CRANSTON INQUIRY

CLOSING STATEMENT ON BEHALF OF THE BEREAVED FAMILIES AND SURVIVOR

1. These closing written submissions are made on behalf of the Bereaved Families and Survivor. They highlight the egregious of failings of the Department of Transport ("**DfT**"), the Maritime Coastguard Agency ("**MCA**"), Her Majesty's Coastguard ("**HMCG**") and the Home Office at all levels of seniority, from the top down, during and prior to the tragic events of 23-24 November 2021, to maintain and operate safe systems for the protection of the lives of those making small boat crossings across the English Channel. They end with recommendations to save lives in the future.

2. They are structured as follows: (a) Legal framework; (b) Predictability; (c) Discrimination; (d) Failures; (e) Causation and survivability; (f) Accountability and oversight; and (g) Lessons learned and recommendations.

A. LEGAL FRAMEWORK

3. Three overarching legal principles arise from the UK's international treaty obligations and the relevant authorities' duties under domestic law. These principles provide a minimum floor for public authorities' conduct in respect of small boat search and rescue ("**SAR**").

4. **First**, the UK is under a duty to establish and maintain an adequate and effective SAR system to protect life as sea. As set out in the Inquiry's legal framework document, specific obligations to this effect are imposed upon coastal States under the various maritime treaties to which the UK is party.[1] These include the development of detailed plans of operation for the conduct of SAR, which, as appropriate, should be developed jointly with representatives of those who may benefit from them.[2] Those provisions have not been *expressly* incorporated into domestic law, but the UK has not entered any reservations to its obligations to qualify their applicability and the Government has expressly accepted, through its witness evidence to this Inquiry, that it is through the MCA that the DfT ensures the implementation of its obligations under relevant international maritime conventions.[3]

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[1] Article 98(2) of the UNCLOS 1982 provides that "*Every coastal State shall promote the establishment, operation and maintenance of an adequate and effective search and rescue service regarding safety on and over the sea and, where circumstances so require, by way of mutual regional arrangements cooperate with neighbouring States for this purpose*". Article 1 of the SAR Convention 1987 obliges States to "*undertake to adopt all legislative or other appropriate measures necessary to give full effect to the Convention and its Annex, which is an integral part of the Convention*". The Annex then contains individual Chapters harmonising definitions relevant to SAR (Chapter 1), Organisation and Coordination of SAR services (Chapter 2), Cooperation between states (Chapter 4), and Operating Procedures, Ship Reporting Systems (Chapter 5).

[2] SAR Convention, Annex, 4.1.3.

[3] INQ010337, Witness Statement of James Driver, §22. It also merits noting that a "*determination*" by the relevant Minister was laid before Parliament on 9 March 1992, which sought to "*clearly define and formally promulgate*" the role of HMCG as follows (emphasis added): "*Her Majesty's Coastguard is responsible for the initiation and co-ordination of civil maritime search and rescue within the United Kingdom search and rescue region. This includes the mobilisation, organisation and tasking of adequate resources to respond to persons either in distress at sea, or to persons at risk of injury or death on the cliffs or shoreline of the United Kingdom*".

5. Those treaty obligations are interpreted in light of, and consistently with, the duties under Article 2 of the European Convention on Human Rights ("**ECHR**")[4] as given effect in domestic law by s 6 of the Human Rights Act 1998 ("**HRA**"), which imposes a range of non-delegable positive duties on public authorities to safeguard life. That includes a positive obligation to put in place an appropriate legislative and administrative framework and procedures which will, to the greatest extent practicable, protect life. The duty is "*an obligation to have proper systems in place*".[5]

6. The systems duty extends beyond implementing an adequate legislative framework; it "*is sufficiently general to allow for more detailed requirements to come under its umbrella*",[6] including practical and effective procedures and operational systems at ground level and systems which function effectively.[7] This include duties to employ and train competent staff, maintain high professional standards, adopt appropriate systems of work, and have in place systems which will detect and remedy individual failings and shortcomings before harm is done.[8]

7. There may be a breach of the systems duty even though no risk has been identified to a specified individual.[9] That is because the systems duty is concerned with the State's systems and their adequacy; it is not contingent on the risk posed to an individual victim and determinations of individual liability.[10]

8. It was suggested by the State Full Participants in their oral closing submissions that attributing responsibility to the authorities would be to ignore the dangerous and perilous conditions at sea that the victims were exposed (whether voluntarily or at the hands of smugglers) to during this tragedy.[11] That is misconceived:

9. **First,** this Inquiry was established in order to and must comply with the investigative duty under Article 2 ECHR. Its core function is to determine whether there were breaches of the right to life *by the state* in this case.

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[4] Article 31(2)(a), Vienna Convention on the Law of Treaties 1969.
[5] *Savage v South Essex Partnership Trust* [2009] 1 AC 681, §97.
[6] *Griffiths v Chief Constable of Suffolk* [2018] EWHC 2538 (QB), §§502, 561.
[7] *Savage*, §31; *R (Humberstone) v Legal Services Commission* [2011] 1 WLR 1460, §§58, 69-70; *R (Scarfe) v Governor of Woodhill Prison* [2017] EWHC 1194 (Admin), §54; *LW v Sodexo* [2019] EWHC 367 (Admin), §46; *Cevrioğlu v Turkey* [2017] Inquest LR 37, §66.
[8] *R (Amin) v SSHD* [2004] 1 AC 653, §30; *Middleton v West Somerset Coroner* [2004] 2 AC 182, §1; *Savage,* §§30-31, 36, 45; *Smith v Ministry of Defence* [2014] AC 52, §68.
[9] *Savage*, §31.
[10] *Cevrioğlu*, §69.
[11] Transcript, 27 March 2025, p.56, ln.3-5 (Mr Maxwell-Scott) ("*the real causes of this incident were a number of factors which were outside the control of HM Coastguard*"); p.70, ln. 23-25 - p.71, ln.1-6 (Mr Popat) ("*whilst this Inquiry has rightly focused on the actions of the UK authorities in conducting the search and rescue for those people, it must ... not be forgotten that these vulnerable individuals were in that boat on that night as victims of ruthless, criminal people-smuggling gangs, who did not have any regard or concern for the safety of the people they were sending into perilous, dangerous conditions, with the odds of survival stacked against them*").

10. **Second**, as to operational and systems duties, it is trite Convention law that these can apply in respect of harm which is directly caused by a private third party or the actions of the individual victim.[12]

11. **Third,** that a private activity is dangerous means *heightened* duties are imposed on the State to take steps to protect life. The European Court of Human Rights ("**ECtHR**") has determined that the "*gravity of the potential dangers*" arising from specific activities leads to a "*more compelling responsibility*" to monitor, identify and, if necessary, address the risks arising from them, even if the "*primary responsibility*" lies with other private actors.[13] This principle has been addressed by the ECtHR in a range of regulatory contexts, including SAR for small boats carrying migrants at sea.[14]

12. **Fourth,** "*but-for*" causation does not apply to Article 2 ECHR. In proving a connection between an Article 2 breach and a person's death, there is no requirement to show that life would probably have been saved if the relevant measures had been taken. It is only necessary to show a "*substantial chance*" or "*real prospect*" that the outcome may have been altered or mitigated.[15] Article 2 ECHR therefore admits multiple contributory factors. The existence of additional causative aspects beyond State failings – such as, in this case, the state of the vessels the victims embarked, the smugglers who exploited the victims, and/or the difficult weather conditions – does not displace or relieve the relevant public authorities of their full legal obligations under Article 2 ECHR to the victims.

13. The Civil Contingencies Act 2004 ("**CCA**") imposes duties upon specific public bodies in a range of emergency contexts (including land, sea and air) to undertake risk assessments and contingency planning in relation to emergencies, which complement and overlap with the duties of operational planning and preparedness under the International Convention on Maritime Search and Rescue 1979 ("**SAR Convention**") and Article 2 ECHR. An emergency is defined under s 1 CCA as "*an event or situation which threatens serious damage to human welfare in the United Kingdom or in a Part or region*" with "*serious damage to human welfare*" defined in s 1.2 as threatened "*only if it involves, causes or may cause—(a) loss of human life, (b) human illness or injury*". Part One applies to the territorial sea of the United Kingdom (s 18(2)). Section 2 CCA obliges Category 1 responders, which include the MCA,[16] to risk assess and make plans, and advise the public re the relevant risks. Significantly, the s 2 duty includes a duty to "*maintain plans for the purpose of ensuring, so far as is reasonably practicable, that if an emergency occurs the person or body is able to continue to*

[12] For operational duty, see e.g. *Osman v UK* (2000) 29 EHRR 245, §116; *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72. For systems duty, see e.g. *Cevrioğlu*, §67.
[13] See *Cevrioğlu*, §§66-67.
[14] See *Safi v Greece* (App. no. 5418/15, 7 July 2022), §§151-152 and the cases listed therein.
[15] *Van Colle v Chief Constable of Hertfordshire* [2009] 1 AC 225, §138; *R (Long) v Secretary of State for Defence* [2015] 1 WLR 5006, §32; *Daniel v St George's Healthcare NHS Trust* [2016] 4 WLR 32, §§30, 140; *Talpis v Italy* (App. no. 41237/14, 2 March 2017), §121.
[16] Part 1, Schedule 1, CCA.

perform his or its functions" and considering modification of those plans where necessary or expedient (ss 2.1(c) and (e), CCA).[17]

14. **Second**, there are operational duties under international and domestic law for passing ships to render assistance to persons in distress at sea.

    a. These includes duties imposed on mariners by the International Convention for the Safety of Life at Sea 1974 ("**SOLAS**") and on States under the UN Convention of the Law of the Sea 1982 ("**UNCLOS**") and the SAR Convention, as set out comprehensively in the Inquiry's legal framework document. The obligation on masters of the sea imposed by Regulation 33.1 of SOLAS has been implemented by the Merchant Shipping (Safety of Navigation) Regulations 2020, which renders failure to comply with that obligation a criminal offence.

    b. Importantly for present purposes, the SAR Convention uses a three-fold classification of the phase of an emergency – uncertainty, alert, or distress – with the last of these being a "*situation wherein there is a reasonable certainty that a person, a vessel or other craft is threatened by grave and imminent danger and requires immediate assistance*".[18] Once a boat is in "*distress*", the obligation to proceed with SAR operations as prescribed in the plans of operation[19] continues until "*all reasonable hope of rescuing survivors has passed*"[20] unless there is "*reliable information that a search and rescue operation has been successful, or that the emergency no longer exists*".[21] This downgrading of incidents therefore requires receipt of reliable information that an emergency is no longer ongoing.

    c. Article 2 ECHR also imposes an operational duty on the State to take preventive measures to protect an individual whose life is at a real and immediate risk which the State knows or ought to know of.[22] An "*immediate*" risk to life is one that is "*present and continuing*" as opposed to "*imminent*". In order to establish a "*real*" risk, a "*substantial or significant and not a remote or fanciful one*" is sufficient. In *Rabone*, a 5% risk of death rising to 20% was held to be "*low to moderate (but nevertheless, significant)*", and therefore "*real*".[23]

    d. The risk need not be apparent just before death and an arguable breach can arise where a significant period of time has elapsed between the risk arising and the deaths occurring.

    e. The operational duty is triggered not only where the authorities know of the relevant risk, but also where they ought to know. "*[S]tupidity, lack of imagination and inertia do not afford an excuse*" to a public authority which reasonably ought, on the facts, to make further inquiries

[17] Section 2(1)(c) and (e), CCA.
[18] Annex 1.1.3, SAR Convention.
[19] Annex 4.5.3, SAR Convention.
[20] Annex 4.8.1, SAR Convention.
[21] Annex 4.8.3, SAR Convention.
[22] *Osman*, §115.
[23] *Rabone*, §§39-40.

or investigations.[24] The authority is then to be treated as knowing what such further inquiries or investigations would have elicited.[25] Appeals against the use of "*hindsight*" by public authorities must be addressed in this legal context.

f. The individual at risk need not be identified for the operational duty to arise. "*A duty may be owed to the public at large*", the ECtHR "*has not limited the scope of the article 2 duty to circumstances where there is or ought to be known a real and imminent risk to the lives of identified or identifiable individuals*".[26] The operational duty can therefore arise where the victim is drawn from a broader class i.e. those crossing the Channel in small boats.

g. Where the operational duty is triggered, the authorities are under a duty to take those measures within the scope of their powers which, judged reasonably, might be expected to avoid, minimise, or mitigate that risk.[27] In *Safi,* a case concerning the sinking of a vessel in the Aegean Sea with 27 migrants aboard, the ECtHR held that delays in alerting search and rescue service, and in the rescue operation itself, gave rise to a breach of Article 2. The ECtHR emphasised the "*the paramount importance of the time factor in such situations: every minute counts and may have a critical impact on the rescue effort, as drowning occurs in a matter of minutes*" (§162). The Court specifically criticised a 12-minute delay in making a Mayday relay distress call, that a naval vessel was not requested for a further 20 minutes, that a rescue helicopter took 1 hour 20 minutes to arrive at the scene; and that the first Greek Coast Guard vessel took 1 hour 15 minutes to arrive (§§163-165).

15. **Third**, the principle of non-discrimination with respect to assistance to persons in distress sea is embedded into international and domestic framework.

a. It is explicitly and absolutely provided for under the relevant international maritime treaties.[28]

b. Article 14 ECHR, read with s 6 HRA, requires that public authorities do not discriminate against people in the enjoyment of their ECHR rights, including based on their race, national origin, and immigration status. This encompasses policies or practices which are couched in neutral terms but have unjustified disproportionately prejudicial effects on a particular group; and measures which fail to treat differently persons whose situations are significantly different absent justification.[29] Race discrimination is a suspect ground, and a *jus cogens* prohibition

[24] *Van Colle*, §§31 (Lord Bingham), 86 (Lord Phillips CJ).
[25] *Van Colle*, §32 (Lord Bingham).
[26] *Sarjantson v Chief Constable of Humberside* [2014] QB 411, §§18, 22.
[27] *Osman*, §116; *Van Colle*, §30.
[28] Reg. 33(1), SOLAS; para 2.1.10, SAR Convention.
[29] *Thlimmenos v Greece* (2001) 31 EHRR 411. In assessing a case of alleged discrimination, four questions arise: (1) Does the subject matter of the complaint "*fall within the ambit*" of a Convention right? (2) Has the individual been treated differently to other people in an analogous situation and/or in the same way as other people not sharing that status whose situation is relevantly different from theirs and/or does the policy have disproportionality prejudicial effects on a group of people? (3) Is difference in their situation related to one of the statuses listed in Article 14 or some "*other status*"? and (4) Does the difference or similarity in treatment, or prejudicial effect, have an objective and

under international law.[30] Like discrimination on the basis of nationality, it requires "*very weighty reasons*" to justify the difference in treatment.[31] But even where the ground of discrimination is an "*other* status" not specified in the text of Article 14 – such as an individual's immigration status[32] – this does not absolve the State of showing an objective and reasonable justification for the difference in treatment. Moreover, and crucially in this case, stereotypes cannot amount to sufficient justification for a difference in treatment. [33]

B. PREDICTABILITY

16. As the Bereaved Families and Survivor maintained in their opening and oral closing statements, it was predictable *prior to the disaster* – and not just with the benefit of hindsight – that the UK's SAR function would be overwhelmed by a mass casualty event. The submissions on this issue made in the written opening will not be repeated here. However, they remain accurate following the oral evidence, and the Inquiry is asked to take them into account in considering these closing submissions, in addition to the following points.

17. **First**, the disaster was caused by the state SAR system being overwhelmed. In its oral closing the MCA maintained that "*the real causes of this incident were a number of factors which were outside the control of HM Coastguard.*"[34] For the reasons set out above, that argument is misconceived. The focus of this Inquiry (as a matter of law) is the UK state failures that led to the disaster. The Inquiry is obliged to focus on the elements of the system that were overwhelmed on the night. As set out below, those include, but are not limited to, systems for: communication and cooperation with France; communication with those on small boats; the identification and monitoring of small boats; the maintenance of situational awareness; air surveillance; training adequate competent staff; and the tasking and availability of assets.

