ROSS CRANSTON: Sorry to interrupt. I'm told, could you  
14 just speak into the microphone. People online are not  
15 hearing.

16 MR MAXWELL-SCOTT: Certainly.

17 Coastguards receive emergency calls from and about  
18 people who are in difficulty at sea. They have  
19 the ability to task assets in a search and rescue  
20 operation. Throughout the period under investigation in  
21 this Inquiry, HM Coastguard did not own or operate  
22 ships, helicopters or planes. Instead, it was able to  
23 task lifeboats and Border Force ships. It was also able  
24 to task search and rescue helicopters and planes under  
25 long-term contracts agreed between the MCA and

1 specialist providers.

2 My second topic is: the challenges posed for search  
3 and rescue by what I will call migrant small boats.

4 I use that term because such boats pose distinct  
5 challenges not posed by small recreational boats or  
6 fishing vessels. I will focus on four such challenges.

7 Challenge number one: they are inherently unsafe.  
8 The sea is dangerous, it always has been. Innumerable  
9 sources attest to this. One of the earliest works of  
10 western literature, The Odyssey, tells the story of  
11 a man beset by storms and shipwrecks who takes ten years  
12 to complete a voyage. The great author of the sea,  
13 Joseph Conrad, wrote that "The sea ... has no  
14 generosity" and "has never been friendly to man". In  
15 the case of Safi v Greece, the European Court of Human  
16 Rights emphasised that:

17 "... coastguards ... cannot be expected to effect  
18 the successful rescue of everyone imperilled at sea ... "

19 In a witness statement provided to this Inquiry,  
20 Dr Berksen states:

21 "It is because of these inherent dangers involved in  
22 dinghy crossings that Search And Rescue operations, even  
23 when conducted properly, cannot guarantee that lives  
24 will not be lost."

25 The organisation for which he works, Alarm Phone,

1 provides information to migrants who are contemplating  
2 crossing the Channel. That information expresses  
3 the same point more starkly. It says:

4 "Crossing to the UK is very dangerous."

5 In a recent Court of Appeal case of R v Ibrahim  
6 Bah, the Lady Chief Justice described the migrant small  
7 boat as "not safe at all" and "wholly unsuitable and  
8 unequipped for the crossing of the Channel". In that  
9 case, four people died when the boat collapsed in on  
10 itself. The Lady Chief Justice's description would  
11 apply equally well to virtually all migrant small boats,  
12 including the one involved in this incident.

13 The reality is that crossing the Channel in a small  
14 boat provided by people smugglers is dangerous. Things  
15 may go horribly wrong. If they do, there is no  
16 guarantee that you will be rescued. In all cases, those  
17 ultimately responsible if things go horribly wrong are  
18 the smugglers, criminals, who, as Ms Naik King's Counsel  
19 says in her written opening, engage in the "exploitation  
20 of human beings".

21 Nowadays, most boats, including small recreational  
22 and commercial boats, have safety features to protect  
23 their passengers from shipwreck and its consequences.  
24 Migrant small boats do not. They are unseaworthy,  
25 ill designed, poorly constructed, inflatable dinghies

1 with an underpowered outboard motor on the back. Poor  
2 construction was the very reason for the sinking in this  
3 case. The metal floor ripped a fatal hole in the bottom  
4 of the boat.

5 Challenge number two: migrant small boats are  
6 difficult to find in an area the size of  
7 the Dover Strait, particularly in the dark. Nowadays,  
8 mariners carry a wide range of equipment to enable them  
9 to communicate their position or draw attention to  
10 themselves on the water. They commonly carry some or  
11 all of the following: VHF marine radios, GPS devices,  
12 chart plotters, personal locator beacons, emergency  
13 position indicating radio beacons, distress flares.

14 Sadly, the smugglers who control the cross  
15 Channel routes rarely provide even a single one of these  
16 items of potentially life-saving equipment, many of  
17 which are not expensive. Instead, migrants are  
18 invariably wholly reliant on their phones, yet mobile  
19 phones are not a recognised form of maritime  
20 communication and are dependent on the reliability of  
21 networks designed for land, not sea.

