

THE CRANSTON INQUIRY

CLOSING STATEMENT OF THE MARITIME AND COASTGUARD AGENCY

Introduction

1. On behalf of the Maritime and Coastguard Agency (“MCA”) and His Majesty’s Coastguard (“HMCG”) we offer our sympathies to everyone affected by the tragic events of 24 November 2021.
2. The SAR Convention provides that: *“Parties shall ensure that assistance be provided to any person in distress at sea. They shall do so regardless of the nationality or status of such a person or the circumstances in which that person is found.”*¹
3. HMCG’s commitment to this principle is demonstrated by the fact that it has successfully coordinated the rescue of over 160,000 persons² of foreign nationality with no legal status to enter the UK. During the oral hearings, the Inquiry heard from 10 current and former HMCG officers. We invite the Chairman to find that they were all professional and helpful and were all committed to this principle.
4. In the course of preparing this Closing Statement, we have reviewed the MCA’s written and oral Opening Statements. We consider that their contents remain accurate. We therefore adopt the contents of those statements and invite the Chairman to treat them as forming part of the MCA’s closing submissions.
5. This Closing Statement contains the following sections.
 - (1) The best evidence about how to coordinate search and rescue
 - (2) The challenges faced by HMCG in November 2021
 - (3) The distinction between reported and verified
 - (4) The requirement to make difficult judgement calls
 - (5) Hindsight
 - (6) The approach to be adopted when judging HMCG
 - (7) Pre-planning for the period 23-25 November 2021
 - (8) The events of 23/24 November 2021
 - (9) Causation
 - (10) Recommendations
 - (11) Concluding Remarks

¹ SAR Convention Annex para 2.1.10 (emphasis added)

² As at the date of this Closing Statement (17.4.25). It was over 150,000 at the date of the MCA’s Opening Statement (24.2.25).

The best evidence about how to coordinate search and rescue

6. Coordinating maritime search and rescue (“SAR”) is a specialist activity. In evaluating the evidence it has received, the Inquiry will therefore wish to ask itself:
 - Who are the recognised experts in this specialist field?
 - What is the best evidence available to the Inquiry about how to coordinate SAR?
7. As stated in the MCA’s oral Closing Statement, the answer is that the best evidence available to the Inquiry about how to coordinate SAR comes from HMCG and the US Coast Guard.
8. During the hearings, the Inquiry heard from 8 HMCG officers who had gained a qualification in Search Mission Coordination.³ The Inquiry did not hear from any other witnesses with qualifications or experience in SAR coordination. Simon Ling,⁴ Commander Toy⁵ and Captain Trubshaw⁶ had relevant experience of SAR operations but did not have qualifications or experience in SAR coordination.
9. As to written evidence, the Inquiry instructed experts in the fields of survivability⁷ and communications technology⁸ but not SAR coordination. To the best of our knowledge, Duncan Lewis⁹ did not invite the Inquiry to hear from an expert instructed by them – if they did, the request was rejected.
10. Therefore, the written evidence available to the Inquiry consists of:
 - HMCG’s internal review¹⁰
 - The Marine Accident Investigation Branch (“MAIB”) report¹¹
 - The US Coast Guard Case Study¹²
11. The Lead Reviewer for HMCG’s internal review was Julie-Anne Wood, Assistant Director HMCG Governance, Policy, Standards and International. She has the necessary expertise in SAR coordination. She is an employee of HMCG but was not involved in the events of 23/24 November 2021.

³ Gibson, Bill, Barnett, Crane, Jones, Cockerill, Papadopoulos and Leat.

⁴ Ling is an experienced member of the RNLI and a qualified Operational Launch Authority for RNLI lifeboat taskings, but he is not a qualified SMC. This is consistent with the fact that the RNLI is not a SAR tasking authority. The RNLI declares assets to HMCG which is responsible for tasking them and coordinating SAR operations to which they are tasked.