18. **Second**, the breakdown of these systems on 23-24 November 2021 was related to the specific challenges to SAR practices posed by small boat crossings in the English Channel, when compared with conventional maritime SAR. Multiple witnesses gave evidence in this respect.[35] Neal Gibson,

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reasonable justification? See, *R (DA and DS) v SSWP* [2019] 1 WLR 3289, §136, as adapted for *Thlimmenos*-type cases see e.g., *Vanriel & Tumi v SSHD* [2021] EWHC 3415 (Admin), §44.

[30] *Draft conclusions on identification and legal consequences of peremptory norms of general international law (jus cogens)*, Yearbook of the International Law Commission, 2022, vol. II, Part Two.

[31] *Gaygusuz v Austria* (1996) 23 EHRR 364. This is a particularly high burden and has been applied in a raft of Strasbourg cases, including: *Andrejeva v Latvia* (2010) 51 EHRR 28; *Savickis v Latvia* (2022) 75 EHRR 21; *Poirrez v France* (2005) 40 EHRR 2, §46; and *Ponomaryov v Bulgaria* (2014) 59 EHRR 20.

[32] Immigration status amounts to an "*other status*" for the purposes of Article 14: *Bah v United Kingdom* (App. No.56328/07, 27 December 2011), §§45-46.

[33] *Markin v Russia* (App. No.30078/06, 22 March 2012), §143.

[34] Transcript, 27 March 2025, p.56, ln.2-5 (Mr Maxwell-Scott).

[35] A number of HMCG staff, including Mr Jones, told the Inquiry that there were specific challenges associated with small boat SAR which rendered these operations "*more difficult than a normal SAR response incident*": Transcript, 12 March 2025, p.181, ln. 21-22 (David Jones). See also Transcript, 17 March 2025, p.29, ln.12-20 (George Papadopoulos) (small boat SAR was (unusually) considered a "*defined category*" within HMCG's routine SAR work, in order to "*highlight the requirement for further development and adaptation into our response*") and p.28, ln.19-22; 24 March 2025, p.14, ln.4-9 (Matthew Leat).

Search and Rescue Mission Coordinator ("**SMC**") on the night, gave the novel nature of small boats SAR as a reason for the lack of appropriate HMCG training, stating: "*Small boats were, in maritime terms, in their infancy of −− of a new type of incident, so we didn't have specific training.*"[36]

19. But that contention is unsustainable because, **third**, by November 2021, small boats were not, in any sense, a "*new type of incident*." As is borne out clearly by the Inquiry's Pre-incident Chronology, crossings began in earnest in late 2018. The chances of the systems of identification and communication being overwhelmed depends on the number of persons but also particularly *the number of boats* crossing. Publicly available Home Office statistics demonstrate that the number of people who crossed the Channel on 23/24 November 2021 – 757 – was not particularly high for the period.[37] But the number of boats that crossed on the night – 17 – was not high *at all* in the context of the previous two years. The first time 17 or more boats crossed was 20 July 2020. 17 or more boats had crossed on 20 single days prior to 23 November 2021, over a 16-month period. During July, August and September 2020 there were ten days when 15 or more boats crossed.[38]

20. **Fourth**, officials at the highest levels in the HMCG and Border Force Maritime Command Centre ("**Border Force MCC**"), were well aware, months in advance, of the risk of their SAR response being overwhelmed. As early as 12 May 2020, a DfT document recorded that "*the UK is experiencing record levels of migrant crossings*" and that "*SAR resources can be overwhelmed if current incident numbers persist through the summer.*"[39] At a meeting in June 2021 regarding Operation Sommen attended by senior officials from the Home Office, DfT and HMCG, including Mr Daniel O'Mahoney, Director of Clandestine Channel Threat Command ("**CCTC**"), Stephen Whitton, Head of Border Force MCC, and James Driver, Head of Maritime Security at DfT, the situation was described as a "*humanitarian crisis waiting to happen*" and it was stated it was "*amazing that more people haven't lost their lives already*."[40] During August 2021 at least three separate senior HMCG officials produced internal documents raising the alarm regarding the risk of SAR capabilities being overwhelmed.[41] These reports were consistent in raising the concerns regarding: communication and cooperation with France; the identification and monitoring of small boats, including reliable recording of information; a lack of situational awareness; adequate staff; staff exhaustion; and inadequate surface assets. Each also raised the same risks arising from these inadequacies: loss of organisational reputation; loss of life at sea from ineffective/inadequate

[36] Transcript, 5 March 2025, p.6, ln.8-12 (Neal Gibson).
[37] For example: 3 November 2021 (853 people); 11 November 2021 (1,250 people); 16 November 2021 (1,168 people); and 20 November 2021 (886 people).
[38] The highest numbers of boats crossing in 2020 – 26 boats – occurred twice, on 2 and 11 September 2020.
[39] INQ0001132, Migrant Activity in the English Channel, 12 May 2020.
[40] INQ004900, Notes from Department for Transport meeting, 29 June 2021. The Bereaved Families and Survivor submit the record of this meeting is important given its attendees, the risks recognised, and the steps taken (or lack thereof) after it. They have sought to draw it to the Inquiry's attention in their opening, evidence proposals, and paragraph 11 questions, and ask the Inquiry again to consider it.
[41] INQ007279, Migrant Incident Activity, 4 August 2021 drafted by the COLO; INQ003323, Migrant Incident Activity, 15 August 2021 drafted by HMCG Head of International Liaison; INQ003332, Email from Mike Bill to Chief Coastguard, 17 August 2021; INQ003379, Migrant Activity Debrief, 21 August 2021.

preparation and/or response; inability to adequately defend the organisation at any subsequent investigation; failure to recognise the dangerousness of amber (medium-high activity) days; failure to recognise and/or declare a Major Incident when the criteria were met. Crucially, these risks were explicitly not confined to days when the highest numbers of crossings took place. As Mr Mike Bill, Divisional Commander for MRCC Dover, said in his email of 17 August 2021, "*[i]n comparison to some recent days this was not particularly busy with only 18 incidents and 285 migrants but the same themes are apparent.*"[42] The risk of SAR overwhelm was therefore a general one that related to recognised inadequacies in the system. HMCG was fixed with that knowledge by at least August 2021. It is no answer to that to merely emphasise (as the State Full Participants did in oral closing) the record numbers of people that crossed in November 2021.

21. **Fifth**, when these warning of overwhelm were raised, the response of senior officials was concern at the political impact of improving SAR systems in an environment of overt hostility and discrimination towards migrants. The response at the June 2021 meeting was that Ministers viewed "*numbers of people crossing as a political problem: [which] doesn't fit with narrative of taking back control of borders*."[43] A decision was made to proceed with the doomed plan to conduct dangerous pushbacks at sea. Mr Bill warned in his email of 21 August 2021[44] that the reason a major incident was not being declared was political[45] and confirmed in oral evidence that what he meant by political was: "*it was high profile with the government and migrant crossings, … and they didn't probably want that in the news.*"[46]

22. **Sixth**, the response of the Home Office was to push ahead with border enforcement and its doomed plan to conduct dangerous pushbacks at sea. Mr O'Mahoney accepted in his evidence to the Inquiry that "*a very considerable amount of time and resource*" was spent on Operation Sommen. He said that was directed by the Home Secretary and Prime Minister themselves.[47] He maintained it did not detract from planning for an improved SAR response.[48] But that contention does not withstand basic scrutiny. As CTI suggested to him, the resources ploughed into Operation Sommen – years of time and money which by definition was not spent improving SAR systems – is self-evident from the levels of disclosure in this case. HMCG was against it. The MCA added it to its Corporate Risk Register as early as May 2020. Indeed, the extent to which Ministers sought to use oppressive, inhuman means to prevent crossings is demonstrated by an email Mr Driver sent to MCA colleagues on 8 September 2020 where he commented that "*Ministers are really pushing and expecting operational solutions like water cannon, pushing back, barriers on the median, etc.*"[49] Mr Whitton confirmed in evidence Operation Sommen did have a detrimental effect on SAR: "*we had a huge*

[42] INQ003322, Email from Mike Bill to Pete Mizen, 17 August 2021.
[43] INQ004900, Note of Meeting on 29 June 2021, p.1.
[44] INQ003322, Email from Mike Bill to Pete Mizen, 17 August 2021.
[45] See also INQ003379, Migrant Activity Debrief, 21 August 2021.
[46] Transcript, 12 March 2025, p.25, ln.2-6 (Mike Bill).
[47] Transcript, 20 March 2025, p.223, ln.13-19 (Daniel O'Mahoney).
[48] Transcript, 20 March 2025, p.224, ln.3-7 (Daniel O'Mahoney).
[49] INQ001137, Email from James Driver to MCA Colleagues, p.2.

amount of pressure to try and develop tactics and operations to try and prevent small boats crossing, that pressure was right across the command … organisations, including the Coastguard, were on our knees in terms of the pressure we were under and it was getting hugely challenging."[50]

23. **Seventh**, the response of HMCG was totally inadequate. Indeed, it remained inadequate at a corporate level in evidence at this Inquiry. Assistant Chief Coastguard, Mr Matthew Leat, would not accept that the risks raised in the August documents amounted even to "*inadequacies*" but was unable to point to any significant steps taken at a corporate level in response. But HMCG's factual witnesses were more candid: Mr David Jones, duty Maritime Tactical Commander on the night, agreed it was "*common knowledge within HM Coastguard, that people knew that maritime Tactical Commanders just couldn't cope with the volume*" of distress incidents requiring RAG ratings.[51] He was not aware of any action to address that at the time.[52] Mr Stuart Downs, Maritime Operations Officer ("**MOO**"), considered that HMCG did not have adequate systems in place to cope with small boats SAR in November 2021.[53] Mr Whitton confirmed that agencies were "*really struggling to deal with the huge numbers of SAR operations*", not just in November 2021 but also in the preceding months: "*[t]he whole of '21 was extremely busy.*"[54] Nevertheless, it was not until November 2021 that the risk of SAR overwhelm was added to the MCA's corporate risk register,[55] when the risk to life from Home Office pushbacks had been added as early as May 2020. Attempts at recruitment and new SOPs came too late, training was not put in place, and most fundamentally, there were wholesale failures of risk assessment, emergency and contingency planning.

C. DISCRIMINATION

24. As set out above, treatment which falls within the ambit of Article 2 ECHR (as the SAR response for vessels in distress at sea plainly does)[56] and the duty to ensure assistance to vessels in distress under the applicable maritime conventions, must be discharged without discrimination. Moreover, the procedural Article 2 duty read in conjunction with Article 14 ECHR requires that any "*possible causal link between alleged racist attitudes*" and the relevant deaths is examined through the investigation.[57] It has emerged clearly from the evidence that the race, national origin and/or migrant status of those in small boats materially impacted the authorities' SAR responses, including on the night of the disaster. Whatever the precise ground of the discrimination, there can be no objective and reasonable justification for discrimination in relation to the provision of life saving emergency

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[50] Transcript, 20 March 2025, p.76, ln.13-22 (Stephen Whitton OBE).
[51] A traffic light system denoting risk, where "*RAG*" stands for Red, Amber and Green (red being the highest level of risk, and green being the lowest).
[52] Transcript, 12 March 2025, pp.219-220 (David Jones), p.181, ln.7-16.
[53] Transcript, 13 March 2025, p.37, ln.24 - p.38, ln.4; p.112, ln.19-24 (Stuart Downs).
[54] Transcript, 20 March 2025, pp.62-63 (Stephen Whitton OBE).
[55] INQ000167, Corporate Risk Register MCA, p.25.
[56] The ambit of an Article of the ECHR for Article 14 purposes is significantly wider than its substantive content: *A v Criminal Injuries Compensation Authority* [2021] 1 WLR 3746, §38.
[57] *Nachova v Bulgaria* [GC] (App. Nos. 43577/98 and 43579/98, 6 July 2005), §162. Although *Nachova* was concerned with intentional lethal force by state agents, it is submitted that the wider principle remains applicable to Article 2 breaches where racial or nationality discrimination is a potential causative factor in the deaths.

services discrimination (moreover, as set out above, stereotypes cannot be justified), and the Full Participants have not sought to provide any.

25. Given the evidence of discrimination which has emerged during the hearings, and the inquisitorial nature of the inquiry process, it is submitted that the Inquiry may wish to consider inviting further evidence from the State Full Participants as to their compliance with their equality duties under the Equality Act 2010 ("**EA**") and HRA.[58] Here, we draw attention to two specific aspects of unjustified discriminatory treatment which have emerged from the evidence.

26. **First,** the victims were treated differently than non-migrants in distress would have been treated.

27. Assumptions and stereotypes about the conduct of migrants on small boats infected the SAR response. Most obviously, the response to small boats was permeated by an assumption that migrants tended to exaggerate their level of distress when calling for help. The pervasive and unchallenged nature of that belief was stark: the Inquiry heard evidence there was a widely held belief that when the Mayday Relay was broadcast, "*nine times out of ten*" a caller from a small boat would exaggerate their level of distress.[59]

28. The obvious risk of this assumption is that call operators, and other frontline professionals engaged in the SAR response, would become sceptical about the veracity of the distress calls and – whether consciously or unconsciously – deploy lesser standards of response on small boat operations.[60] Mr George Papadopoulos, former Small Boats Tactical Commander ("**SBTC**"), initially asserted that even though it is "*widely known*" people on small boats exaggerate their level of distress, decisions would not be based on that belief.[61] But in oral evidence, he accepted there would "*definitely be a risk*" that believing that small boats would exaggerate could cause officers to "*jump to premature conclusions or be biased in certain directions*".[62]

29. That risk was borne out in the evidence. Mr Dominic Golden, Aviation Tactical Commander, was unable to maintain the fiction that the belief migrant calls were exaggerated had no effect on search and rescue responses. He accepted it was a "*consideration*" and a "*relevant factor*" which was "*at the back of [his] mind*".[63] Words such as "*we're all going to die*" were, in that context, deemed to be insufficiently "*specific*".[64] He noted that one specific consideration for him was that if he allocated resources to a call, an asset would be tied into something that "*could be a false alarm, of cry wolf*".[65] As detailed below, the Inquiry has not heard any evidence that any training was put in place to ameliorate this risk.

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[58] See further Recommendation Four at [xx] below.
[59] Transcript, 12 March 2025, p.109, ln.7-16 (Christopher Barnett); 13 March 2025, p.108, ln.17 (Stuart Downs).
[60] Transcript, 17 March 2025, p.57, ln.25 - p.58, ln.1-6 (George Papadopoulos).
[61] Transcript, 17 March 2025, p.55, ln.6 (George Papadopoulos).
[62] Transcript, 17 March 2025, p.57, ln.25 - p.58, ln.1-6. (George Papadopoulos).
[63] Transcript, 11 March 2025, p.103, ln.17-21; p.123, ln.4-7; p.106, ln.11 (Dominic Golden).
[64] Transcript, 5 March 2025, p.181, ln.24-25 - p.182, ln.1-12 (Neal Gibson).
[65] Transcript, 11 March 2025, p.101, ln.13-23 (Dominic Golden).

30. That migrants on small boats were subject to other forms of differential treatment is also apparent on the evidence. Those responding to small boats in distress appear to have applied a specific practice whereby distress calls from migrants were uniquely subject to requirements to *corroborate* their level of distress, and distress incidents concerning migrants were downgraded without proper justification. Mr Gibson said he would seek to corroborate information from migrant boats before making a tasking decision because of the assumptions that those on small boats will exaggerate their situation. He said this led to the need to "*verify*", "*assess*", and "*analyse*" the information provided from distress calls. He wanted "*visual confirmation*" or "*eyes on*" to observe that the callers were not, in fact, "*all sat there quite happy.*"[66] Thus, it was not enough for Mubin Rizghar Hussein to say repeatedly, in English, on the first call (01:48), "*we're finished*", or on a second call (02:31) that there were "*40 people... we're dying and two are children*".[67] The occupants had not satisfied him of whether the boat was "*just*" full of water or whether it was in fact sinking.[68]

31. Mr Gibson also gave evidence that he used a Mayday relay – the highest alert available to mariners, which conveys a grave and imminent danger requiring immediate assistance – merely to get "*some sort of visual confirmation of what the level of distress was*".[69] The Mayday relay and SAR response was then terminated without any adequate basis *before* the *Valiant* had rescued even a single boat. As a matter of law, SAR can only be terminated when reliable information has been received that the emergency no longer exists. As set out below at §§11-121112, there is no evidence that was the case. It cannot seriously be maintained that any craft other than a migrant small boat would have been subject to such incredulity, second-guessing, doubt and premature termination by HMCG.