22 Challenge number three: migrant small boat incidents  
23 are difficult to reconcile. The boats don't have names,  
24 they don't have passenger lists, and they often look  
25 almost identical. HM Coastguard's experience is that,

1 rather than assigning one person on board to be  
2 the single point of contact with the emergency services,  
3 multiple passengers make multiple calls from the same  
4 nameless boat. That obviously adds to the challenge for  
5 HM Coastguard, as does the fact that calls disconnect as  
6 mobile phone signal is lost, or are difficult to hear or  
7 understand because of poor signal strength, poor sound  
8 quality, or background noise.

9 Challenge number four: the lack of reliable  
10 information. HM Coastguard will not have up-to-date,  
11 independent information about how many migrant small  
12 boats have been launched, or when and where they  
13 launched from, or about the condition of those boats, or  
14 how many are on board, or about the condition of their  
15 passengers, or about which of the boats are in greatest  
16 need of rescue. The cumulative effect of all of  
17 the challenges that I have identified is increased by  
18 the number of boats attempting the crossing on any given  
19 night. And there was no precedent for the number of  
20 crossings that took place in November 2021.

21 In summer 2021, there were predictions that 60,000  
22 people might make the crossing the following year, and  
23 as explained in our written opening, and in the witness  
24 statement of Assistant Chief Coastguard Leat,  
25 HM Coastguard were taking steps to prepare for that.

1 What was not predicted was that November 2021 would see  
2 more crossings than any previous month, that there would  
3 be significantly more crossings in November than in any  
4 month that summer, despite the less favourable weather  
5 conditions.

6 My third topic is the legal framework and  
7 the importance of events in the French Search and Rescue  
8 Region. I can take this topic fairly shortly, because  
9 your team have prepared a paper summarising the legal  
10 framework and I can say that I agree with it. So I will  
11 confine my comments to drawing out some of  
12 the implications of the fact that approximately half of  
13 the Channel falls within the UK Search and Rescue  
14 Region. The other half, of course, falls within  
15 France's Search and Rescue Region. A boat launched from  
16 the French coast will have to travel a minimum of 9  
17 nautical miles from France's Search and Rescue Region  
18 before it reaches the UK's Search and Rescue Region.

19 The global maritime search and rescue system is  
20 underpinned by international conventions. I would like  
21 to highlight three important objectives of those  
22 conventions.

23 Firstly, ensuring that the Earth's oceans and seas  
24 are divided into clearly defined Search and Rescue  
25 Regions.

1 Secondly, ensuring clarity as to which state is  
2 responsible for coordinating search and rescue in each  
3 region.

4 And thirdly, ensuring that necessary arrangements  
5 are in place for the coordination of search and rescue  
6 in each region.

7 The UK and France have achieved all three objectives  
8 for the Channel. They have achieved the first two by  
9 agreeing a document called the MANCHEPLAN, a document  
10 which clearly defines the boundaries of each country's  
11 Search and Rescue Region and clearly defines  
12 responsibility for search and rescue in each of them.  
13 They have achieved the third objective by both having  
14 search and rescue services that work 24 hours a day,  
15 365 days a year, and which are capable of coordinating  
16 search and rescue operations within their respective  
17 regions at all times.

18 By November 2021, there was a well established  
19 working practice whereby the French Coastguard would  
20 email HM Coastguard a document known as the French  
21 tracker. This document listed search and rescue  
22 incidents it had opened in relation to migrant small  
23 boats in France's Search and Rescue Region. The French  
24 tracker provided valuable early notice of crossings and  
25 has assisted the rescue of thousands of people. It

1 would be updated and sent to HM Coastguard a number of  
 2 times during a shift in which there was migrant small  
 3 boat activity .  
 4 As explained in our written opening, the French  
 5 Coastguard is responsible for coordinating the search  
 6 and rescue of boats as they pass through France's Search  
 7 and Rescue Region. It is only when a transfer of  
 8 responsibility for an incident has been expressly  
 9 accepted by HM Coastguard, or when HM Coastguard becomes  
 10 aware that a boat has entered the UK Search and Rescue  
 11 Region that responsibility for its search and rescue  
 12 passes from France to the UK. It is only at this point  
 13 that HM Coastguard is required to coordinate a search  
 14 and rescue operation. Until that point,  
 15 the responsibility for any migrant small boat rested  
 16 with France.  
 17 By November 2021, HM Coastguard was regularly doing  
 18 two things which we say it was not actually required to  
 19 do. It was booking planes to fly at times when  
 20 crossings were considered more likely, but before it  
 21 knew that any crossings were taking place. The SAR  
 22 convention did not require it to do that. There is no  
 23 requirement on a state to task assets to carry out  
 24 patrols or surveillance in the absence of information  
 25 that there are persons in distress in its Search and