⁵ Toy had been a Commander of a Border Force vessel since 2008 and had experience of migrant small boat SAR in the Mediterranean as well as in the Dover Straits. (Day 5 page 1 line 19 to page 4 line 2)

⁶ Trubshaw is a qualified SAR helicopter pilot. There is an overlap between his area of expertise and an SMC’s but Trubshaw’s expertise does not cover the full field of SAR coordination. (Day 4 pages 94-95)

⁷ Professor Michael Tipton INQ010283

⁸ Iain Ivory INQ010133

⁹ Duncan Lewis represent a survivor and the families of some of the deceased

¹⁰ Draft Final Review (subject to French information) INQ008905

¹¹ INQ010445

¹² INQ004345

12. Unlike a conventional expert report, the MAIB report provides neither the identity of its author(s) nor their CV, expertise and qualifications. The MAIB report expressly states that the MAIB sought, and obtained, assistance from 5 sets of external experts:
- The MAIB commissioned expert reports on drift analysis from 3 forensic oceanography specialists.¹³
 - The MAIB engaged with the Met Office to understand and assess the visibility and potential performance of infrared and night vision equipment.¹⁴
 - The MAIB used specialist forensic equipment and software to extract and analyse data from the coastguard mobile phone at MRCC Dover.¹⁵
13. The MAIB report makes no reference to the MAIB having commissioned a report from, or engaged with, experts in SAR. The Inquiry is therefore invited to infer that the MAIB did not do so.
14. An Information Leaflet published by the MAIB states that:
- “The Branch has four teams of experienced accident investigators, each comprising a principal inspector and three inspectors drawn from the nautical, engineering, naval architecture or fishing disciplines. The inspectors are supported by an administrative team who also deal with finance, contracts, data analysis and publications.”*¹⁶
15. We have seen no evidence to suggest that MAIB inspectors hold Search Mission Coordination qualifications or similar qualifications in SAR coordination and the Inquiry should not assume that they do.
16. In this regard we note that the MAIB Business Plan 2023/24 includes the following statement in relation to Training and Development:
- “MAIB inspectors are recruited from industry where they have already gained appropriate levels of qualification and experience. On joining the branch, they are required to develop and maintain an extensive range of investigative skills. The branch’s inspector accreditation scheme comprises theoretical and practical modules covering all aspects of marine accident investigation and, in parallel, all inspectors are expected to achieve a post-graduate certificate (PGC) in marine accident investigation, awarded by Cranfield University.”*¹⁷
17. Our understanding is that the none of the modules in the MSc in Safety and Accident Investigation at Cranfield University¹⁸ include SAR and that persons recruited as inspectors by the MAIB are not routinely required to hold any formal SAR qualifications.

¹³ INQ010445 pages 62-67

¹⁴ INQ010445 page 62

¹⁵ INQ010445 page 67

¹⁶ <https://assets.publishing.service.gov.uk/media/61a4ce8bd3bf7f0551f2d2df/2021-MAIBInformationLeaflet-UK.pdf>

¹⁷ <https://www.gov.uk/government/publications/maib-business-plan-2023-24/maib-business-plan-2023-24>

¹⁸ <https://www.cranfield.ac.uk/courses/taught/safety-and-accident-investigation>

18. In the light of the above, and the fact that no witness from the MAIB was asked to give oral evidence or provide a witness statement, the opinions expressed in the MAIB report should be treated with a degree of caution. For the avoidance of doubt, we do not have reservations about the sections in the MAIB report which set out, or are based on, the views of the external experts who assisted the MAIB.
19. As with other fields of human endeavour, one does not become an expert in SAR coordination merely by reading a manual. HMCG asked the US Coast Guard to prepare an independent case study because no organisation in the UK had the necessary expertise. The US Coast Guard is both independent and an expert in maritime SAR coordination. Its Case Study therefore deserves to be given appropriate weight and respect.
20. The views of the SMCs who gave evidence to the Inquiry also deserve to be given appropriate weight and respect. Gaining expertise in SAR coordination requires formal training and supervised practical experience. All of this takes time. The formal training course to become a Maritime Operations Officer (“MOO”) lasts 10 weeks and the whole programme, including consolidation back at home station, takes 10 months.¹⁹ It takes several years to progress from being a MOO to becoming a qualified SMC. Achieving the formal qualification requires successful completion of an intensive 3 week training course.²⁰
21. In the circumstances, the best evidence available to the Inquiry about how to coordinate SAR comes from HMCG and the US Coast Guard.