32. Should it be suggested by State Full Participants that such differential treatment is justified on the grounds that migrants do – in fact – tend to exaggerate their levels of distress which resource constraints demand responders have regard to, that should be rejected for the following reasons:

33. **First**, and importantly, any such submission would pray in aid of the very discriminatory stereotype which renders the treatment discriminatory to justify the differential treatment. As set out above, stereotypes based on race, national origin, or immigration status are not in and of themselves capable of justifying discriminatory treatment.

34. **Second**, the Inquiry should treat with caution evidence from those SAR responders who stated that migrants commonly (innocently or deliberately) exaggerate their levels of distress. The evidential foundation for this view is limited. No research or official statistics have been tendered to support the identification of this supposed trend. Many of the witnesses who cleaved to the belief that migrants tend to exaggerate their distress did not identify the source of their knowledge.[70] Others

[66] Transcript, 5 March 2025, p.85 ln.19-25 (Neal Gibson).
[67] INQ007655, Transcript of call between Neal Gibson and Mubin, 02:31, p.2.
[68] Transcript, 5 March 2025, p.148, ln.3-5 (Neal Gibson).
[69] Transcript, 5 March 2025, p.102, ln.18-19 (Neal Gibson).
[70] See, for e.g., Transcript, 5 March 2025, p.82, ln.17 - p.85, ln.5 (Neal Gibson), (noting, *inter alia*, that it was "*very difficult*" to assess how often callers were exaggerating their calls based on his experience).

asserted the belief absent any first-hand SAR experience, such that it could only be based on second information or rumour.[71] This reveals a deeper problem with the evidence: even those witnesses who *did* assert their knowledge was based on direct experience may too have been impacted by the embedded assumptions and rumour in respect of calls from small boats. A clear example is Mr Downs, who operated under the belief that migrants were given leaflets instructing them to exaggerate the levels of distress.[72] In evidence he was forced to accept the facts underpinning that belief were not necessarily accurate, and the leaflets may simply have advised to call for help.[73]

35. Several HMCG and Home Office witnesses gave evidence that they understood migrants were instructed by smugglers to throw their phones in the water to evade border controls.[74] And yet Issa Mohammed, the only person to give evidence to the Inquiry who has actually attempted to cross the Channel, stated that on none of the three occasions he attempted to cross did any smuggler tell him to throw his phone, nor did anyone tell him about this practice in the weeks before he crossed.[75] Neither do any of the families' statements suggest the victims were instructed in this way.

36. Thus, while the Inquiry can safely conclude those charged with the SAR response to small boats held discriminatory beliefs and/or perceptions, the evidence is too tenuous and unreliable to conclude that migrants *in fact* exaggerated their levels of distress.

37. **Third**, in the absence of an adequate system to properly identify the extent to which a boat is in distress, and in circumstances where all small boats were defined by HMCG as in "*distress*", there was (and is) no sustainable basis for the relevant authorities to disbelieve any caller who stated, for example, that a particular vessel is taking on water, or individuals are in the water. Indeed, in the absence of any system to properly categorise or prioritise distress calls, any arguments praying in aid of resource limitations must similarly be rejected. The relevant public authorities cannot have it both ways. The Inquiry is reminded of the evidence of the MCA's corporate witness, Mr Leat, who told the Inquiry that the "*asset that was there in 2021 was busy, but not overwhelmed*".[76] If that were true, there would have been adequate resourcing to take at face value all distress calls from migrants on small boats, because that is what the system designed by MCA required. But if it was, as the evidence heard demonstrates, untrue, then it remains a failure to allow a situation to arise whereby those providing SAR services felt they had to make difficult choices and relied upon discriminatory beliefs to make decisions.

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[71] See, for e.g., Transcript, 11 March 2025, pp.99-100 (Karen Whitehouse), (noting that she was "*aware of discussions informally*" from "*several sources*" about potential exaggeration, and her understanding that she should be "*taking into account, when responding to calls about small boats, the fact that there was potential exaggeration and that that should be impacting on [her] decision-making*").
[72] INQ010208, Witness Statement of Stuart Downs, §127.
[73] Transcript, 13 March 2025, p.107, ln.13-18 (Stuart Downs).
[74] See, for e.g., Transcript, 12 March 2025, p.96, ln.15-16 (Christopher Barnett).
[75] Transcript, 4 March 2025, p.26, ln.3-18 (Issa Mohammed).
[76] Transcript, 24 March 2025, p.44, ln.22-23 (Matthew Leat).

38. The **second** way in which the victims were subject to discriminatory treatment is that the authorities failed to take positive steps to address the different challenges that small migrant boats presented when compared with conventional SAR taskings. To note just two examples:

39. Absence of training: The authorities failed to provide any specific training to those charged with responding to small boats crossing the Dover Strait. Operators were provided no guidance or training on how to assess information being provided from small boat callers. Instead, informal and flawed practices developed without assurance testing, which were not reflected in SOPs or policies (see further below).

40. Failure to address language barriers: A high proportion of those on small boats cannot speak English. HMCG had a contract with an interpretation service, Language Line, but it was not commonly used to respond to calls from the Channel given the poor mobile signal.[77] Call operators had no specific training on language barriers and call handling. Mr Thomas Willows, an Immigration Officer at Border Force MCC, gave evidence he was not even aware that an interpretation service was available.[78] Callers were in practice expected to communicate in English. The burden of communication difficulties which inevitably arose were then put back onto the caller – call handlers doubting the common sense meaning and veracity of what was being said to them. Nowhere is this more stark than in the evidence of Mr Gibson who doubted the quality of Mubin's (in fact excellent) spoken English, when he was told in no uncertain terms of the danger *Charlie* was in: "*they're using the words, but with no real basis ... So it is very hard, knowing there is a language barrier and trying to ascertain what is factual and what is not factual*".[79] The authorities failed to take steps which could have addressed language barriers.

D. FAILURES

41. The Inquiry has heard evidence of a catalogue of systemic and operational failings which contributed to the disaster. The finding of the relevant failures is a core function of the Article 2 investigative process. Breaches of the right to life require to be identified. It is no answer to this to say, as the MCA sought to in its oral closing, that the Inquiry has not heard independent expert evidence. This is not a civil trial, but an inquisitorial process. The relevant standards of SAR practice are apparent from SOLAS, UNCLOS, the SAR Convention and IAMSAR. The Inquiry has ought to build on the specialist MAIB report. The vast majority of the failings are in any event so stark that they engage no specialist knowledge. Moreover, the investigative Article 2 duty requires that "*culpable and discreditable conduct is exposed and brought to public notice*" and "*that dangerous practices and procedures are rectified*."[80]

[77] Transcript, 24 March 2025, p.145-146 (Matthew Leat).
[78] Transcript, 13 March 2025, p.97, ln.6-12 (Thomas Willows).
[79] Transcript, 5 March 2025, p.182, ln.7-12 (Neal Gibson).
[80] *Amin v SSHD* [2004] 1 AC 653, §31 (Lord Bingham).

42. The failings are identified under the key themes identified by CTI in their opening. The evidence heard not just supports CTI's observations, but has gone well beyond. The list is not exhaustive.

(1) Resources

(a) The relevant authorities failed to recruit competent staff

43. Chronic and persistent understaffing: MRCC Dover suffered from "*poor retention of staff*", meaning "*experience and [competence] weren't the best*".[81] Mr Downs' evidence was that this high level of turnover was the consequence of poor working conditions, including "*[t]he volume of the work, ... the whole package, the whole experience ... of the way it's structured in relation to managing the incidents, the training programmes, etc.*"[82] Senior staff were well aware of the concerns, with Mr Bill acknowledging the risk that MRCC Dover would "*lose some more officers because of overworking, stress.*"[83]

44. As a result, there was a paucity of qualified staff: there were only three qualified SMCs,[84] and it was anticipated that additional SMCs would not be qualified until at least May of 2022.[85] Mr Bill described taking exceptional steps to rush newly hired trainees through basic training, in order that they would have "*some competence that they could support what was going to be a busy summer.*"[86]

45. Mr Papadopoulos was appointed as SBTC to "*review and oversee Dover's response to migrant incidents*".[87] However, given the staff shortages, his "*priority was ... operational support*",[88] acting as an SMC or MC**,** including on the day watch of 24 November 2021, to "*fill in those gaps [in the operations room]*".[89] This had knock-on effects on the oversight and leadership aspects of the role: while Mr Papadopoulos should have been contacted for assistance on the night in question, his assistance may not have been "*feasible ... given [his] working hours around that time of the night... for [him] to have an earlier start.*"[90]

46. On the night, Mr Gibson was not only the sole SMC at MRCC Dover (which itself fell below recommended seasonal levels); he was also the only non-trainee member of staff and the only qualified MC on shift. Whereas the SMC's role entailed "*oversight of all the incidents and [giving] guidance as to…how [they were] progressed*",[91] understaffing meant that Mr Gibson was required to take on routine work, putting him in "*quite an impossible position.*"[92]

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[81] Transcript, 12 March 2025, p.19, ln.15-17 (Mike Bill).
[82] Transcript, 13 March 2025, p.111, ln.23-25 – p.112, ln.1 (Stuart Downs).
[83] Transcript, 12 March 2025, p.22, ln. 2-4 (Mike Bill).
[84] Transcript, 12 March 2025, p.19, ln.14 (Mike Bill).
[85] INQ003322, Migrant Activity, 17 August 2021, p.2. See also Transcript, 12 March 2025, p.19, ln.17-19 (Mike Bill).
[86] Transcript, 12 March 2025, p.33, ln.23 – p.34, ln.8 (Mike Bill).
[87] INQ003195, Migrant ops Dover, 29 July 2021.
[88] Transcript, 17 March 2025, p.26, ln.10-11 (George Papadopoulos).
[89] Transcript, 17 March 2025, p.30, ln.24 (George Papadopoulos).
[90] Transcript, 17 March 2025, p.69, ln.13-17 (George Papadopoulos).
[91] Transcript, 12 March 2025, p.19, ln.4-7 (Mike Bill).
[92] Transcript, 13 March 2025, p.119, ln.13 (Stuart Downs). See also Transcript, 12 March 2025, p.124, ln.18-23 (James Crane).

47. Mr Downs and the Trainee MOO took on significant responsibilities for which there were not qualified, with limited oversight. The Trainee MOO made a call to CROSS Gris-Nez during which information was incorrectly recorded[93] (and relayed to Border Force MCC)[94] and answered a phone call from *Charlie* to the standalone mobile phone,[95] contrary to instruction and practice.[96] The MCA's corporate position – that there was nothing in principle objectionable about the Trainee taking on an operational role because "*[u]tilising a mobile phone is something that everybody does today*"[97] – is untenable, fails to recognise the specialist nature of the work (something the MCA is otherwise keen to emphasise), and is at odds with the views expressed by both SMCs on shift.[98]

48. By summer 2020, hundreds of persons were crossing the Channel on single nights. But no recruitment action was taken by HMCG until August 2021[99] – and even then, only in response to a prediction from the Home Office that crossings were likely to reach 60,000 in 2022.[100]

49. There was no clear ownership of the staffing issues at MRCC Dover. Mr Bill (whose responsibilities included acting as a "*link with seniors… within the organisation to try and get extra staffing at Dover or get recruitment campaigns to fill vacancies*"[101]) received no response when he raised concerns as to the safety of staffing levels with the Chief Coastguard in August 2021.[102] Even then, the staff who *were* recruited were only to become fully operational by 2022.[103] In the face of resounding evidence to the contrary, Mr Leat gave evidence that it was (and remains) the MCA's corporate position that the resources available to MRCC Dover on the night in question were "*wholly appropriate and adequate*",[104] and that HMCG was – as far as staffing was concerned – "*in a good place and ... evolving its response*."[105] Mr Leat even stated that it would not have been appropriate for measures to have been taken to increase staffing at MRCC Dover in advance of August 2021.[106]

50. Requests for cover from other stations / overtime: HMCG's official response to the gap between operational demand and available resources was limited to reliance on the national network by way of "*zone-flexing*" (see further §§56-57 below) and offers of overtime and secondment to MRCC Dover. But these did not work. Mr Bill attempted to "*persuade*" more experienced staff at other

[93] See INQ007647, Transcript of call between MRCC Dover and CROSS Gris-Nez at 01:06; INQ004737, Interview Notes, Trainee MOO; INQ000237, *Charlie* incident log, p.1.
[94] INQ007648, Transcript of call between MRCC Dover and Border Force MCC, 01:20, p.1. See also Transcript, 13 March 2025, pp.133-135 (Stuart Downs).
[95] INQ004737, Interview Notes, Trainee MOO.
[96] Transcript, 5 March 2025, p.25, ln.4-19 (Neal Gibson); 13 March 2025, p.126, ln.6-19 (Stuart Downs).
[97] Transcript, 24 March 2025, p.85, ln.2-5 (Matthew Leat).
[98] Transcript, 5 March 2025, p.36, ln.11 – p.37, ln.24 (Neal Gibson); 12 March 2025, p.87, ln.14-20 (Christopher Barnett).
[99] Transcript, 24 March 2025, p.65, ln.13-16 (Matthew Leat).
[100] Transcript, 24 March 2025, p.65, ln.21-24 (Matthew Leat).
[101] Transcript, 12 March 2025, p.16, ln.1-4 (Mike Bill).
[102] INQ003322, Migrant Activity, 17 August 2021; Transcript, 12 March 2025, p.29, ln.4-10 (Mike Bill).
[103] Transcript, 24 March 2025, p.73, ln.19-21 (Matthew Leat).
[104] Transcript, 24 March 2025, p.67, ln.22-23 (Matthew Leat).
[105] Transcript, 24 March 2025, p.36, ln.6-7 (Matthew Leat).
[106] Transcript, 24 March 2025, p.66, ln.20-22 (Matthew Leat).

stations to assist Dover, with limited success.[107] Staff seconded to MRCC Dover to "*gain experience and understand*"[108] the unique challenges of small boat SAR had to learn on the job, in the absence of training by HMCG.

51. Recruitment failures led to staff exhaustion: Staff were forced to work back-to-back shifts,[109] or to start work earlier.[110] It was "*quite common*[111] to miss breaks, to work "*non-stop*",[112] and to eat meals at desks.[113] On the night, Mr Gibson was unable to take his break.[114] Having worked at "*quite an intense pace*" for 12 hours, he felt overwhelmed and fatigued,[115] and has since linked this to his failure to adhere to SOPs.[116] Mr Leat considered this overwork "*voluntary [and] nothing mandated by the organisation*".[117] He denied any link to understaffing,[118] dismissing Mr Gibson's inability to take his break as "*coastguards being coastguards… [wanting] to save life*",[119] and altered shift patterns as being for "*personal reasons.*"[120]

(b) The relevant authorities failed to train and supervise staff

52. The evidence bore out a failure to train staff in relation to small boats SAR. By 2018 it was "*quite evident [to HMCG] that it was an aspect of [SAR] operations we needed to focus on and make sure that we learned more about it to adapt as a [SAR] authority*",[121] and that HMCG were "*aware of all [the] different difficulties and challenges*" presented by small boat SAR.[122]

53. Resources deployed within HMCG to develop training and/or SOPs in respect of small boats were not focused on HMCG's primary lifesaving mandate. Staff were under pressure by senior leadership to develop an "*essential*"[123] SOP in relation to SAR termination. But, as Mr Leat confirmed, that document was intended to govern HMCG's actions under Operation Sommen.[124] While Mr Leat denied that resource put towards this had any impact on day-to-day operations,[125] Mr Papadopoulos

[107] Transcript, 12 March 2025, p.32, ln.11-13 (Mike Bill). See also Transcript, 13 March 2025, p.186, ln. 24 – p.187, ln.1 (Richard Cockerill).
[108] Transcript, 13 March 2025, p.186, ln.3-5 (Richard Cockerill).
[109] Transcript, 5 March 2025, p.31, ln.2-8 (Neal Gibson).
[110] Transcript, 17 March 2025, p.12, ln.2-5 (George Papadopoulos); 14 March 2025, p.188, ln.1-10, p.189, ln.22-24 (Richard Cockerill).
[111] Transcript, 17 March 2025, p.85, ln.19-21, 23-24 (George Papadopoulos).
[112] Transcript, 12 March 2025, p.21, ln.16 (Mike Bill).
[113] Transcript, 12 March 2025, p.21, ln.24 (Mike Bill).
[114] Transcript, 5 March 2025, p.48, ln.19-25 (Neal Gibson).
[115] Transcript, 5 March 2025, p.49, ln.5-6 (Neal Gibson).
[116] Transcript, 5 March 2025, p.165, ln.1-4 (Neal Gibson).
[117] Transcript, 24 March 2025, p.76, ln.10-15 (Matthew Leat).
[118] Transcript, 24 March 2025, pp.80-81 (Matthew Leat).
[119] Transcript, 24 March 2025, p.29, ln.14-15 (Matthew Leat).
[120] Transcript, 24 March 2025, p.76, ln.16-17 (Matthew Leat).
[121] Transcript, 17 March 2025, p.28, ln.19-22 (George Papadopolous).
[122] Transcript, 24 March 2025, p.14, ln.4-6 (Matthew Leat).
[123] INQ003385, "Training for Dover and Network for Migrant Protocol and SOP", p.1.
[124] INQ007381, Protocol for HMCG Termination of SAR, 13 September 2021; Transcript, 24 March 2025, pp.196-198 (Matthew Leat).
[125] Transcript, 24 March 2025, p.201, ln.8-10 (Matthew Leat).

confirmed that, as far as training was concerned, Operation Sommen was "*definitely one of the priorities*."[126] Time spent on it was time not spent on SAR training.