1 Rescue Region. HM Coastguard was also proactively  
 2 tasking helicopters, ships and lifeboats whilst  
 3 individual migrant small boats were still in France's  
 4 Search and Rescue Region.  
 5 I do wish to make it clear that the MCA had a good  
 6 working relationship with the French Coastguard at the  
 7 time, and continues to do so. But there is no  
 8 sugar-coating the fact that there are very real issues  
 9 about what happened in the French Search and Rescue  
 10 Region on the night and what the French Coastguard did  
 11 and did not do.  
 12 The Inquiry's list of issues includes events on  
 13 23 November as well as the 24th. Until after midnight  
 14 on 23 November, the boat we are calling Charlie and its  
 15 passengers were in France. The evidence is likely to be  
 16 that they travelled through the French Search and Rescue  
 17 Region for over four hours and did not enter the UK  
 18 Search and Rescue Region until approximately 1.30 am on  
 19 24 November.  
 20 We therefore urge you to investigate the following  
 21 highly relevant matters. Why wasn't the French tracker  
 22 that night first emailed to HM Coastguard until  
 23 56 minutes past midnight? The French Coastguard had  
 24 been aware of migrant small boat activity since 9.02 pm.  
 25 Under the MANCHEPLAN, it was expected to share

1 information without delay. Why didn't the French  
 2 warship Flamant respond to the Mayday broadcast by  
 3 HM Coastguard? And why did the French Coastguard not  
 4 order it to do so? What was the Flamant doing at  
 5 2.42 am that was supposedly so important that it did not  
 6 go to the rescue of Charlie, despite being much nearer  
 7 its estimated position than the Border Force ship  
 8 Valiant? What conversations took place between Charlie  
 9 and the French Coastguard that night? Those on board  
 10 did not suddenly switch from speaking to the French  
 11 Coastguard to speaking to HM Coastguard as the boat  
 12 entered the UK Search and Rescue Region. They were  
 13 wholly dependent on how mobile phone networks operate,  
 14 and, as explained by your expert, that is not how those  
 15 networks work in the Channel.  
 16 The evidence is that some people on board Charlie  
 17 continued to speak to the French Coastguard while others  
 18 were speaking to HM Coastguard, and there is evidence  
 19 that the last conversation between anyone on board and  
 20 the emergency services was not with HM Coastguard, it  
 21 was a 17-minute long call with the French Coastguard  
 22 which started at 3.16 am and ended at 3.33. What was  
 23 said in that call was not shared with HM Coastguard.  
 24 Even on the basis of this limited evidence, it is  
 25 clear that had the French authorities acted differently ,

1 events would have unfolded in a different way. Had  
 2 HM Coastguard received information from the French  
 3 Coastguard when the French Coastguard obtained it,  
 4 the outcome could have been very different. Had Flamant  
 5 responded to the Mayday and joined the search for  
 6 Charlie, we might not be here today.  
 7 Topic number four: HM Coastguard's systems. As  
 8 I have explained, migrant small boats pose particular  
 9 challenges. Nevertheless, searching for and rescuing  
 10 migrant small boats remains very much a search and  
 11 rescue operation. Standard search and rescue principles  
 12 remain highly relevant. Knowledge, skills and  
 13 experience gained in the search and rescue of more  
 14 conventional vessels are all relevant to migrant small  
 15 boat search and rescue. Many of HM Coastguard's generic  
 16 Standard Operating Procedures were applicable to migrant  
 17 small boat search and rescue and much of the material  
 18 covered in the training programmes for maritime  
 19 operations officers and search mission coordinators was  
 20 directly applicable to migrant small boat search and  
 21 rescue. In addition, by November 2021, HM Coastguard  
 22 had introduced a number of Standard Operating Procedures  
 23 that were specific to migrant small boat search and  
 24 rescue, and earlier that month, HM Coastguard had taken  
 25 part in a multi-agency simulation training exercise