The challenges faced by HMCG in November 2021

22. The challenges faced by HMCG in November 2021, and which affected the search for small boat Charlie, did not have quick and easy solutions.
23. In these submissions, we will focus on four such challenges.
 - (1) The increasing demands on its maritime SAR service.
 - (2) Limitations on its ability quickly to increase the assets available to it.
 - (3) Limitations on its ability quickly to increase staffing levels.
 - (4) Technological limitations of the equipment available to HMCG and its SAR partners.
24. The number of arrivals in 2021 represented an increase of over 200% from the number in 2020 and an increase of over 1,400% from the number in 2019.²¹ The associated increase in demand for rescue would inevitably create huge challenges for any organisation in the public or private sectors regardless of whether the increase was predicted.
25. Further, the clear evidence was that the number of crossings in November 2021 was not predicted. Dan O’Mahoney²² was the witness best qualified to assist the Inquiry on this

¹⁹ Leat WS para 1.51 INQ010098 page 18

²⁰ Leat WS para 1.60 INQ010098 page 23

²¹ 1,843 in 2019; 8,466 in 2020; 28,526 in 2021

²² Director of the Clandestine Channel Threat Command

issue. His evidence was that “*we actually had extremely accurate predictions of the numbers of migrants that had crossed the Channel in any given month, to sort of minus 3% accuracy, and that proved to be completely inaccurate in November 2021*”.²³ He stated that the number of boats arriving in November 2021 was not foreseeable,²⁴ it was a “*complete anomaly ... my professional opinion is that it was not predictable what happened ... in that month.*”²⁵

26. Simon Ling of the RNLI noted that November 2021 formed part of a period from September to November 2021 in which the spike in rescue demand was “*simply unprecedented*”.²⁶ He said that “*it was a very difficult period*”²⁷ and that HMCG and all of its SAR partners were under immense strain and pressure with unprecedented increases in rescue demand.²⁸ The evidence suggests that in November 2021 the RNLI attended approximately 30% of migrant small boat incidents.²⁹ Given that it usually attended 10%,³⁰ and that November 2021 saw the highest ever number of small boat crossings, it is unsurprising that RNLI crews were suffering from “Red Day stress” at this time.³¹
27. The predictions to which Mr O’Mahoney referred will have been the predictions in the Commander’s Dashboard on each Operation Deveran Weather Assessment.³² The Operation Deveran forecast issued on 1 November predicted that 1,911 migrants would complete the crossing in November 2021.³³ That prediction was updated during the month but the last prediction before the incident was that there would be 2,451 arrivals in the whole of November 2021.³⁴
28. Mr O’Mahoney was asked about a submission dated 3 December 2020 which he had written for the Home Secretary.³⁵ We make two points about this document. First, the predictions made within it need to be seen in the context of the level of arrivals at the time that he wrote it (34 boats in October 2020; 48 boats in November 2020). Secondly, this submission was not shared with anyone within DfT or the MCA.³⁶
29. Mr O’Mahoney rightly pointed out that a huge amount was in place in November 2021 that was not in place at the time of his December 2020 submission.³⁷ HMCG and its SAR partners were constantly evolving their policies, procedures and practices³⁸ to address an evolving challenge. There came a point in 2021 when, based on predictions which had

²³ O’Mahoney Day 11 page 172 line 24 to page 173 line 3

²⁴ O’Mahoney Day 11 page 186 line 24 to page 187 line 8

²⁵ O’Mahoney Day 11 page 189 lines 4-7

²⁶ Ling Day 10 page 52 lines 2-5

²⁷ Ling Day 10 page 71 lines 10-11

²⁸ Ling Day 10 page 75 lines 18-21

²⁹ 66 incidents out of a total of 209 – compare Ling WS INQ010101 graph on page 14 with INQ010674

³⁰ INQ008168 and INQ008169

³¹ Ling Day 10 page 71 lines 1-4

³² See for example INQ000150 table in top right corner of page 3

³³ INQ007293 page 3

³⁴ INQ000150 page 3

³⁵ INQ008338

³⁶ See the copy list on page 11

³⁷ O’Mahoney Day 11 page 189 lines 13-22

³⁸ For example, Standard Operating Procedure “Incidents Involving Migrants” was on version 12.0 by November 2021 INQ000428

previously proven accurate, HMCG and its SAR partners were planning ahead for 2022 rather than planning for the unprecedented number of crossings that occurred in November 2021, which had not been predicted.³⁹ They should not be criticised for doing so.