54. The lack of training, SOPs, and supervision meant non-standard practices were allowed to develop and fester; and that individual operators relied on their own subjective judgment and instincts in responding to distress calls. Improvised practices included: advising callers to hang up and call 999 as a means of identifying whether the call originated from within the UK Search and Rescue Region ("**UKSRR**") – an obviously flawed practice that arose from been "*shared ... verbally around the control room*";[127] the use of a standalone mobile phone that was not incorporated into HMCG's information management systems, nor any SOPs or guidance delivered to staff; and the failure to take steps to verify safety before an incident was closed.[128]

55. That HMCG staff relied on instinct to triage caller distress, leaving room for bias within decision-making and inconsistent and discriminatory outcomes. A stark example emerges from Mr Downs' phone call with a person believed to be on small boat incident *Charlie,* who stated that part of his body was in the water – Mr Downs told the Inquiry this was "*similar to other calls that night ... [and] on other occasions ... people say it quite often*".[129]

56. Remote coverage: HMCG were increasingly reliant on the use of remote coverage to mitigate staffing shortages at MRCC Dover. This was despite the fact that "*zone-flexing*" had been "*definitely identified as a challenge*".[130] Operational staff were unanimous in their evidence to the Inquiry that remote cover was no substitute for physical presence in the operations room.[131] Mr Downs explained that a remote SMC "*added another link in the ... communication to be done ... it took more resource to actually make the zone flexing part work. When it was perhaps there to assist, sometimes it actually made it more complicated.*"[132] Despite HMCG being aware of these challenges, no guidance or training was delivered to staff as to best practice and/or adaptations to be implemented where a remote SMC was used.[133]

57. Reflecting the disconnect between corporate leadership priorities and operational experience on the ground, MCA's corporate position was that "*the concept [of zone-flexing] absolutely works*",[134] and

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[126] Transcript, 17 March 2025, p.39, ln.23-24 (George Papadopoulos). See also INQ003294, "Small Boat Crossing HMCG/BF discussion", 11 August 2021.
[127] Transcript, 13 March 2025, p.98, ln.13-14 (Stuart Downs).
[128] Mr Downs' said that it was not feasible or useful to attempt to contact the numbers associated with incidents before closure (INQ010208, Witness Statement of Stuart Downs, §120). This was also the view expressed by MCA's corporate witness (INQ010098, §1.30). However, Mr Papadopoulos' said that as SMC he would have expected staff to make such attempts before closing any incidents (Transcript, 17 March 2025, p.89, ln.1-7 (George Papadopoulos)).
[129] Transcript, 13 March 2025, p.154 ln.21-24 (Stuart Downs).
[130] Transcript, 12 March 2025, p.20, ln.23-24 (Mike Bill). See also p.20, ln.16-17 ("*certainly appeared to be a problem*"); p.20, ln.21-23 (incident during which a remote SMC "*lost control*" of an operation).
[131] Transcript, 5 March 2025, pp.8-9, ln. 23-25, 1-3 (Neal Gibson); 12 March 2025, p.75, ln.1-2 (Christopher Barnett); 17 March 2025, p.8, ln.23-25 (George Papadopoulos).
[132] Transcript, 13 March 2025, p.116, ln.12-14, 20-22 (Stuart Downs).
[133] Transcript, 13 March 2025, p.114, ln.14-17 (Stuart Downs).
[134] Transcript, 24 March 2025, p.70, ln.1-2 (Matthew Leat).

was and remains "*absolutely vital to ensure that [HMCG] can deliver the best service to the public*".[135] The Inquiry heard that over 50% of HMCG's work in respect of small boat SAR between 2018 and 2024 was led by remote SMCs.[136]

(c) The available assets were inadequate for the task at hand

58. BF assets were unsuitable for small boat SAR: Despite this, Border Force responded to 89% of small boat SAR events at the time.[137] Mr O'Mahoney stated that cutters used by Border Force were "*not particularly stable*",[138] a feature which posed challenges for the embarkation of people from small boats, particularly in challenging sea conditions.[139] Mr Toy agreed that Border Force's assets were not designed or equipped to carry out mass rescue operations from small boats.[140] Mr Toy drew on his experience (rather than on any training) to plot a search area.[141] There is also a stark contrast with the evidence as to the specialised training provided by RNLI to its crews.[142] As RNLI's Head of Lifeboats put it, the role played by Border Force crews in SAR operations was "*a lot to ask*" of mariners who had not received any training in SAR.[143]

59. Delay in tasking the *Valiant*: The *Valiant* was not tasked until 01:30, 15 minutes after *Charlie* was opened as a distress incident, and 30 minutes after HMCG was aware of at least three small boats entering UK waters. It could and should have been tasked sooner. As Mr Toy told the Inquiry, "*[t]he sooner we can get moving, the sooner we can get to the position*".[144]

60. Valiant had insufficient capacity: The *Valiant*'s maximum safe capacity of 100 passengers was insufficient for the 110 people Mr Gibson knew required rescue. Mr Gibson was aware that he was "*pushing our luck for the Valiant*".[145] His hope that "*[f]ingers crossed the French can't count*"[146] demonstrated a lack of professionalism and prioritisation of safety of life.

61. In any event, Mr Gibson denied that the above amounted to a good reason to deploy an additional asset. Instead, it was his view, based on a focus on "*efficiency*" in the use of available assets , that consideration should only have been given to tasking an additional Border Force asset if there was reason to believe that an additional 40 people (i.e. a total of 150 people) needed rescue – which would have amounted to one and a half times the *Valiant*'s maximum capacity. In fact, the *Valiant*

[135] Transcript, 24 March 2025, p.71, ln.16-18 (Matthew Leat).
[136] Transcript, 24 March 2025, p.64, ln.12-14 (Matthew Leat).
[137] INQ010134, Witness Statement of Daniel O'Mahoney, §4; Transcript, 20 March 2025, pp.13-14 (Daniel O'Mahoney).
[138] Transcript, 20 March 2025, p.169, ln.4 (Daniel O'Mahoney).
[139] Transcript, 20 March 2025, p.81, ln.14-23 (Daniel O'Mahoney).
[140] Transcript, 10 March 2025, p.31 ln.8-12 (Kevin Toy).
[141] Transcript, 10 March 2025, pp.109-110 (Kevin Toy).
[142] See, for e.g., INQ010101, Witness Statement of Simon, Ling, §§16-21.
[143] Transcript, 18 March 2025, p.54, ln.16-24 (Simon Ling).
[144] Transcript, 10 March 2025, p.82, ln.2-3 (Kevin Toy).
[145] INQ007602, Transcript of call between Neal Gibson and Thomas Willows, 03:11, p.4.
[146] Ibid.

rescued 98 persons on the night. If it had located *Charlie,* there would not have been the capacity to safely embark all those in need of rescue.

62. Availability of Border Force assets: The Inquiry has heard concerns as to the capacity of Border Force to provide 24/7 SAR cover to HMCG. Mr Whitton told the Inquiry that Border Force lacked sufficient assets relative to operational demand and that "*[t]here just wasn't enough capability to support the whole SAR response, of which we were only part*".[147] Mr Toy's team was under considerable pressure and "*overstretched*" in light of the limited scope for rotation of assets at the relevant time.[148] He personally felt overwhelmed and under extraordinary stress, both of which had taken their toll.[149] He told the Inquiry that more assets – of any type or configuration – were urgently needed: "*anything would have helped*."[150] Mr James Crane, Team Leader and qualified SMC, considered that the situation was "*simply not sustainable.*"[151]

63. Mr Whitton told the Inquiry that while Border Force had identified a need to increase the number of assets, no steps had been taken in this regard.[152] There was a lack of urgency on the part of Border Force, informed by the view that "*the Home Office was not responsible for [SAR]*".[153] This had two key consequences. First, there was insufficient resource to meet operational demand. Mr Crane's evidence from the day shift of 24 November 2021 was that when the *Valiant* was forced to return to Ramsgate following a technical fault,[154] he was left without adequate surface assets to maintain operational control of the Channel.[155] Second, an attitude developed within Border Force MCC and HMCG that the preservation of assets was a legitimate consideration in the conduct of small boat SAR operations.

64. Failure to task RNLI: The failure to task RNLI was a grave error by Mr Gibson. All three RNLI stations serving the Dover Strait were operational on the night,[156] and were available to HMCG for tasking.[157] Notwithstanding Mr Gibson's evidence regarding the need to "*preserve finite resources*",[158] there were no unusual resource pressures on RNLI.[159] While Mr Gibson conceded that RNLI craft were faster than Border Force assets, his view remained that "*the arrival time on scene would probably have been quite similar.*"[160] However, if RNLI assistance had been requested, Mr Simon Ling, Head of Lifeboats, confirmed that a lifeboat could have been deployed to arrive at

[147] Transcript, 20 March 2025, p.81, ln.2-3 (Stephen Whitton OBE).
[148] Transcript, 10 March 2025, p.2, ln.7-8 (Kevin Toy).
[149] Transcript, 10 March 2025, p.23, ln.21-22; p24, ln.4-9 (Kevin Toy).
[150] Transcript, 10 March 2025, p.23, ln.7 (Kevin Toy).
[151] INQ003735, Observations from 24/11/2021, 26 November 2021.
[152] Transcript, 20 March 2025, p.41, ln.5-9, 20-25 (Stephen Whitton OBE).
[153] Transcript, 20 March 2025, p.42, ln.1-2 (Stephen Whitton OBE).
[154] INQ010142, Witness Statement of James Crane, §64.
[155] Transcript, 12 March 2025, p.146, ln.7-11 (James Crane). See also INQ003735, in which Mr Crane identified a need for more resources within Border Force to ensure adequate 24/7 SAR coverage.
[156] Transcript, 18 March 2025, p.85, ln.1-5 (Simon Ling).
[157] Transcript, 12 March 2025, p.177, ln.17-21 (David Jones).
[158] Transcript, 5 March 2025, p.129, ln.8 (Neal Gibson).
[159] Transcript, 18 March 2025, p.86, ln.11-17 (Simon Ling).
[160] Transcript, 5 March 2025, p.130, ln.7-10 (Neal Gibson).

the median line within 63 minutes (*cf.* the *Valiant*'s response time of over 110 minutes).[161] Mr Gibson considered that RNLI craft were "*limited by survivor capacity*",[162] but the Inquiry has had no reasonable explanation for why RNLI was not tasked in addition to the *Valiant*.

(d) HMCG failed to declare a major incident, make a request for military aid to the civil authorities, or conduct risks assessments and emergency planning in breach of its duties under the Civil Contingencies Act 2004

65. As the Inquiry is aware, a major incident within the framework of the CCA was not declared in connection with small boats in the English Channel: not in the summer of 2021, when Mr Bill was raising the alarm,[163] and not in November 2021.

66. The Inquiry is invited to scrutinise closely the reasoning underpinning this decision. The MCA's corporate position, expressed through Mr Leat, was that the threshold to declare a major incident was "*nowhere near being close to met*" at the time of the incident in November 2021.[164] That, however, was not the view on the ground, as expressed by Mr Bill in August 2021, who was clear that the threshold had been met.[165] HMCG's Major Incident Plan identifies the "*search for, or rescue of, large numbers of people from (for example) … many small craft in distress simultaneously in a geographic region*" as a potential major incident.[166]

67. **First**, the decision not to declare a major incident had clear political motivations. Mr Bill was candid about his understanding that the Home Office would not have welcomed HMCG declaring a major incident due to the risk of bad press.[167] HMCG noted in August 2021 that "*if we do declare [a major incident], the political ramifications could be significant.*"[168] Concern about political fallout and negative headlines was not an acceptable reason for failing to declare a major incident in circumstances in which the threshold was otherwise met.

68. **Second**, both Mr Leat and Mr Bill considered that declaring a major incident would have been futile, because there was nothing useful which could be offered by way of external support. Indeed, Mr Bill suggested it would have been "*pointless*" because "*they didn't have vessels, they didn't have aircraft. All they could offer us was support on land and on land wasn't the issue*".[169] If and to the extent that view is correct, the CCA (which was not enacted with maritime legal obligations in mind) is not an adequate framework for emergency operational planning and preparedness in the maritime

[161] INQ010739, Second Witness Statement of Simon Ling, §11.
[162] Transcript, 5 March 2025, p.128, ln.25 (Neal Gibson).
[163] INQ003322, Migrant Activity, 17 August 2021.
[164] Transcript, 25 March 2025, pp.36-38 (esp. p.38, ln.7-9) (Matthew Leat).
[165] INQ003322, Migrant Activity, 17 August 2021; Transcript, 12 March 2025, p.24, ln.16-20. See also Transcript, 13 March 2025, p.110, ln.7-13 (Stuart Downs).
[166] INQ000415, Major Incident Plan (version 3), October 2020.
[167] Transcript, 12 March 2025, pp.24-25 (Mike Bill).
[168] INQ003379, Migrant Activity Debrief, p.1.
[169] Transcript, 12 March 2025, p.26, ln.11-16 (Mike Bill).

SAR context. Consideration could and should have been given to a context-specific maritime and SAR statutory framework.

69. **Third**, the MCA is a Category 1 Responder listed in Schedule 1 CCA, and has a duty to assess, plan, and advise on the risk of an emergency occurring (s 2). A mass casualty event in UK waters plainly meets the definition of an "*emergency*", but HMCG's Major Incident Plan was scant on detail for how to respond.[170] There is no evidence of an assessment, in accordance with the above, of the risk of an emergency in the context of small boats or whether the Major Incident Plan required modification in view of the unique challenges of small boat SAR. Where the risks of an emergency were obvious, that lack of planning is contrary to the prevention duty (s 2(1)(d)), which in this context means "*carrying out the functions of the organisation in such a way as to prevent an emergency which is imminent, or which might be predicted, from occurring at all*".[171]

70. A further option open to the MCA was a request for military aid to the civil authorities ("**MACA**"). Ultimately, the Ministry of Defence ("**MOD**") were called upon and assumed operational primacy in relation to small boats from 14 April 2022 to 31 January 2023 under Operation Isotrope.[172] No such requests were made of the MOD in November 2021,[173] despite MACA being an appropriate response where, as here, "*civil capabilities and capacities are overwhelmed by an incident*".[174] The benefits which accrued from MOD operational primacy from April 2022 were significant. During Operation Isotrope, there were only seven uncontrolled beach landings, compared to 39 in 2021.[175] The MoD's involvement resulted in (*inter alia*) a "*coherent command, control and communication structure to the multi-agency... operation*"[176] and the provision of additional Crew Transfer Vessels ("**CTVs**") to Border Force for use in conducting SAR operations.[177]

71. To the best of Mr Leat's knowledge, the MCA did not consider utilising MACA prior to the incident.[178] While "*stretched*", he considered that HMCG was "*coping*"[179] and was "*not overwhelmed.*"[180] That contention is unsustainable. At a minimum, consideration ought to have been given to whether to make a MACA request.