1 involving multiple capsized migrant small boats.  
 2 My fifth and final topic is the events of 23 and  
 3 24 November 2021. This opening statement is not  
 4 the time to engage in a comprehensive analysis of  
 5 the events of those two days. At least 12 people who  
 6 were on duty on one or both of those days will be giving  
 7 oral evidence about those events over the next  
 8 four weeks. But I would like to take this opportunity  
 9 to dispel some myths about those two days by posing and  
 10 answering the following questions. Did HM Coastguard  
 11 receive calls from Charlie? Yes. Were those calls  
 12 taken seriously? Yes. Did HM Coastguard task assets to  
 13 search for Charlie? Yes, the Border Force ship Valiant  
 14 and a helicopter. Did they search in the right place?  
 15 Yes. Did they spot boats? Yes. Did they rescue  
 16 migrants? Yes. Did HM Coastguard believe that Charlie  
 17 had been found and those on board rescued? Yes. Did  
 18 any of the assets tasked by HM Coastguard in fact spot  
 19 Charlie at any time during their searches? Knowing what  
 20 we now know, the answer is no.  
 21 Elaborating slightly on what I have just said.  
 22 HM Coastguard's night shift started at 7 pm.  
 23 The recommended staffing level for the shift was 22  
 24 Coastguards across the national network. In fact, 35  
 25 Coastguards were on duty. The Incident Charlie log was

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1 opened at 1.19 am. It is likely that at that time  
 2 Charlie was still in the French Search and Rescue  
 3 Region. The log was opened because of information  
 4 received from the French Coastguard. HM Coastguard  
 5 contacted Border Force Maritime Command. At 1.25 am,  
 6 Valiant was tasked to co-ordinates linked to Charlie.  
 7 At 1.48, HM Coastguard received a phone call from  
 8 a person now known to have been on Charlie. The call  
 9 lasted 21 minutes. The call was taken so seriously that  
 10 HM Coastguard broadcast a Mayday relay on the designated  
 11 radio channel, channel 16. The Mayday gave a position  
 12 for Charlie, a position someone on board had provided to  
 13 HM Coastguard through WhatsApp. The Mayday stated that  
 14 the boat required immediate assistance. It ended: "any  
 15 vessel that can assist to contact Dover Coastguard".  
 16 All ships are required to monitor channel 16, therefore  
 17 all ships in the Dover Strait should have heard  
 18 the Mayday relay. All were required to render  
 19 assistance if they could.  
 20 Shortly afterwards, Valiant confirmed that it was  
 21 responding. A specialist search and rescue helicopter,  
 22 call sign R163, was given initial search instructions at  
 23 2.50 am. R163 was airborne by 3.50 and then provided  
 24 with amended search instructions taking account of  
 25 WhatsApp positions sent by those on board Charlie.

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1 Some months after this incident, HM Coastguard  
 2 commissioned the United States Coastguard to carry out  
 3 an independent review. Their report found that there  
 4 was a high probability that a disabled vessel that began  
 5 drifting from the time and location of Charlie's last  
 6 WhatsApp position would end up in the location where  
 7 Valiant rescued migrants from a small boat. Analysis  
 8 carried out after the incident by the Marine Accident  
 9 Investigation Branch and separately by HM Coastguard  
 10 concluded that the search area covered by R163 would  
 11 have encompassed the likely position of Charlie.  
 12 Returning to the events of 24 November, R163 spotted  
 13 several small boats and directed Valiant to two of them.  
 14 In total, Valiant rescued 98 migrants from three boats  
 15 and also saw one other migrant small boat which was  
 16 making way under engine power. That boat was not  
 17 Charlie. Both Valiant and R163 were equipped with  
 18 specialist technology that stood some of the best  
 19 chances of spotting a migrant small boat or persons in  
 20 the water, but, sadly, neither of them did. By the time  
 21 that Valiant and R163 completed their missions, there  
 22 would have been no further calls from Charlie to  
 23 HM Coastguard for several hours and no relevant  
 24 sightings. HM Coastguard believed that Charlie had been  
 25 found and there was no new information to cause a change