30. There were limitations on HMCG's ability quickly to increase the assets available to it. We repeat our submission that the SAR Convention does not require a State to patrol its SAR region: there is no requirement on a State to task assets to carry out patrols or surveillance in the absence of information that there are persons in distress in its SAR region.⁴⁰ In the circumstances, HMCG and its SAR partners were under no obligation to spend public money on additional aerial assets. However, the MCA had before 23 November 2021 increased the aerial capability available to it and was in the process of further increasing it. The MCA had required 2Excel to provide a surge line of tasking, to be fulfilled through the use of a Panther aircraft.⁴¹ It had also commenced Project Caesar to procure increased aerial asset capability.⁴² There is no scope for criticism of the MCA's actions in this regard.
31. As to surface vessels, procuring new vessels with suitably trained crews takes time. By 23 November 2021, Border Force was in the process of enhancing its fleet. The first Crew Transfer Vessel was deployed in July 2021. Four more were deployed in April 2022. It is important to bear in mind the clear evidence that patrolling with surface vessels had very little practical impact and was not the best use of resources.⁴³ Further, RNLI lifeboats could only be tasked to carry out SAR; they could not be tasked to patrol.⁴⁴
32. There were also limitations on HMCG's ability quickly to increase staffing levels. We have referred in the previous section to the length of time it takes to become a qualified MOO. By November 2021, HMCG had taken a number of steps to increase headcount at Dover MRCC - three recruitment exercises were run between August and November 2021 with a view to having qualified MOOs in post in Dover in 2022.
33. Finally, it is essential to appreciate the technological limitations of the equipment available to HMCG and its SAR partners. The MCA is not responsible for the pace of technological development or the limitations of the equipment available in November 2021. Mr O'Mahoney's evidence was that: *"The game-changer is surveillance and technological surveillance."*⁴⁵ He developed this theme in the following exchange with CTI:

"And, I mean, it would be unwise to talk in absolutes, but I think it's fair to say if these circumstances that happened on the night of the 23 November happened again today, one could provide a fairly high level of assurance that the outcome would have been different ... I make the point to illustrate that we were on a trajectory of capability development at that point in time. We had delivered a lot of that surveillance capability in November 2021."

³⁹ O'Mahoney Day 11 page 202 lines 13-23

⁴⁰ MCA Opening Statement para 30

⁴¹ INQ006324 pages 2, 4 and 10; Norton WS paras 10 and 11 INQ010335 page 3

⁴² See MCA Opening Statement para 19

⁴³ Whitton WS para 19 INQ010137 pages 8 and 9; Toy WS para 48 INQ010136 pages 17 and 18

⁴⁴ Leat WS para 5.13 INQ010098 page 79

⁴⁵ O'Mahoney Day 11 page 164 line 25 to page 165 line 1

But the key element that was not in place was the surveillance capability that was both persistent and not affected by low cloud, which is in place today.

*Q. And by that, you are referring to, for example, aerial assets that were able to conduct surveillance in adverse weather conditions, is that right? A. Correct.*⁴⁶

34. In November 2021, there was no like for like replacement for 2Excel's planes if they could not fly. Prudent deployment of a helicopter was the only available Plan B. But helicopters have different capabilities and a different primary function.

35. In summary, in November 2021, HMCG had to work with the staff and assets available to it and to manage them judiciously. As Stephen Whitton explained:

*"Where assets were deployed during the night, they would be unavailable during the day, due to the need to replenish stores and comply with the requirement for mandatory crew rest periods. Conversely, if we were able to respond to all small boat incidents during a given night with one asset being deployed, then the remaining assets would be available during daylight hours, which was when migrant vessels tended to reach UK waters.... Where possible, we would preserve some capacity for use during daylight hours, for the practical and operational reasons explained..."*⁴⁷

The distinction between reported and verified

36. With migrant small boats the distinction between what is reported and what can be verified is important.

37. There were occasions during questioning when it was put to witnesses that they "knew" something.⁴⁸ The correct analysis is that, with migrant small boats, few facts are sufficiently reliable for it to be accurate to describe them as "known". Telephone numbers provided by the EISEC system and sightings by SAR assets are known facts. But every other item of so-called knowledge is in fact an unverified report rather than a known fact.