(2) Cooperation and information sharing with other stakeholders

(a) Failure to clarify the role of Border Force in SAR missions

72. As outlined above, there was a dissonance between Border Force's law enforcement function and its role in SAR operations. A muddled picture emerged in oral evidence as to the delineation of

[170] INQ000415, Policy – Major Incident Plan v3 HMCG, October 2020.
[171] Cabinet Office, Chapter 5 (Emergency Planning), Revision to Emergency Preparedness, October 2011, §5.3.
[172] INQ009649, Witness Statement of Jennifer Armstrong, §1.8.
[173] Ibid., §1.6.
[174] INQ008935, Joint Doctrine Publication 02: UK Operations: the Defence Contribution to Resilience, p.17, §1.2.
[175] INQ009649, Witness Statement of Jennifer Armstrong, §7.4.
[176] INQ008948, Op Isotrope – Return of HMG's Counter Small Boats Operation to the Home Office, p.1.
[177] INQ009649, Witness Statement of Jennifer Armstrong, §7.8.
[178] Transcript, 24 March 2025, p.43, ln.23 (Matthew Leat).
[179] Transcript, 24 March 2025, p.44, ln.4-5 (Matthew Leat).
[180] Transcript, 24 March 2025, p.44, ln.23 (Matthew Leat).

responsibility between HMCG and Border Force. Mr Whitton and Mr O'Mahoney explained that Border Force had three different types of maritime assets with differing capabilities.[181] Selecting the most appropriate asset for a SAR mission fell outside Border Force MCC's remit;[182] Ms Whitehouse confirmed that information as to whether a boat was swamped or taking on water would not make any difference to the Border Force response.[183] However, there was no suggestion from Mr Whitton that HMCG could themselves select the most appropriate BF asset,[184] leaving a lacuna in the tasking process, with no consideration given to asset suitability.

73. Ms Whitehouse explained that a second Border Force asset was not tasked on the night simply because HMCG never requested it.[185] However, Mr Willows took an active role in dissuading HMCG from tasking a further vessel. When Mr Gibson explained that there was believed to be four boats in the Sandettie area, Mr Willows responded "*we don't want to call any other assets out just yet.*"[186] This is consistent with his belief that small boats crossing the Channel "*weren't necessarily in distress*" even if they were classified as such by HMCG.[187] Border Force MCC staff were not trained in risk assessment or incident triage.[188]

74. Border Force MCC were tasked with issuing a "*Mike*" or "*M*" number for each rescued vessel, but their role in updating the shared tracker to record this information against an incident was unclear.[189] In oral evidence, Mr Crane said that Border Force MCC's failure to fill in the shared tracker left HMCG "*asking more questions of who's got what, what are the numbers, how many have we picked up*",[190] which posed challenges to HMCG's ability to reconcile boats. Mr Papadopoulos accepted that there was scope for error where Border Force MCC were not in contact with HMCG, who had to decide to which incident the M number related.[191] Ms Whitehouse struggled to confirm whether Border Force MCC even had editing access to the tracker.[192] Mr Bill had not heard anything about Border Force MCC being supposed to enter the M numbers,[193] and Mr Christopher Barnett's recollection was that HMCG would enter the *M* number themselves.[194]

(b) Failures in information sharing between HMCG and the Home Office/Border Force

75. Preparation for periods of increased small boat activity were hampered by poor cross-departmental coordination and intelligence sharing. Crucial intelligence received by the CCTC estimating that

[181] Transcript, 20 March 2025, pp.56-57 (Stephen Whitton OBE); p.121 (Daniel O'Mahoney).
[182] Transcript, 20 March 2025, p.70 (Stephen Whitton OBE).
[183] Transcript, 11 March 2025, p.22 (Karen Whitehouse).
[184] Transcript, 20 March 2025, p.70 (Stephen Whitton OBE).
[185] Transcript, 11 March 2025, p.84 (Karen Whitehouse).
[186] INQ007602, Transcript of call between MRCC Dover and Border Force MCC at 03:11.
[187] Transcript, 13 March 2025, p.17, ln.16-17 (Thomas Willows).
[188] Transcript, 13 March 2025, pp.16-18, ln.21-25, 1-25, 1-21 (Thomas Willows); 11 March 2025, p.24, ln.4-17 (Karen Whitehouse).
[189] See, for e.g., INQ003735, Email exchange between George Papadopoulos and James Crane, 24 November 2021.
[190] Transcript, 12 March 2025, p.134, ln.21-24 (Christopher Barnett).
[191] Transcript, 17 March 2025, p.65 (George Papadopoulos).
[192] Transcript, 11 March 2025, pp.36-38 (Karen Whitehouse).
[193] Transcript, 12 March 2025, p.43 (Mike Bill).
[194] Transcript, 12 March 2025, p.71, ln.8-14 (Christopher Barnett).

"*hundreds*" of people were expected to attempt to cross between 22:00-06:00 on 23/24 November was not relayed to the Border Force MCC.[195] Ms Whitehouse confirmed that until this Inquiry she had never heard of RVL, which was tasked by the Home Office to complete an intelligence-gathering surveillance flight on the night of the incident.[196] Mr Jones confirmed that there were no channels through which Border Force would provide information to him, as Maritime Tactical Commander, about the number of crossings predicted.[197]

76. The arrangement between HMCG and Border Force during a busy shift relied on timely information sharing via phone calls, as well as accurate recording keeping. Ms Whitehouse accepted that the plan[198] to deploy a Border Force vessel to meet a small boat as it entered the UKSRR required precise information from HMCG, which Border Force MCC "*didn't often have*"[199] and that "*information would sometimes be everything all at once, or nothing for a considerable time.*"[200] On the night of the incident, Border Force MCC received coordinates too late to task a vessel in time for this plan to work.[201] There was an approximately 80-minute delay between HMCG receipt of information relating to small boat activity in the Channel and provision of information to Border Force MCC.[202] Mr Gibson could not confirm whether he could request Border Force assets to be tasked proactively.[203] The *Valiant*'s tasking was delayed until Mr Downs estimated that *Charlie* was "*in UK waters*", at which time Mr Willows responded that he would "*look at getting an asset tasked to it then if it's in UK waters*".[204] Mr Willows admitted in oral evidence that he did not check HMCG's tracker during the first 6 hours of his shift.[205]

77. Crucial information was not recorded in the tracker. HMCG were aware from calls received that women and children were on board *Charlie*,[206] but this was never recorded against the incident. Nor was other important identifying information, such as the state of distress or updated estimates of the number of people on board.

78. Border Force witnesses were quick to distance themselves from the task of reconciling rescued boats with live incidents; as Ms Whitehouse explained, "*it wasn't my job to delve further.*"[207] Considering this, the process by which HMCG expected Border Force to input the M number against an incident remains unclear. The Inquiry has heard that the M number was incorrectly inserted into both the shared tracker and Border Force live update case register. The termination of

[195] Transcript, 11 March 2025, pp.46-47 (Karen Whitehouse).
[196] Transcript, 11 March 2025, p.84 (Karen Whitehouse).
[197] Transcript, 12 March 2025, p.175 (David Jones).
[198] Transcript, 11 March 2025, pp.10-11(Karen Whitehouse).
[199] Transcript, 11 March 2025, p.15, ln.21-25 (Karen Whitehouse).
[200] Transcript, 11 March 2025, p.12, ln.15-17 (Karen Whitehouse).
[201] Transcript, 11 March 2025, p.56, ln.1-10 (Karen Whitehouse).
[202] Transcript, 11 March 2025, p.56 (Karen Whitehouse); INQ001201, Email from CROSS Gris-Nez to HMCG.
[203] Transcript, 5 March 2025, pp.64-65 (Neal Gibson).
[204] INQ007648, Transcript of call between MRCC Dover and Border Force MCC, 01:20, p.3.
[205] Transcript, 13 March 2025, pp.38-39, ln.11-25, 1-15 (Thomas Willows).
[206] INQ007655, Transcript of call at 02:31; INQ007657 Transcript of call at 03:06.
[207] Transcript, 11 March 2025, p.20 (Karen Whitehouse).

the search for *Charlie* is considered in greater detail below, however it is clear that *had* the shared tracker contained detailed and accurate information pertaining to the incident, and had information been properly gathered and recorded in relation each rescued boat, the erroneous belief that *Charlie* had been rescued could have been prevented.

79. The evidence reveals a web of fragmented communication channels between the CCTC, Border Force MCC, and HMCG. This was a symptom, not just of the absence of a governing framework, but of an overreliance on a branch of the Home Office untrained in SAR and fundamentally ill-equipped to provide resourcing to SAR missions. As Mr O'Mahoney made clear, the Home Office held, and continue to hold, no formal responsibility for SAR.[208]

(3) Situational awareness and preparedness on the night

(a) Delays in obtaining the French tracker

80. Far more than a "*bonus*" or "*little bit of a heads-up*",[209] the French tracker was a vital means of ascertaining the maritime picture. It "*identified all the incidents that had started in France and were heading towards the UK waters*",[210] and if provided promptly, enabled HMCG to better prepare for the incoming distress incidents.[211] Mr Downs confirmed the "*common*" nature of delays in receiving the tracker.[212] His relaxed attitude to this reflected a lack of urgency and failure to understand the importance of this issue.[213] Although he speculated in evidence that he might have,[214] there is no evidence that Mr Gibson or any other personnel requested the French to provide the tracker. It was not received until 00:56.[215] Even then, it appears the information took some time to filter through HMCG, with Mr Golden observing at 02:04: "*the French are now reporting to us that [there] are upwards of at least 11 vessels ... on their way across... they forgot to tell us until just now.*"[216] The evidence demonstrated HMCG did nothing to mitigate the (commonplace) delay in receiving the tracker on the night.

(b) Over-reliance on and operational failures of 2Excel

81. 2Excel was the "*Plan A*"[217] and "*normal de facto solution*"[218] for aerial surveillance. However, it presented a reliable solution if and only if it was able to fly: the simple fact was that "*[i]f we can't fly, we can't provide the picture.*"[219] HMCG recognised the serious "*consequences of non-delivery*"

[208] Transcript, 20 March 2025, p.139 (Daniel O'Mahoney).
[209] Transcript, 5 March 2025, p.60 (Neal Gibson).
[210] Transcript, 12 March 2025, p.22 (Mike Bill).
[211] Transcript, 5 March 2025, p.60 (Neal Gibson).
[212] Transcript, 13 March 2025, pp.130, ln.24 – p.131, ln.1 (Stuart Downs).
[213] Transcript, 13 March 2025, p.130 (Stuart Downs).
[214] Transcript, 5 March 2025, p.64 (Neal Gibson).
[215] INQ001201, Point Migrant Gris-Nez, 24 November 2021 at 00:56.
[216] INQ007824, Transcript of call between 2Excel Pilot and ARCC at 02:04 on 24 November 2021.
[217] Transcript, 11 March 2025, p.136 (Dominic Golden).
[218] INQ007824, Transcript of call between 2Excel Pilot and ARCC at 02:04 on 24 November 2021.
[219] Transcript, 6 March 2025, pp.51-53 (Christopher Norton).

– namely, that it would "*[b]e detrimental to the building and analysis of the Maritime Domain Awareness Picture*".[220]

82. On 24 November 2021, Mr Golden recognised that HMCG had "*dropped back into the assumption that we're always going to get aircraft, and they're always going to give us the recognised maritime picture ... you know, life's a good one. And surprise surprise ... the plan doesn't always work. So what's our plan B?*"[221] This was a rhetorical question. There was no Plan B – 2Excel was the "*only plan for aviation patrolling aircraft that night*".[222] As Mr Golden accepted, "*whether they are going to fly or not, there is very little I can do at this point to change any plans*".[223] When Plan A failed following the cancellation of the 2Excel fixed-wing flights at 23:53 on 24 November 2021, the consequence was clear: "*[w]e've got no recognised maritime picture out there*."[224]

83. For its part, 2Excel was aware from at least 20:01 on 23 November 2021 that there was a risk that weather would prevent completion of the taskings, but failed to raise this with HMCG at the relevant time.[225] Instead, Mr Golden was assured that "*[w]e should have it pretty covered*",[226] when in fact "*the weather forecasts were getting worse, so [2Excel] knew there was risk*".[227] Mr Christopher Norton, Accountable Manager at 2Excel, understood – or rather, assumed – that "*that risk would be articulated*" to HMCG, but ultimately, was unable to identify any evidence that was done.[228]

(c) Decisions not to task RVL / Tekever

84. Despite the lack of aerial surveillance, two aerial assets *that were* operating in the relevant area on the night were not tasked to assist. The first was an RVL fixed-wing aircraft, which was flying for surveillance purposes in the vicinity of the *Valiant* between 22:05 and 04:25.[229] The second was a Tekever unmanned aerial vehicle ("**UAV**"), contracted at the relevant time by the Home Office, which was tasked to fly (and did in fact fly) between 22:05 and 04:25.

85. Neither of the above were re-tasked. Mr Golden considered re-tasking the RVL fixed-wing "*very briefly*" but concluded "*very quickly in [his] head*" that they were "*flying on behalf of another Government department, the Home Office*", were "*already briefed*" and "*not at alert*",[230] and in any event, that their crew were not "*competent or qualified to fly the sort of patrol that we would be*

[220] INQ000148, Air Asset Tasking Reform Form (HMCG Op EOS) MCA 719, p.3.
[221] INQ007824, Transcript of call between 2Excel Pilot and ARCC at 02:04 on 24 November 2021.
[222] Transcript, 11 March 2025, pp.135-136 (Dominic Golden).
[223] Transcript, 11 March 2025, pp.135-136 (Dominic Golden).
[224] INQ007824, Call between 2Excel Pilot and Dominic Golden at 02:04 on 24 November 2021.
[225] Transcript, 6 March 2025, p.40 (Christopher Norton); 11 March 2025, p.134 (Dominic Golden); INQ000224, Incident Log.
[226] INQ008827, Transcript of call between 2Excel and ARCC at 08:01 on 23 November 2021.
[227] Transcript, 6 March 2025, p.40 (Christopher Norton).
[228] Transcript, 6 March 2025, p.40 (Christopher Norton).
[229] INQ010409, Witness Statement of Neil Honeyman, 15 January 2025, §17.
[230] Transcript, 11 March 2025, pp.145-146 (Dominic Golden).

looking for at night at low level".[231] Neither Mr Jones[232] nor Mr Gibson[233] were even aware that RVL was operating in the area that night. Mr Golden also had an emergency call-out number but did not attempt to contact Tekever. He said any request would have been futile.[234] Mr Jones confirmed that Tekever "*could have been requested to move their planned taskings*" earlier in the evening, but he does not recall any discussion of requesting Tekever to do so.[235]

(4) Communication failures between the Coastguard and small boats

(a) Call handling, including inadequacy of information requested and provided

86. The catalogue of failures in call handling, including in relation to information requested, information provided, and the monitoring of all relevant call lines, were addressed in the written opening (§§24-25). The oral evidence only confirmed the nature and extent of those failures. Critical among them, there was no system or standard practice in place to enable the identification of multiple calls originating from the same small boat. Callers were not given a reference number or any other information by which to identify themselves to operators. Staff did not consistently ask callers to share their geolocation via WhatsApp, or even for their names – vital information which would plainly have assisted in correlating cases.[236] In practice, staff relied on either their instincts or sheer luck to identify repeat callers, with varying degrees of success.[237] As a result, MRCC Dover frequently failed to correlate calls, and at times, opened so many incidents that they would go "*through the alphabet three or four times*".[238]

(5) Adequacy of the SAR operation

(a) Mayday relay

87. Mr Gibson took the unprecedented decision in the context of small boat crossings to broadcast a Mayday relay. In his witness statement he explained that this was based on his "*gut feeling*" after hearing the "*level of shouting and panic in people's voices.*"[239] But in oral evidence he said, for the first time, that the Mayday was used as a mechanism to obtain "*some sort of visual confirmation of what the level of distress was.*"[240] If the Inquiry finds Mr Gibson did use a Mayday relay "*to get eyes on*"[241] *Charlie*, that constitutes a breach of SOLAS Regulation 35 of Chapter V.[242]

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[231] Transcript, 11 March 2025, pp.145-146 (Dominic Golden).
[232] Transcript, 12 March 2025, p.204 (David Jones).
[233] Transcript, 5 March 2025, p.75 (Neal Gibson).
[234] Transcript, 11 March 2025, pp.154-155(Dominic Golden).
[235] Transcript, 12 March 2025, p.204 (David Jones).
[236] See, for e.g., Transcript, 5 March 2025, p.133 (Neal Gibson); 13 March 2025, p.155 (Stuart Downs).
[237] See e.g. Transcript, 5 March 2025, p.113, ln.18-25 (Neal Gibson); cf. 13 March 2025, p.150, ln.8-15 (Stuart Downs).
[238] Transcript, 12 March 2025, p.96, ln.2 (Christopher Barnett).
[239] INQ010392, Witness Statement of Neal Gibson, §90.
[240] Transcript, 5 March 2025, p.85 (Neal Gibson).
[241] Transcript, 5 March 2025, p.85 (Neal Gibson).
[242] "*[T]he use of an international distress signal, except for the purpose of indicating that a person or persons are in distress... are prohibited.*" Annex IV of the International Regulations for Preventing Collisions at Sea contains a similar prohibition.