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1 of mind until its occupants were found by a French  
 2 fishing boat in the French Search and Rescue Region  
 3 after midday on 24 November.  
 4 It has been suggested that this tragedy was  
 5 preventable. At the outset of the evidence, I would  
 6 urge you to treat that proposition with caution and not  
 7 to be swayed by hindsight. At sea, safety is never  
 8 guaranteed, nor is rescue.  
 9 Mr Chairman, that brings me to the end of this  
 10 opening statement. Nothing that I have said in it is  
 11 intended in any way to detract from the fact that what  
 12 happened on 24 November 2021 was, above all, a human  
 13 tragedy. We offer our profound sympathies to each and  
 14 every bereaved person and to the survivors. The MCA is  
 15 committed to assisting your Inquiry and hopes that it  
 16 will answer questions that the families and survivors  
 17 have.  
 18 SIR ROSS CRANSTON: Well, thank you, Mr Maxwell—Scott.  
 19 Now, Mr Mallet for the Home Office, I understand  
 20 that your leading counsel isn't here today, but you are  
 21 going to present the Home Office opening statement.  
 22 Opening statement by MR MALLET  
 23 MR MALLET: Thank you, Mr Chairman.  
 24 I appear for the Home Office with Freya Foster. As  
 25 you mention, we're led by Prashant Popat King's Counsel,

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1 who's not able to attend today due to a pre-booked  
 2 engagement. He wishes to emphasise that no discourtesy  
 3 is intended to you, the Inquiry team or any of  
 4 the participants by his absence. We're instructed by  
 5 the Government Legal Department.  
 6 First and foremost, the Home Office wishes to take  
 7 this opportunity to again express its profound and  
 8 sincere sorrow at the events that unfolded in  
 9 the Channel during the early hours of 24 November 2021.  
 10 It is now known that at least 27 people tragically lost  
 11 their lives in desperate circumstances whilst attempting  
 12 to cross from France. The Home Office has been involved  
 13 at all levels of the organisation in the preparation for  
 14 this Inquiry, and anyone who has considered the moving  
 15 written testimony of those so tragically affected can  
 16 but offer their deepest condolences for  
 17 the heart-breaking events that unfolded over that night.  
 18 These condolences are echoed by the minister for border  
 19 security and asylum, who expresses her personal sadness  
 20 and sympathies for those who lost their lives, or loved  
 21 ones, in the Channel in such horrific circumstances.  
 22 I make it clear that nothing said or done by  
 23 the Home Office in the course of this Inquiry is  
 24 intended in any way to belittle the tragedy or  
 25 the devastating losses it has led to.

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1 The Home Office is extremely grateful to the Inquiry  
 2 team for taking on the task of examining  
 3 the circumstances surrounding this tragic incident. It  
 4 hopes that this Inquiry brings some degree of resolution  
 5 to the survivors and the friends and families of those  
 6 who died. In particular, it particularly hopes that  
 7 the evidence the Inquiry will hear serves to address  
 8 the concerns expressed in some of the statements of  
 9 the survivor and the families of the victims, that there  
 10 were no efforts to come to their rescue.  
 11 The Home Office has been and continues to be  
 12 committed to supporting the Inquiry in its  
 13 investigation. It welcomes the exercise that  
 14 the Inquiry will conduct in identifying any further  
 15 lessons to be learned from the events of that night, and  
 16 will consider carefully any relevant recommendations  
 17 that emerge, as it did with regards to the Marine  
 18 Accident Investigation Branch investigation and report  
 19 into the tragedy.  
 20 The Home Office has the status of Full Participant  
 21 in this Inquiry. Within the Home Office, UK  
 22 Border Force has responsibility for securing the UK's  
 23 borders, and carrying out immigration and customs  
 24 controls for people and goods entering the country.  
 25 Border Force Maritime Command operates within UK

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1 Border Force and is responsible for maritime borders.  
 2 It maintains vessels to discharge that function. In  
 3 addition, the Home Office supports other governmental  
 4 departments in the performance of search and rescue at  
 5 sea. Since 2018, the Home Office's at sea functions  
 6 have increasingly been deployed to address the  
 7 challenges posed by migrants' use of small boats to  
 8 cross the Channel, with the number of such crossings  
 9 having been made increasing exponentially since then.  
 10 It is important to make clear at the opening of this  
 11 Inquiry that the Home Office's overall response to  
 12 the small boat arrivals has always been guided by  
 13 the aim to preserve life, whether by deploying its law  
 14 enforcement vessels to aid in search and rescue  
 15 operations when requested to do so by His Majesty's  
 16 Coastguard, or by working with colleagues in the UK and  
 17 abroad to break the criminal organisations who profit  
 18 from and prey upon those who want to come to this  
 19 country.  
 20 The dramatic increase in crossings in the lead up to  
 21 this tragedy required the Home Office to deploy  
 22 additional resources and hone its expertise in  
 23 responding to the new, unique and evolving challenges  
 24 posed by small boats. It has also required Home Office  
 25 staff to take significant personal risks, including