88. Mr Gibson hoped that the *Flamant* would respond to the Mayday relay.[243] He accepted that he could have made a direct request to CROSS Gris-Nez to task their vessel to assist, but felt that "*instructing a foreign military asset to comply with an instruction*" was "*probably not something I thought I should tell them to do*".[244] Mr Jones admitted that he "*wasn't aware*" that HMCG could directly request that CROSS Gris-Nez deploy the *Flamant*.[245] These are significant failures to understand SAR obligations. Pursuant to Article 35 of the ManchePlan, "*any assets belonging to a State Party may be requested by the other State Party.*" Mr Leat reluctantly accepted that "*perhaps*" Mr Gibson had not been clear enough during his call with CROSS Gris-Nez.[246] By Mr Gibson's calculation, the *Flamant* was only 15 minutes away from incident *Charlie* at 02:28,[247] meaning it could have arrived on scene some 45 minutes before the *Valiant*. Not enough was done to ensure it responded.

89. Mr Jones confirmed there was a failure to make him aware of the Mayday relay.[248] Had he been made aware, he would have "*looked a little bit more into the incident to see what the mission plan was and what was going to be done to prosecute that mission.*"[249] That, and the fact the relay did not use the most up to date coordinates, were failures on Mr Gibson's part.

90. Most seriously, however, Mr Gibson terminated the Mayday relay without any adequate justification, contrary to his own understanding that the "*usual*" procedure for termination would be when "*the emergency situation ceases to be.*"[250] Mr Papadopoulos expressed his surprise that the Mayday relay was terminated before the *Valiant* had located any small boat.[251] That appears to constitute a straight breach of Chapter 5 of the SAR Convention, as set out at §112 below.

91. The final Mayday relay was broadcast at 03:20. Professor Tipton's view was the majority of the occupants of the boat were alive just 4 minutes later, at 03:24.[252] At 03:39, Mr Gibson terminated the Mayday relay. His actions were totally inconsistent with his initial "*grave and imminent concern*"[253] about the safety of the occupants of incident *Charlie*.

(b) Communication between Dover MRCC, Border Force MCC and the Valiant

92. Both HMCG and Border Force MCC had channels of communication with Mr Toy during the SAR mission. However, Mr Toy was not informed of crucial information:

[243] Transcript, 5 March 2025, p.107 (Neal Gibson).
[244] Transcript, 5 March 2025, p.125 (Neal Gibson).
[245] Transcript, 12 March 2025, p.217 (David Jones).
[246] Transcript, 24 March 2025, p.165 (Matthew Leat).
[247] Transcript, 5 March 2025, p.107 (Neal Gibson).
[248] Transcript, 12 March 2025, p.217 (David Jones).
[249] Transcript, 12 March 2025, p.215 (David Jones).
[250] Transcript, 5 March 2025, p.109 (Neal Gibson).
[251] Transcript, 17 March 2025, p.79 (George Papadopoulos).
[252] INQ010283, Report by Professor Tipton, 8 December 2025, §4.10
[253] Transcript, 5 March 2025, p.102 (Neal Gibson).

93. **First**, the "*primary*" information the *Valiant* required was the last known co-ordinates of the small boat it was tasked to rescue,[254] yet updated location data received via WhatsApp from small boat incident *Charlie* at 02:20 and 02:21 was never relayed.

94. **Second**, Mr Toy was aware that small boat incident *Charlie* was "*taking water*".[255] Mr Whitton accepted that a SAR mission would be "*wholly different*" if a small boat was taking on water or if people were already in the water.[256] However, even once Mr Gibson had been informed by CROSS Gris-Nez of reports that people were "*in the water*"[257] and Mr Willows appraised that the boat was "*full of water*",[258] this was not relayed to Mr Toy. In fact, Mr Toy could not remember a time when the urgency of a tasking had been stressed to him.[259]

95. **Third**, key identifying information, such as the composition of the boat, the number of people wearing lifejackets, and number of boats requiring rescue in the Sandettie area, was never communicated to Mr Toy.[260] Key questions essential to ascertaining *which* boats had been rescued were never asked. Mr Toy explained he did not ask the occupants of the first boat if anyone was named Mubin, despite the request from HMCG, because he "*wanted the officers to concentrate on rescuing the people.*"[261] He had not been told how important the information was. When asked by Ms Whitehouse "*how many migrants did you embark for incident Charlie*", Mr Toy confirmed "*three and five*".[262] When questioned about whether this could have been interpreted by Border Force MCC as confirmation that *Charlie* had been rescued, Mr Toy explained that he had "*hoped*" Border Force MCC and HMCG "*would be 'talking together --- to sort that out'*"[263] and had "*assumed ... they had worked out with the information they had and come to that conclusion.*"[264]

(c) Communication between Dover MRCC, the ARCC and R163

96. Helicopter R163 was not provided with the essential information it required to enable its crew to conduct an effective search. The IAMSAR manual emphasises the importance of briefing air search personnel, stating expressly that the briefing should include "*a full description and nature of the distress*".[265] Mr Gibson accepted that he never communicated the requirement to search for people in the water to the ARCC or Christopher Trubshaw, Captain of R163, directly.[266] Mr Golden explained that the practical impact of Dover MCC and ARCC using incompatible ViSION systems

[254] Transcript, 10 March 2025, pp.63-64 (Kevin Toy).
[255] Transcript, 10 March 2025, p.87 (Kevin Toy).
[256] Transcript, 20 March 2025, p.101 (Stephen Whitton OBE).
[257] INQ007656, Transcript of call between CROSS Gris-Nez and HMCG at 02:42 on 24 November 2021.
[258] INQ007602, Transcript of call between Thomas Willows and Neal Gibson at 03:11 on 24 November 2021.
[259] Transcript, 10 March 2025, p.39 (Kevin Toy).
[260] Transcript, 10 March 2025, pp.115,131 (Kevin Toy).
[261] Transcript, 10 March 2025, p.130 (Kevin Toy).
[262] INQ00762, Transcript of call between Border Force MCC and *Valiant* at 05:04 on 24 November 2021.
[263] Transcript, 10 March 2025, p.132 (Kevin Toy).
[264] Transcript, 10 March 2025, p.138 (Kevin Toy).
[265] IAMSAR Vol II Chapter 5, §5.15.
[266] Transcript, 5 March 2025, p.138 (Neal Gibson); INQ010392, Witness Statement of Neal Gibson, §§153, 174.

at the time was that the ARCC was only privy to details about an incident which the latter chose to share.[267] R163's initial tasking was "*non-specific*" (i.e. to "*go and see what we could see*").[268]

97. The IAMSAR manual contains detailed and comprehensive guidance about the processes to be followed when determining a search area. The search calculations are exacting and rely on the search planner calculating the "*possibility area*", which is the smallest area containing all possible locations allowing for position error, survivor motion after the distress incident, and maritime drift.[269] It is unsurprising, then, that had Mr Trubshaw been informed about the prospect of people in the water, he would have changed R163's search point and pattern.[270]

98. The IAMSAR manual is clear that the number of accurate computations which can be done by the search planner without a computer are "*necessarily quite limited.*"[271] Mr Gibson admitted in oral evidence that he did not model for drift at all, instead relying exclusively on his opinion[272] and his own mental calculation.[273]

99. The IAMSAR manual contains recommended track spacings and a specific formula used to calculate them, based on the variables of the search. Mr Gibson accepted in oral evidence that track spacing was "*very much*" contingent on what the aircraft was seeking to locate.[274] However, in the absence of any indication that there were people in the water, R163 used a track spacing of 0.7nm, which, according to the IAMSAR formula, was suitable for locating a boat of 10m, not people in the water.[275] While in oral evidence Mr Trubshaw was insistent that 0.7nm was the minimum track spacing the R163 could take,[276] his supplementary statement conceded that the R163 could have used a track spacing of 0.2nm which would have allowed for an "*incredibly intensive*" saturation of an area.[277] When asked whether reference was made to any guidance or documents when determining the appropriate track spacing, Mr Trubshaw replied, "*at that point in the morning, no.*"[278] The MAIB report found that with a track spacing of 0.7nm the "*chance of detecting those in the water was negligible unless the helicopter flew almost directly over them.*"[279]

100. Despite the clear limitations in R163's search, Mr Gibson took the view that the nil return was a reliable basis on which to conclude that "*the emergency situation that i believed to be there no longer existed.*"[280] The Inquiry has heard Mr Graham Hamilton's view that radar had "*very low*

[267] Transcript, 11 March 2025, p.109 (Dominic Golden).
[268] Transcript, 6 March 2025, p.123 (Christopher Trubshaw).
[269] IAMSAR Manual Vol II Chapter 4.
[270] Transcript, 6 March 2025, pp. 146,148 (Christopher Trubshaw).
[271] IAMSAR Vol II Chapter 4, §4.8.1.
[272] Transcript, 5 March 2025, p.144 (Neal Gibson).
[273] INQ010392, Witness Statement of Neal Gibson, §153.
[274] Transcript, 5 March 2025, p.145 (Neal Gibson).
[275] INQ010445, MAIB Report, §1.13.6.
[276] Transcript, 6 March 2025, pp.140-141 (Christopher Trubshaw).
[277] INQ010743, Second Witness Statement of Christopher Trubshaw, §2.2.
[278] Transcript, 6 March 2025, p.140 (Christopher Trubshaw).
[279] INQ010445, MAIB Report, §2.4.5.
[280] Transcript, 5 March 2025, p.176 (Neal Gibson).

probability" of detecting a person in their water[281] and Mr Trubshaw's view that detecting people in the water was "*exponentially harder*", than detecting boats.[282]

101. Contrary to Mr Trubshaw's acceptance that he did not have all the information he required, and the MAIB's conclusion as to the unsuitable track spacing, Mr Leat was trenchant in his refusal to accept that the effectiveness of the search was hampered by the failure to give full search instructions.[283]

102. The lack of communication between Dover MRCC and the ARCC also precluded support from additional air assets. Mr Golden explained in oral evidence that had he known that the small boat was taking on water or there were people in the water, he would "*absolutely*" have treated it as a "*true SAR incident*" and explored the possibility of tasking an additional helicopter to the incident, from Lee-on-Solent or Humberside.[284]

(6) Information management and record keeping

(a) Inadequate recording of information in ViSION

103. HMCG's information management system, ViSION, was described by Mr Gibson as the "*single source of truth*". The evidence before the Inquiry is that the catalogue of information recording failures on the night were in no way exceptional, but rather symptomatic of persistent issues of which HMCG were well aware.

104. There was a failure by HMCG to accurately and fully record critical information from calls onto ViSION. Mr Downs' evidence was that in light of the pressures faced by operational staff, it was "*quite common for mission statements and things to be done a bit later... you didn't necessarily have the time to do that part*".[285] Mr Crane similarly gave evidence that "*quite often*" shifts were too busy to allow for proper recording of information, including in relation to the closure of incidents.[286] On the night, there were failures to record critical information, the rationale for the identification of duplicate incidents,[287] and the closure of incidents.[288] This caused considerable problems not only for the incoming shift (see below), but also for the adequate supervision by the SMC of ongoing incidents. As the Inquiry heard from Mr Gibson, supervision was in practice achieved through ViSION: "*everything goes in ViSION, their thoughts, their requests, and then it can be approved, signed off, enhanced.*"[289] As noted by Mr Bill in his email of August 2021, the failure to properly update ViSION was mission critical where incidents were being handled by a remote SMC who was entirely reliant on the contemporaneous written record.[290] While HMCG had been made aware

[281] Transcript, 6 March 2025, p.76 (Graham Hamilton),
[282] INQ00632, Meeting Transcript of Mr Trubshaw, 21 April 2022, p.29.
[283] Transcript, 24 March 2025, p.176 (Matthew Leat).
[284] Transcript, 11 March 2025, p.170 (Dominic Golden).
[285] Transcript, 13 March 2025, p.117, ln.20-23 (Stuart Downs).
[286] Transcript, 12 March 2025, p.155, ln.24 – p.156, ln.12 (James Crane).
[287] See e.g., INQ000237, Incident log; Transcript, 13 March 2025, p.143, ln.4-7 (Stuart Downs).
[288] See e.g., INQ000235, Incident log; Transcript, 13 March 2025, pp.149-150, ln.23-25, 1 (Stuart Downs).
[289] Transcript, 5 March 2025, p.43, ln.1-4 (Neal Gibson).
[290] INQ003322, Email from Mike Bill to Pete Mizen, 17 August 2021.

of the impact of staff overwhelm on the quality of recordkeeping, mitigating action was limited to reminders to staff of the importance of recordkeeping.[291]

105. There was an absence of training or agreed protocols relating to the use of ViSION. The Inquiry heard conflicting evidence about the use of the Administration Log and the Network Management Log. Mr Jones used the Administration Log to record an important warning on the basis that "*everybody that would be involved in small boat activity would only be looking at the administrative log for migrant activity, not the national network.*"[292] However, Mr Gibson and Mr Richard Cockerill both told the Inquiry that they would not normally have been monitoring the Administration Log, and would have been more likely to see the message if it had been put on the Network Management Log.[293] Staff at MRCC Dover did not know that it was possible to create an incident on ViSION without providing a position.[294] Similarly, Mr Gibson told the Inquiry of a limitation of ViSION which meant that all the activities of a rescue asset would automatically be logged against the incident to which it was first deployed (an issue which is linked with the issue of *Charlie* being mistakenly identified as M958, see §110 below).[295]

106. Lack of systems for reconciling repeat incidents: Allied to concerns about the absence of systems to identify repeat calls (see above), there were no systems in place for reconciling potential duplicate incidents once these had been opened. There was inadequate information recorded on ViSION to enable duplicate incidents to be identified, as well as inaccuracies in the recording of key information which confounded these efforts.[296] There were also failures in practice by staff to attempt to cross-reference various sources of information to identify repeats in a timely manner.[297]

107. Mr Leat conceded that there should have been some guidance provided to staff, but asserted that training provided to staff in the summer of 2021 addressed the issue[298] – though this is not reflected in any of the evidence disclosed to the Inquiry.

(b) Impact of recording failures on ViSION and tracker on the ability of the incoming day watch to understand operational detail of response from the previous night

108. The Inquiry has heard from Mr Crane that it was rare in practice for incidents to be formally terminated and/or for any reason to be recorded as to the closure of incidents. Incoming shifts were therefore entirely reliant on the verbal handover, and in practice did not treat open incidents on

[291] Transcript, 24 March 2025, p.180, ln.19 – p.181, ln.3 (Matthew Leat).
[292] Transcript, 12 March 2025, p.203, ln. 4-7 (David Jones).
[293] Transcript, 13 March 2025, p.201, ln.21-25 (Richard Cockerill); 5 March 2025, p.74, ln.19-25 (Neal Gibson).
[294] INQ010208, Witness Statement of Stuart Downs, §§108-109.
[295] Transcript, 5 March 2025, pp.155-156, ln.14-25, 1-21 (Neal Gibson).
[296] See e.g., INQ007654, Call between Stuart Downs and distress caller possibly on board *Charlie*, noting that a telephone number was not collected (see also Transcript, 13 March 2025, p.142, ln.8-15 (Stuart Downs)); and INQ007658, Call between Stuart Downs and distress caller possibly on board *Charlie*, noting that neither the caller's name nor telephone number was collected (see also Transcript, 13 March 2025, p.155, ln.20-23 (Stuart Downs)).
[297] e.g. Failure promptly to identify French Migrant 1, 9 and 7 (*Charlie*) as potentially linked, based on information contained in the French tracker received at 0152. See INQ010392, Witness Statement of Neal Gibson, §96.
[298] Transcript, 24 March 2025, p.199, ln.16-19 (Matthew Leat).

ViSION as unresolved.[299] The Inquiry has seen evidence that MRCC Dover in practice relied on standard form reasoning for the mass closure of incidents, the use of which appears to have acted as a substitute for careful analysis and review of open incidents.[300]

109. On the night in question, Mr Gibson failed to record any information relating to his "*opinion*" that small boat incident *Charlie* had likely been picked up by the *Valiant*, or any residual uncertainty he held in his mind as to its recovery, or any other rationale its regard. On this basis, the Inquiry heard from Mr Crane that the comment placed in the *Charlie* ViSION log at 10:08:47 by Network Commander, Mr George Close, confirming that *Charlie* had been rescued and disembarked by the *Valiant,* taken together with the absence of any commentary from Mr Gibson to the contrary, led him to believe that the incident had been resolved.[301]

(7) Cessation of the SAR response for Incident Charlie

(a) Misplaced assumption that M958 was *Charlie*

110. In his evidence, Mr Gibson explained that because of the way in which the ViSION recording system worked, all entries relating to the *Valiant* were automatically recorded in the *Charlie* incident log.[302] The result was confusion. When Mr Kevin Toy, Commander of the *Valiant*, was called by the Border Force MCC, he was asked how many people had been disembarked from *Charlie* and answered that 35 people had been disembarked. But what he meant was that 35 people had been rescued from the first boat that the *Valiant* came across. He had no way of knowing at that point whether the first boat, M958, was in fact *Charlie*.[303] This confusion appears to have led Karen Whitehouse, Border Force Higher Officer at Border Force MCC, to record that *Charlie* had been rescued.[304] As Mr Toy explained, the crew of the *Valiant* itself was focused on completing the rescues of the three boats it had found and was not focused on identifying whether or not any of those boats was *Charlie*.[305]

(b) SAR response terminated even though Charlie had not been identified

111. No adequate explanation has ever been given for the decision to terminate the search for *Charlie,* given none of the boats recovered by the *Valiant* came close to meeting the levels of distress conveyed to HMCG by those on board. Mr Gibson's explanation in evidence that he relied upon the nil return from the helicopter search completed by R163 is unsustainable.[306] The helicopter search could not have reliably demonstrated that there were no casualties in the water. It would have been extremely difficult for R163 to spot *Charlie* or anyone in the water and, critically, it had not been told to look for anyone in the water.

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[299] Transcript, 5 March 2025, p.169, ln.13-21 (Neal Gibson); 17 March 2025, p.71, ln.8-18 (George Papadopoulos).
[300] Transcript, 17 March 2025, pp.89-93, see esp. p.92, ln.4-25, p.93, ln.1-4 (George Papadopoulos).
[301] Transcript, 12 March 2025, p.152, ln.16 – p.154, ln3 (James Crane).
[302] Transcript, 5 March 2024, p.156, ln.17-21 (Neal Gibson).
[303] Transcript, 10 March 2025, pp.130, 136, 138 (Kevin Toy).
[304] Transcript, 11 March 2025, p.87, ln.6-21 (Whitehouse).
[305] Transcript, 10 March 2025, p.48, ln.6-25 (Kevin Toy).
[306] Transcript, 5 March 2025, p.176, ln.1-8 (Neal Gibson).

112. The true explanation more likely relates to the prejudicial general belief amongst those working at MRCC Dover that callers exaggerating their level of distress. As Mr Downs explained: "*My belief was that we'd recovered and rescued everybody that we had gone to look for or were looking for. As I say, it was normal that people would overstate the level of distress that they were in, so I had nothing to tell me any different.*"[307] According to the discriminatory beliefs prevalent amongst staff at MRCC Dover, it was likely that boats, when found, would not match the levels of distress heard on distress calls. The result was a breach of the procedure for termination of SAR operations under Chapter 5 of the SAR Convention. MRCC Dover had not been informed by any appropriate source that the emergency phase no longer existed.

E. CAUSATION AND SURVIVABILITY

113. The failings set out above were causatively linked with the disaster sufficiently to found breaches of the ECHR which *require* to be recognised through the Inquiry's findings.[308]

114. Causation is made out even if only the operational failures on the night are considered. The Coastguard were first made aware of Charlie at 01:06. The last call from the boat was not until 1 hour and 24 minutes later, at 03:12. Mr Ling's evidence was that *had* the RNLI all-weather lifeboat been tasked, it would likely have arrived at the location provided for Charlie in 1 hour and 13 minutes.[309] So there was time for a vessel to reach the area.

115. Professor Tipton's evidence is that, although *some* would have died upon entering the water, "*the majority"*[310] of occupants of incident *Charlie* survived entry into the water – and were alive 12 minutes after the last call from the boat, at 03:24. The *Valiant* reached the original coordinates to which it had been (incorrectly, without update) directed just three minutes after that, at 03:27. Mr Gibson erroneously updated the *Charlie* log to record the *Valiant* on scene at just 03:50; and gave it the number M597 at 03:56.

116. Professor Tipton's evidence is that by 07:03 – when the *Valiant* returned to port and the search for Charlie was abandoned – "*some*" of the victims would have died.[311] But the corollary is of course that some were alive. That means, it may have been possible for more people to be rescued alive, right up until just after 13:00 that afternoon – some 12 hours after the first call from the boat. Issa Mohammed's evidence was that people survived for a number of hours even after they entered the

[307] Transcript, 13 March 2025, p.167, ln.16-25 (Stuart Downs).
[308] This is a submission that the breaches must be reflected in the Inquiry's factual findings in order to comply with the investigative Article 2 duty. Whether they are labelled explicitly in terms as ECHR breaches is a matter, in law, for the Inquiry. It is submitted that such an approach, which was adopted in the Brook House Inquiry Report, has the benefit of providing public legal clarity (and there is no prohibition on such language being used as arises in the inquest context).
[309] INQ010739, Second Witness Statement of Simon Ling, §12.
[310] INQ010283, Expert Witness Report of Professor Michael Tipton, §4.10.
[311] Ibid.

water: "*in the morning,.. around ten people were still alive*",[312] and that Mohammed Hussein Mohammadie was alive until around 30 minutes before he was finally rescued.

117. Of course, had the search not been abandoned prematurely, not only is it probable that more victims would have survived, but the chances of locating *all of the victims* would have been far greater. As it was the search only resumed some six hours later[313]. The suffering and anguish of those whose loved ones remain missing is unfathomable. It should be remembered that the negligent abandonment of the search meant not just that potential survivors were lost, but also that the families of the missing were deprived of the opportunity of closure.

118. Even considering the operational failings in isolation then, the Article 2 causation threshold – a "*real prospect*" that the outcome may have been altered or mitigated – is easily met. However, the operational failings must also be considered against the wider panoply of systemic failings set out in sections C, D and E above. When those are taken into account, as they must be, the evidence that state failings deprived the victims of a "*substantial chance*" of survival is overwhelming.

F. FAILURES: ACCOUNTABILITY AND OVERSIGHT

119. The DfT is the MCA's "*parent department*".[314] The MCA, an executive agency, is the body through which the "*DfT ensures the UK's implementation of its obligations under the relevant international maritime conventions*".[315] There is no domestic statutory framework giving direct effect to the obligations in the Annex to the SAR Convention. Unlike other emergency services, there is no independent inspectorate tasked with assessing the effectiveness and efficiency of the SAR service. The DfT's role in overseeing the delivery and maintenance of an adequate and effective civil maritime and aeronautical SAR service through the MCA is therefore of vital importance, and scrutiny of its effectiveness is critical to the Inquiry fulfilling its Terms of Reference.

120. In written evidence, Mr Driver described the means by which the DfT purports to monitor the work of the MCA.[316] In oral closing, Counsel for DfT relied on this same "*suite of formal and informal*" mechanisms of purported oversight.[317] However, when CTI pressed Mr Driver in questioning, the veneer of effective oversight quickly fell away, despite Mr Driver, a senior civil servant who has been in post as Head of the Maritime Security Division since 2017, confirming the Departmental view that he was the person best placed to provide a statement and answer questions on its behalf.[318] The DfT failed in its oversight role in at least four ways.

121. **First**, oversight by the MCA Sponsorship Board was ineffectual. Mr Driver described this as the primary means through which DfT oversees overall performance of the MCA. He was confident

[312] Transcript, 4 March 2025, p. 46, ln.8 (Issa Mohammed).
[313] INQ000320, Incident Log X-Ray 2.
[314] INQ0010337, Witness Statement of James Driver, §53.
[315] INQ010337, Witness Statement of James Driver, §§21-22.
[316] INQ010337, Witness Statement of James Driver, §§163-199.
[317] Transcript, 27 March 2025, p.98, ln.21-22 (Mr Blundell KC).
[318] Transcript, 25 March 2025, p.2, ln.17-20 (James Driver).

that the Board, which meets quarterly, discussed and went through the "*highest risks*" facing the MCA.[319] And yet, there is no evidence whatsoever that the Board considered the new and high red-rated entry made to the MCA Corporate Risk Register in November 2021, which warned that HMCG may become "*overwhelmed due to unquantifiable levels of migrant channel crossing activity occurring during periods of good weather*".[320] The Inquiry is invited to conclude that this failure was not, as suggested by Mr Driver, a "*limitation in the minute*".[321]

122. **Second**, other limbs said to comprise DfT's oversight and assurance of the MCA had little to do with small boats or little to do with DfT. Only one "*deep dive*" discussion by the MCA Sponsorship Board addressed small boats and did not take place until 9 November 2022.[322] As to the MCA Board (as distinct from the Sponsorship Board), again, the best Mr Driver could do was to point to one passage in one briefing from 23 July 2020 on the topic of small boats.[323] Even the "*weekly huddles*" – which are not a formal system for oversight – were initiated to discuss the response to Operation Sommen, rather than a recognition of the need for proactive departmental engagement on the issue of small boats and the consequent pressures on the MCA.[324]

123. **Third**, departmental processes for formal review were clearly inadequate. A DfT departmental review of the MCA described *itself* as a "*light-touch assessment*" and the draft report dated 19 November 2021 – which was never published – goes out of its way to emphasise that it "*did not go as far as examining efficacy and efficiency*".[325] The Inquiry will note, as CTI put it, the "*apparent disconnect*" between how that review was framed by Mr Driver in his witness statement, and "*what the report appears to be at pain to stress*".[326] On its limited terms, that review did make recommendations, including an important point relating to the MCA's approach to KPIs (key performance indicators). It appears, however, that the entire response to that recommendation is contained in one short passage from the minute of the MCA Board dated 4 October 2021.[327] Mr Driver could not give a clear answer in response to CTI asking whether that that response to the DfT's analysis was "*good enough*".[328]

124. **Fourth**, both Mr Driver and Mr Leat placed great stock in the IMO III Code audit.[329] Mr Leat emphasised that an audit which took place in October 2021 concluded with no recommendations for HMCG.[330] However, on closer look, the auditing process is obviously limited in its depth. First, it takes place only every five years. Second, the 2021 audit took place remotely. Third, so far as the

[319] Transcript, 25 March 2025, pp.58-59 (James Driver).
[320] INQ000167, MCA Corporate Risk Register, p.24.
[321] Transcript, 25 March 2025, p.59, ln.14 (James Driver).
[322] Transcript, 25 March 2025, pp.59-60 (James Driver); INQ010337, Witness Statement of James Driver, §§166ff.
[323] Transcript, 25 March 2025, p.63 (James Driver).
[324] Transcript, 25 March 2025, p.35 (James Driver).
[325] INQ008152, MCA Departmental draft Review, 19 November 2021 (attached to INQ00815).
[326] Transcript, 25 March 2025, pp.66-68 (James Driver).
[327] INQ008153, Response to the DfT Review of the MCA Recommendations, 4 October 2021, p.2.
[328] Transcript, 25 March 2025, pp.72-73 (James Driver).
[329] Transcript, 24 March 2025, pp.58-60 (Matthew Leat); 25 March 2025, pp.74-77 (James Driver).
[330] Transcript, 24 March 2025, p.58 (Matthew Leat).

Coastguard was concerned, the IMO auditors spent just 3.5 hours on the SAR functions within the MCA.[331] Fourth, it is unclear how the IMO III Code audit can properly be relied upon as an oversight mechanism *by the DfT* when Mr Driver could only give his "*estimation*" as to what the audit process actually covers.[332] As to other external audits, Mr Driver did not know when the UK Government Internal Audit Agency ("**GIAA**") last reviewed the Coastguard.[333]

125. On any metric, the DfT, both at the time of the disaster and since, has not provided an effective system of oversight of the work of the MCA.

G. LESSONS LEARNED AND RECOMMENDATIONS

126. The Bereaved Families and Survivor submitted detailed preliminary submissions on recommendations on 16 August 2024. Those submissions are maintained and the Inquiry is asked to have reference to them in writing its report. As the inquiry is aware, is a fundamental part of any Article 2 ECHR compliant investigation. Learnings lessons to enable lives to be protected in the future goes to the heart of the Inquiry's purpose.[334] **We make seven key recommendations**:

Recommendation One: Independent Oversight body

127. In the light of the failures of oversight of HMCG and the DfT set out above, and in the particular, the fact that HMCG is the only UK emergency service which does not currently benefit from one, it is submitted the Inquiry should recommend that HMCG is subject to regular review by an independent inspectorate. From the questions asked by CTI during in the hearings, the Bereaved Families and Survivor anticipate this lacuna is something the Inquiry is already mindful of. However, the following brief submissions are emphasised.

128. **First**, the evidence of the failures and predictability set out above has demonstrated the crucial importance of regulatory oversight capable of reviewing conditions regularly so that concerns are raised and addressed, or at least are capable of being addressed prior to any disasters occurring. Post hoc safety reviews, such as the investigation conducted by the MAIB, HMCG internal review, and the US Coastguard peer review, are simply inadequate. The ICIBI Reports on the Home Office response to clandestine arrivals from May to December 2019[335] and the processing of migrants at Tug Haven during December 2021 to January 2022[336] provide an instructive counterpoint to the lack of independent review of HMCG in this case. ICIBI Reports are required to be presented to Parliament for scrutiny. The former report contains a comparison between Border Force and

[331] Transcript, 25 March 2025, pp.80-81(James Driver).
[332] Transcript, 25 March 2025, pp.75-76 (James Driver).
[333] Transcript, 25 March 2025, p.79 (James Driver).
[334] *Amin v SSHD* [2004] 1 AC 182, §31.
[335] ICIBI, An inspection of the Home Office's response to in-country clandestine arrivals ('lorry drops') and to irregular migrants arriving via 'small boats', 11 November 2020.
[336] INQ005200, An inspection of the initial processing of migrants arriving via small boats at Tug Haven and Western Jet Foil December 2021 – January 2022, 21 July 2022.

comparator European Coastguard's (far greater) number of assets.[337] It sounded a contemporary, public warning regarding the paucity of Border Force's assets as early as November 2020.

129. **Second**, the lack of regulatory oversight of HMCG's SAR performance raises an issue of compliance with the UK's Article 2 ECHR. In *Safi* the ECtHR affirmed the systems duty applies in a small boats SAR context, observing specifically that it applies in the context of dangerous or risky activities and in cases where national authorities are alleged to have breached safety regulations.[338] The obligation (of means, not result) is to adopt and *comply* with regulations to protect human life. Allegations of breach of the duty must be subject "*to the most careful scrutiny... including such matters as the planning and control of the actions under examination.*" In *Cevrioğlu* the lack of an inspectorate constituted a systems breach as "*the protection offered by the relevant safety measures would be illusory in the absence of an adequate mechanism of inspection to ensure compliance.*"[339] The paucity of SAR oversight clearly raises a potential breach of the systems duty.

130. **Third**, in its oral closing the MCA submitted that the best evidence as to SAR standards and their efficacy in this Inquiry comes from its own witnesses and the US Coastguard, and sought to rely on the absence of any independent expert evidence heard by the Inquiry.[340] As set out above, that submission, in an Article 2 investigatory context, is flawed, and does not address the requisite judgmental conclusions. But the technical, specialist nature of SAR is a factor that militates in favour of, and not against, specialist SAR oversight, inspection, and regulation. The submission that "*no other organisation in the UK has the necessary expertise*"[341] is overly defensive. The whole point of an Inspectorate would be to recruit persons with such expertise, in the UK and/or from overseas and make appropriate recommendations for but not limited to emergency planning. The SAR Convention, SOLAS, IAMSAR and the ManchePlan provide a ready set of regulatory and legal requirements against which to assess SAR function. HMCG has long accepted it is bound by these provisions of international law. Inspection could only improve adherence to standards it professes commitment to.