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1 those presented by the disembarking of migrants from  
 2 totally unsuitable and often overloaded small boats in  
 3 challenging maritime conditions, often at night and at  
 4 times in inclement weather. They do so professionally  
 5 and with great courage, and it is of critical importance  
 6 to the Home Office's that this Inquiry understands that  
 7 the terrible loss of life which occurred in the early  
 8 hours of the 24 November 2021 was a tragedy, and  
 9 devastating to the Home Office, whose staff all take  
 10 justified pride in the performance of their professional  
 11 duties.  
 12 The Home Office would also like me to express its  
 13 firm hope that, in addition to bringing some degree of  
 14 solace to the survivors and families of the victims,  
 15 this Inquiry's review of the events of the night of  
 16 24 November 2021 will also draw attention to  
 17 the terrible jeopardy that people smugglers place people  
 18 in. The Home Office has no doubt that this will be made  
 19 clear by the evidence.  
 20 May I conclude by reiterating the Home Office's  
 21 deepest sympathies to the survivors, the families of  
 22 the victims, and all those who have been affected by  
 23 what happened on 24 November 2021. It is hoped that  
 24 this Inquiry will assist the UK authorities in ensuring  
 25 that such a tragedy will never happen again.

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1 Sir, I thank you for the opportunity to make this  
 2 statement.  
 3 SIR ROSS CRANSTON: Thank you very much, Mr Mallet.  
 4 The Department for Transport is represented by  
 5 David Blundell King's Counsel.  
 6 Opening statement by MR BLUNDELL  
 7 MR BLUNDELL: Thank you, sir.  
 8 As you have indicated, I'm making this statement  
 9 today on behalf of the Department for Transport, and  
 10 I appear today on behalf of the Department with  
 11 Mr Grandison and Ms Wakeman.  
 12 At the outset of these public hearings,  
 13 the Department wishes to express its deepest sympathies  
 14 to the bereaved, the survivors and to all others who  
 15 have been affected by the events that took place on  
 16 24 November 2021, when at least 27 people tragically  
 17 lost their lives crossing the Channel.  
 18 The Department recognises that a number of those  
 19 affected by this tragedy will be taking part in  
 20 the Inquiry and that their experiences will rightly be  
 21 at the heart of the Inquiry's work. Their voices will  
 22 be heard. They set the context for everything  
 23 the Inquiry is doing. The Department recognises,  
 24 therefore, the very real importance of this Inquiry and  
 25 the public interest in seeking to understand both what

1 happened on 24 November 2021 and what can be learned  
 2 from it.  
 3 The Department has worked hard over the past year to  
 4 assist the Inquiry with its investigations through  
 5 the provision of a comprehensive and detailed witness  
 6 statement from Mr James Driver, the Head of the Maritime  
 7 Security Division at the Department, as well as  
 8 disclosing in excess of 1,000 documents. The Department  
 9 has sought, and will continue to seek, to cooperate  
 10 fully with all requests from the Inquiry.  
 11 The intention of this opening statement is not to  
 12 rehearse the contents of Mr Driver's evidence, but  
 13 rather to provide the Inquiry with what is hoped to be  
 14 a helpful summary of three things: first of all,  
 15 the Department's role and responsibilities in relation  
 16 to small boats; secondly, the developing small boat  
 17 situation in 2021 prior to this incident; and thirdly,  
 18 key changes to the response to small boat crossings made  
 19 since the incident.  
 20 So, sir, may I first turn to deal with the first of  
 21 those topics: the Department's role and  
 22 responsibilities. Now, the Department's role in  
 23 relation to small boats attempting to cross  
 24 the Channel is twofold. First of all, it's largely  
 25 defined through its work with the Maritime and