Recommendation Two: Stakeholder engagement

131. Annex 4 to the SAR Convention (as amended on 18 May 1998) states (with bold added):

> *4.1.3 Each rescue coordination centre and rescue sub-centre shall have detailed plans of operation for the conduct of search and rescue operations.* ***Where appropriate, these plans shall be developed jointly with the representatives of those who may assist in providing, or who may benefit from, the search and rescue services.***

[337] Ibid, p.69.
[338] *Safi*, §§151-152.
[339] *Cevrioğlu*, §62.
[340] Transcript, 27 March 2025, p.61, ln.5-22 (Mr Maxwell-Scott KC).
[341] Transcript, 24 March 2025, p.62, ln.14-17 (Matthew Leat) ("*there is a very, very small… group of people that have the requisite knowledge and skills to be able to provide [oversight] and provide it in a way that would add value*").

132. HMCG and DfT have repeatedly made clear their commitment to comply with their international law obligations under the SAR Convention. However, to the knowledge of the Bereaved Families and Survivor and their legal representatives, the interests of those who make the small boats journeys have never been consulted on the development of SAR plans and systems. It is submitted that the Inquiry should make a recommendation that NGOs representing the interests of migrant groups should be consulted and SAR plans developed jointly with them, for the following reasons.

133. **First**, the evidence heard by this inquiry has demonstrated that this is an area of SAR practice where it is "*appropriate*" for the steps in paragraph 4.1.3 to be taken. Communications between those on small boats and the UK emergency services play a vital role in the protection of life at sea. Ineffective and/or unreliable communication of the location and condition of small boats in both UK and French waters poses a risk to life. Further, those in the camps in Northern France are prone to exploitation by smugglers, and may be given unreliable or inaccurate information regarding how they should seek to communicate with State authorities, which may have a negative effect on SAR efficacy. The reliable provision to those making the crossings of practical advice on sea safety (Professor Tipton's evidence regarding people in the water not attempting swim, for example) could save lives in the future.

134. **Second**, the NGOs which represent the interests of migrants in the camps in Northern France are uniquely well placed to assist in improving SAR systems, in line with the purpose of the SAR Convention and paragraph 4.1.3. Utopia 56, in particular, have set out in evidence to the Inquiry the steps they already take via their helpline to facilitate the provision of information vital to SAR between those on boats and the UK and French authorities.[342] As of December 2022 there is a direct phone line from Utopia 56 to MRCC Dover. However, HMCG's WhatsApp number intended to receive small boat locations is only provided once a vessel has made contact with UK emergency services (a practice which in itself gives rise to potential risks of future deaths given the unreliability of mobile phone communications in the channel).[343] Consultation and the joint development of plans could save lives.

Recommendation Three: Statutory framework review

135. The Bereaved Families and Survivor submit that the Inquiry should make a recommendation to the DfT that a wholesale review is undertaken of HMCG's role and duties within the civil contingencies framework. That review should include scrutiny of the adequacy of the current legislation governing HMCG and this should include cross-departmental considerations including the Equalities Office (see Recommendation Four).

136. The failings of the HMCG and MCA in relation to the CCA framework are set out above at §65-71. The CCA is the only key piece of domestic legislation intended to ensure risk assessment and

[342] INQ009645, Witness Statement of Nikolai Posner (Utopia 56), §23.
[343] INQ009645, Witness Statement of Nikolai Posner (Utopia 56), §§17-23.

planning are conducted in relation to emergencies which threaten the lives and safety of those within the jurisdiction. It is of grave concern to the Bereaved Families and Survivor that, not only was the framework not adhered to, but the most senior HMCG witnesses indicated they considered neither the declaration of a major incident, nor a MACA request, would have been of any practical assistance (as set out above). If that is correct, it means there is a major gap in the 2004 Act framework and the system for provision of military assistance. If it is incorrect, it demonstrates that officials at the highest level in HMCG have misunderstood and failed to apply the framework.

137. HMCG's own lack of clarity as to its role under the civil contingencies framework is compounded by the outdated and inadequate nature of its own legal framework. The Coastguard Act 1925, again in contrast to other more modern legislation governing other emergency services, does not set out the functions and duties of HMCG. The "*determination*" laid before Parliament in 1992 is outdated and provides no clarification as to the functions of HMCG[344] other than it is to mobilise, organising and task only "*adequate*" resources to respond to persons in distress at sea.[345] Given the ongoing risk to life from small boats crossings in the English Channel, and the failings of emergency planning, assessment and response in this case, any review should examine the adequacy of the legislation governing HMCG to protect lives in the 21st century. Again, the high-level concerns about HMCG's duties and functions raised by this Inquiry raise a clear issue of compliance with the systems duty under Article 2 ECHR.

138. The lack of any adequate oversight by the DfT as set out at §119-125 above, is the responsibility of the DfT and the Minister herself. A review of the domestic legislative framework is required in light of the significant SAR developments since 2018. This may include hard-edged obligations under the SAR Convention being given domestic effect, and considering an amendment to the CCA to ensure that the duties relating to emergency planning – and in particular, the s 2 duty to "*maintain plans for the purpose of ensuring, so far as is reasonably practicable, that if an emergency occurs the person or body is able to continue to perform his or its functions*" are discharged in a manner that gives effect to the minimum requirements imposed by the SAR Convention.

Recommendation Four: Discrimination – review and training to ensure compliance with statutory human rights and equalities duties

139. Given the evidence which has emerged, of discriminatory treatment based on race, national origin and/or immigration status, the Inquiry is asked first, to consider inviting further evidence from the State Full Participants as to their compliance with regard to small boat SAR with their equality duties under the HRA and EA, including the public sector equality duty ("**PSED**") under s 149 EA; but also second, to recommend that the DfT, MCA, and Home Office conduct a reviews of, and provide staff training on, compliance with those duties. The PSED is an integral and important part

[344] INQ010337, Witness Statement of James Driver, §24 (accepting the applicability of the determination).
[345] Hansard, HC Deb 09 March 1992 vol 205 cc409-10W.

of the mechanisms for ensuring the fulfilment of the aims of anti-discrimination legislation.[346] It is a duty imposed personally on the Minister.[347] The obligation to have due regard requires public authorities to be properly informed before taking a decision. Where relevant material is not available, the PSED engages a *Tameside* duty of inquiry.[348] The Inquiry has heard no evidence to suggest there has been any consideration of or change in the attitudes and practices of those engaged in SAR operations in the English Channel since the events of November 2021, nor that any steps have been taken to put an end to the discrimination faced by people on small boats. As set out above, the discriminatory attitudes and practices in this case extended to at least Commander level within HMCG and had a material effect on the SAR failings on the night. Ensuring SAR functions are performed without discrimination is critical, not only to ensuring Full Participants discharge their legal obligations, but to prevent the loss of life at sea.

140. This Inquiry should consider whether to further examine the implications of race as a factor either directly or indirectly to the treatment of or practices affecting those who died or nearly died, before it draws to a close and reaches its final conclusions.

Recommendation Five: MCA should no longer rely on Border Force to fulfil its SAR duties in the English Channel

141. The Inquiry has heard evidence regarding the unsuitability of Border Force vessels to perform SAR functions, as well the lack of clarity caused by Border Force's dual role in performing SAR alongside its primary law enforcement role. Concerns relating to Border Force's role in fulfilling the MCA/HMCG's SAR duties are not new. They were raised by the Home Office itself in December 2021[349] and November 2022[350] and the MoD in September 2022.[351] In July 2022 Alexander Downer concluded that Border Force maritime should not be providing an ongoing SAR function in the English Channel, and that its vessels were not appropriate to the task.[352] He recommended that appropriate vessels and crews should instead be sought under contract. That was also the recommendation in December 2021, prior to the intervention of Operation Isotrope.[353]

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[346] *R (Elias) v Secretary of State for* Defence [2006] 1 WLR 3213; [2006] EWCA Civ 1293, §274 (Arden LJ).
[347] *R (National Association of Health Stores) v Department of Health* [2005] EWCA Civ 154, §§26-27 (Sedley LJ).
[348] See *SSES v Tameside Metropolitan Borough Council* [1977] AC 1014, 1065, and in the PSED context, *R (Hurley & Moore) v Secretary of State for Business, Innovation and Skills* [2012] EWHC 201 (Admin) (Divisional Court), per Elias J (as he then was) at §§77-78, and §§89-90, and *R (Bracking & Ors) v SSWP* [2013] EWCA Civ 1345.
[349] INQ005272, Internal Home Office Letter, 23 December 2021; INQ000837, Internal Home Office cover email, 23 December 2021.
[350] INQ004117, Options for the operational maritime response to small boats post-military primacy, 28 November 2022; Witness Statement of James Driver, §113.
[351] INQ004072, Proposal by the Joint Inter Agency Task Force, 21 September 2022.
[352] INQ000012, Independent Review of Border Force by Alexander Downer, 20 July 2022, p43.
[353] INQ005272, Internal Home Office Letter, 23 December 2021; INQ000837, Internal Home Office cover email, 23 December 2021.

142. At this Inquiry, Mr Toy's evidence was that Border Force's assets were not designed or equipped to carry out mass rescue operation.[354] Mr Ling's evidence was to similar effect.[355] The priorities of migration enforcement are incompatible with the priorities of SAR. The evidence heard bears out that SAR is a specialist process, which requires trained, competent personnel, and specialist assets. Indeed, it is the MCA's position that it is so specialist that only it and the US Coastguard are able to express a view on it.[356] There have been no joint training exercises on small boat SAR. Mr Ling's evidence was that the Home Office have been invited to attend training with the RNLI in September 2025, but he considered an obstacle to their attendance might be the "*optics*".[357] Whilst the MCA relies on volunteer capacity from RNLI to supplement and on occasions fulfil its SAR obligations, the reliance on volunteers providing services on behalf of a charity is unsustainable in the context of small boats, due to the nature and scale of the emergency and the need for properly resourced assets to be made available. All vessels retain individual duties of rescue towards boats in distress. But the services the State calls on as its SAR emergency services should be trained, qualified, and properly equipped. The MCA commissions private aeronautical SAR assets and crew, and there is no reason why it should not do so in respect of surface services. The retention of the Border Force's role as (in effect) a core part of the designated SAR emergency service is emblematic of an inadequate system which without meaningful change gives rise to the risk of further deaths at sea.

Recommendation Six: Joint training exercises

143. The Bereaved Families and Survivor are shocked and disappointed, given the commitment expressed by the Home Office and MCA to improve SAR services, that to date there have been no joint small boat SAR/mass casualty training exercises conducted between HMCG, the RNLI, and Border Force.[358] The evidence heard by the Inquiry has demonstrated the fundamental importance of the effective coordination of and communication between services in engaged in SAR. Mr Ling said he believed "*quite strongly*" in the importance of such exercises taking place, despite the scale of the undertaking.[359] It is submitted that a recommendation that such exercises are undertaken forthwith should be made. That should include a recommendation that the French Coastguard also participate, given the need for cooperation and coordination under the ManchePlan and the crucial (and causative) role that failures in coordination and communication between Gris-Nez and MRCC Dover played on the night.

Recommendation Seven: Consideration of safe, legal and accessible routes to the UK

144. For the Bereaved Families and Survivor, safe routes remain an overarching and urgent consideration.[360] The unavoidable context to the following and final recommendation is the most

[354] Transcript, 10 March 2025, p.31 ln.8-12 (Kevin Toy).
[355] See e.g., Transcript, 18 March 2025, p.54, ln.1-24 (Simon Ling); INQ010101, Witness Statement of Simon Ling, §§56-58.
[356] Transcript, 27 March 2025, p.61, ln.5-22 (Mr Maxwell-Scott KC).
[357] Transcript, 24 March 2025, p.134, ln. 4-9 (Simon Ling).
[358] Transcript, 24 March 2025, pp.130-133 (Matthew Leat).
[359] Transcript, 24 March 2025, p.133, ln.25 - p.134, ln.1 (Simon Ling).
[360] As was made clear in our submissions on recommendations in August 2024.

recent statistics, published on 14 April 2025, that the number of people who have undertaken the crossing in 2025 has exceeded the record number for the first four months of any other year.[361] This demonstrates both the unpredictable nature of good weather patterns, and that there has been no general diminution in crossing levels since 2021.[362] Dramatic spikes in numbers continue to occur. Asylum-seekers must reach UK soil before they can lodge an asylum claim. It should be remembered, in the light of references to "*illegal migration*" in the evidence, that at the time of the disaster, entering English waters in a small boat with the intention of claiming asylum at a port of entry or once rescued was not unlawful.[363] The crime of illegal arrival (including of attempt) as opposed to illegal entry, only became a criminal offence under the Nationality and Borders Act 2022.[364] Seven years of ever-increasing securitisation measures have not deterred those who have no choice but to make the crossing if they are to claim asylum in the UK. As previously submitted, those measures have only stimulated smuggling gangs to take higher risks with asylum seekers' lives.[365] The evidence from NGOs working in Northern France vividly bears out the inhumane conditions which force people into the hands of the smugglers.[366] But Government promises to crackdown on smuggling gangs have proved hubristic, and the unbearable conditions in the camps remain. The result is that vulnerable, exploited people continue to die in the English Channel. 78 people died attempting to cross the Channel in 2024, the highest number since 2018.[367] The risks to human life remain acute, and the need for humane solutions imperative.

145. Search and rescue is by its very nature responsive and not preventative. Any meaningful assessment of how risk to life can be minimised will require an awareness and/or consideration of how small boat crossings can be prevented. The Bereaved Families and Survivor's final submission is therefore that the Inquiry should make a recommendation that the Government consider the expansion and/or creation of safe routes for asylum seekers to reach the UK. Such routes could take any number of forms, recognising the drivers for those seeking to migrate to the UK, such as a refugee visa scheme, an asylum processing centre in France (as proposed by the 2022 Home Affairs Committee Report)[351] and/or expanding existing resettlement schemes both as to refugees and family reunion, and/or in respect of unaccompanied asylum-seeking children. The Bereaved Families and Survivor recognise

[361] 8,064 had crossed by Saturday 12 April 2025, with the previous record for the first four months of the year being 7,567 in 2024: BBC News, "Record Number of Migrants Cross Channel in 2025 so far", 14 April 2025.
[362] Home Office Official Statistics: Irregular migration to the UK.
[363] *R v Bani* [2021] EWCA Cri 1958.
[364] Section 40 of which amended the offence of illegal entry under s 24 of the Immigration Act 1971.
[365] Bereaved Families' and Survivor's Preliminary Submissions on Issue VI(d),16 August 2024, §27.
[366] In 2023, only 59% of asylum seekers eligible for accommodation were effectively accommodated, meaning at least 84,971 asylum seekers did not have access to state accommodation in France, with many living in informal makeshift camps located in industrial wastelands on the outskirts of towns, or in wooded areas. Residents of these camps lack basic amenities, such as access drinking water, a reliable food supply, health care, and sanitary facilities. The UN Committee on the elimination of racial discrimination criticised the shortcomings of the French reception system and the 'deplorable' living conditions for asylum seekers in its report published in December 2022.
[367] "Migrant dies during attempt to cross English Channel", BBC News, 9 March 2025.

that it is not for the Inquiry to specific the precise form any routes might take. However, the duty to ensure lessons are learned is one of the very purposes of an Article 2 investigation.[368]

H. CONCLUSION

146. Improvement in SAR services can only go so far to minimise the risk to the lives of those crossing the Channel in small boats. This Inquiry has gone to great lengths, for which the families and survivor will always be grateful, to humanise and give a voice to those who perished, those who remain missing, and the two survivors of 23-24 November 2021. But the Bereaved Families and Survivor's most fundamental hope is that the Inquiry leads to effective systemic change to prevent other families from having to endure such uncertainty and grief. The evidence heard at this Inquiry has made crystal clear that the only truly effective change to prevent deaths in the English Channel in the future is the provision of safe routes.

147. Finally, the Bereaved Families and Issa Mohammed would like to reiterate their thanks to the Chair and his team for the sensitive, thorough and fearless way they have conducted this Inquiry to date.

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17 APRIL 2025

[368] *Amin*, §31.