1 Coastguard Agency, the MCA, who you've already heard  
 2 from, an executive agency of the Department, and, by  
 3 extension, His Majesty's Coastguard, HMCG, which forms  
 4 part of the MCA. And, secondly, in interacting with  
 5 other government departments, in advocating on behalf of  
 6 HMCG, and highlighting the UK's obligations from  
 7 a search and rescue, or SAR, perspective.  
 8 The Secretary of State for Transport has  
 9 responsibility for establishing, operating and  
 10 maintaining an adequate and effective civil maritime and  
 11 aeronautical SAR service. Whilst the Department does  
 12 not itself have any operational functions in relation to  
 13 small boats, the Secretary of State discharges her  
 14 responsibility through the MCA, HMCG and Aviation  
 15 Airspace Division. Through HMCG, the Secretary of State  
 16 discharges her statutory responsibility to initiate and  
 17 coordinate the operational SAR response within the UK's  
 18 SAR Search and Rescue Region. HMCG provides a national  
 19 24-hour maritime SAR service that can operate throughout  
 20 the UK, at sea and internationally.  
 21 Within the Department, there are two teams that  
 22 engage on issues relating to small boats and their  
 23 search and rescue. First of all, there is the Maritime  
 24 Security Division, of which Mr James Driver is the head,  
 25 which primarily engages on issues relating to small

1 boats. Secondly, then, there is the MCA Sponsorship  
 2 Team, which provides a core part of the Department's  
 3 oversight of the MCA, who, in turn, oversee SAR  
 4 operations through HMCG. The Department is responsible  
 5 for the policy framework within which the MCA operates  
 6 and for agreeing its strategic objectives, and it is  
 7 the MCA Sponsorship Board, which is attended by the MCA  
 8 Sponsorship Team and others from the Department, which  
 9 oversees the overall performance of the MCA.  
 10 In terms of its cross-government interactions,  
 11 I just want to make two points at this stage. First of  
 12 all, the Department's main role is to contribute to  
 13 the proposed policies of other government departments  
 14 and other cross-government initiatives. The Department  
 15 is not responsible for developing policy to counter  
 16 illegal migration; that, of course, is a matter for  
 17 the Home Office. The Department's role in all these  
 18 interactions is to ensure that there is no impact on  
 19 the UK's obligations to safeguard lives at sea,  
 20 by liaising with search and rescue experts within HMCG  
 21 and advocating on their behalf.  
 22 Secondly, the Department also plays a role in  
 23 internal incident reporting and cross-government  
 24 communication, such as media and Parliamentary handling.  
 25 It regularly engages with HMCG on small boats

1 specifically and, on some occasions, liaises with HMCG  
 2 about the details of specific operations on  
 3 a fact-finding basis.  
 4 Now I'm going to move to the second of those three  
 5 topics: the developing small boat situation in 2021  
 6 prior to the incident.  
 7 From autumn 2018, migrant numbers arriving by small  
 8 boats across the English Channel started to rise very  
 9 substantially, and you've already seen those figures  
 10 this morning. This led to an increased focus across  
 11 Government on the issue of small boats. The number of  
 12 small boat crossings significantly increased in 2021 to  
 13 28,526 over the course of the year compared to 8,466  
 14 crossings in 2020. In November 2021 specifically,  
 15 a record number of 6,971 people crossed the Channel by  
 16 small boats, a significant increase from 2,701  
 17 the previous month.  
 18 This rapid and significant increase presented  
 19 a unique challenge for Government. Whilst work was  
 20 taking place to understand the nature and extent of  
 21 the challenge and to respond effectively, the sharp rise  
 22 in small boat crossings placed a considerable strain on  
 23 both surface and aerial assets. Notwithstanding this  
 24 increase, the Department's position in November 2021 and  
 25 prior to this incident was that HMCG was able to meet

1 its SAR responsibilities, albeit that difficulties might  
 2 arise if the high volume of small boat crossings were to  
 3 continue in the longer term.  
 4 Now I'm going to move to the third of the three  
 5 topics that I highlighted at the outset, that's: key  
 6 changes to the responses to small boat crossings  
 7 following the incident.  
 8 Work was already underway in autumn 2021 as a result  
 9 of growing crossing numbers and projections for 2022.  
 10 There was recognition that maritime assets were under  
 11 pressure from the then recent increase in migrant  
 12 crossings, and that, based on the projections for 2022,  
 13 there might be an adverse impact on the availability of  
 14 resources to respond.  
 15 Ministers were informed in a submission dated  
 16 26 November 2021 that the current high number of small  
 17 boats crossing the Channel were expected to continue,  
 18 and that if they did, that would place pressure on HMCG  
 19 operational staff and Border Force and RNLI maritime  
 20 surface assets. The submission also noted that work was  
 21 underway to address this challenge. Thereafter,  
 22 a further ministerial submission, dated  
 23 14 December 2021, was jointly prepared by the Department  
 24 and HMCG. This noted that the increase in small boat  
 25 crossings was stretching maritime assets to the limit

1 and that if the numbers continued to increase it would  
 2 be considered unsustainable. Accordingly, Ministers  
 3 were asked to agree to a number of proposals, including  
 4 that HMCG should explore increasing additional maritime  
 5 surface SAR assets and HMCG should explore developing  
 6 enhanced situational capabilities.  
 7 The submission made reference to a work strand,  
 8 which was already in train from October 2021, to develop  
 9 enhanced situational awareness through an increase in  
 10 the number of unmanned aerial vehicles, via  
 11 Project Ceasar. Project Ceasar involved a £35 million  
 12 investment over a three-year period to enable  
 13 the procurement of 5-100 unmanned aerial vehicles to  
 14 increase aerial surveillance over the Channel.  
 15 The project was formally endorsed by the Department and  
 16 HM Treasury in member 2022 and it was mobilised in  
 17 March 2022. The objective of Project Ceasar was to  
 18 assist HMCG in discharging its SAR obligations in  
 19 relation to small boats by improving its ability to  
 20 locate and determine the status of the small boats that  
 21 were crossing, and by prioritising its response.  
 22 At the end of December 2021, through what was  
 23 called "Operation Isotrope", the Prime Minister asked  
 24 the Ministry of Defence, the MoD, to assume primacy over  
 25 all aspects of the Government's operational response to

1 illegal migration by small boats. The Department worked  
 2 with MoD and Home Office to ensure that the UK's SOLAS  
 3 obligations and HMCG's responsibilities for SAR were  
 4 understood and reflected in the terms of that operation.  
 5 During Operation Isotrope, HMCG continued to work at an  
 6 operational level with Border Force and the Royal Navy  
 7 to provide an effective SAR response irrespective of  
 8 the change in ultimate responsibility for the response  
 9 to illegal migration by small boats in the Channel.  
 10 Additional funding was provided through  
 11 Operation Isotrope which enabled an uplift in maritime  
 12 surface assets, including the procurement of five Crew  
 13 Transfer Vessels. Following these changes, HMCG  
 14 reported to the MCA's Sponsorship Board on  
 15 20 October 2022 that it was satisfied that it was  
 16 ensuring "adequate and proportionate provision of Search  
 17 and Rescue in the Channel, which met its domestic and  
 18 legal obligations".  
 19 In addition to the extra resources which were  
 20 implemented through Project Ceasar, and the changes made  
 21 through Operation Isotrope, the Department was also  
 22 aware that HMCG were developing and improving their  
 23 handling of small boat operations in the period  
 24 immediately following the incident by increasing  
 25 staffing numbers, developing training, and improving

1 their ability to identify the location of small boats in  
 2 distress through improved communications with the French  
 3 authorities .  
 4 Sir, in conclusion, following this serious and  
 5 tragic incident, it is of course important to identify  
 6 any lessons that can be learned to ensure that history  
 7 does not repeat itself . In that regard, the Department  
 8 fully co-operated with the Marine Accident Investigation  
 9 Branch's safety investigation into this incident, and  
 10 the Department understands that both of  
 11 the recommendations to MCA made by the Marine Accident  
 12 Investigation Branch have been implemented and closed.  
 13 The Department welcomes the opening of these public  
 14 hearings, which will form a key part of the Inquiry's  
 15 investigation . Throughout the hearings, the Department  
 16 continues to stand ready to provide the Inquiry with any  
 17 and all assistance it may require in discharging  
 18 the terms of reference. Sir, thank you very much for  
 19 the opportunity to --  
 20 SIR ROSS CRANSTON: Thanks very much, Mr Blundell. And  
 21 I want to thank all the Full Participants for their  
 22 opening statements this afternoon.  
 23 I don't think there's anything further today, so  
 24 we'll meet again tomorrow morning at 10 o'clock and  
 25 we'll hear our first witness. So thanks very much.

1 (3.18 pm)  
 2 (The hearing adjourned until 10.00 am on Tuesday,  
 3 4 March 2025)  
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