- A telephone number provided verbally during a call can be misheard or misstated.
- A WhatsApp position can be inaccurate.⁴⁹
- The reported condition of a boat – underway, taking on water, sinking – can be inaccurate or out of date.
- The reported number of men, women and children on board can be inaccurate.

38. It is not accurate to describe any of the above as known facts. They are all examples of reported information which needs to be evaluated and, ideally, verified.

39. The importance of verifying information reported to them was emphasised by HMCG officers in their oral evidence.

⁴⁶ O'Mahoney Day 11 page 166 line 13 to page 167 line 5

⁴⁷ Whitton WS para 119 INQ010137 page 47

⁴⁸ See for example Gibson Day 3 page 76 line 25 and page 159 line 17

⁴⁹ Ivory expert report INQ010133 section 5.2.3

“So it only makes sense that we treat those reports and incidents as being in distress unless, ideally, we have that credible information from reliable assets, so our assets or Border Force assets or even French coastguard assets ... Our training as coastguards is, you know, we need to take information, validate that information, analyse the information and be able to task the right asset to do the right thing at the right time.”⁵⁰

“Q. You need to have the credible evidence or the reliable evidence —

A. Exactly, and that is a big, big part of our training at all levels, especially mission co-ordinator and above as well.”⁵¹

“... just be mindful when you gather the information, analyse it, assess it, verify it, to get what you can. And that could be from the plane flying overhead ... So it’s gathering the information, assessing what you’ve been told and then getting some sort of visual confirmation, or eyes on, whether that be from French Coastguard, our planes, passing commercial shipping, stuff like that. It’s — it’s about verifying what they’ve told us.”⁵²

40. Their evidence was consistent with the guidance in the IAMSAR Manual which states:

“Information evaluation and analysis. As information is gathered, it should be verified to the extent possible and then evaluated and analysed with respect to all the information previously gathered.”⁵³

“Assumptions. In the early stages of a SAR incident, it is almost certain that the SMC will need to make some assumptions about the cause, nature, time, or place of the SAR incident. It is very important that such assumptions be kept separated from the known facts. It is always important to distinguish conclusions based strictly on known facts from those based partially on assumptions. It is also important to re-evaluate all assumptions regularly and as new information becomes available. Re-evaluating assumptions is especially critical.”⁵⁴

41. The problem of exaggeration makes reliable information particularly important. Witnesses from HMCG, Border Force, the RNLI and Bristow all confirmed that exaggeration occurred.

“It is common knowledge amongst those who operate within MRCCs and who take emergency calls that migrants who are attempting to cross, may exaggerate their levels of distress, in order to elicit a rescue. Callers often state that the vessel they are travelling in is taking on water, people are in the water and need rescuing, women or children are in distress, or threaten to puncture the vessel if help is not sent.”⁵⁵

“... I was aware of incidences where migrants had exaggerated their level of distress and, indeed, I had experienced it myself ...”⁵⁶

⁵⁰ Papadopoulos Day 9 page 34 lines 20-24 and page 35 lines 7-10

⁵¹ Papadopoulos Day 9 page 59 lines 1-5

⁵² Gibson Day 3 page 85 lines 13-16 and page 85 line 23 to page 86 line 3

⁵³ IAMSAR Manual Vol II para 3.8.3

⁵⁴ IAMSAR Manual Vol II para 3.8.4

⁵⁵ Papadopoulos WS para 51 INQ009632 page 20

⁵⁶ Toy WS para 39 INQ010135 page 14

*“As part of this information sharing BFMC staff were aware that migrants calling from MVs might exaggerate the level of distress they were in, in order to speed up the rescue response ... BFMC staff have rendered assistance to a large number of small boats which they were led to believe were in serious risk, only to arrive at the coordinates to discover the occupants were reasonably safe i.e. still afloat and making way and not sinking or with serious casualties onboard ...”*⁵⁷

*“Finally, the OCGs coach the casualties to call UK government numbers (the Coastguard) and relay a vast array of distress on board narratives that invite a priority rescue response.”*⁵⁸

*“... the migrants have been using certain key words. And we’ve seen a definite pattern of that over the past two or three years. Where they will use trigger words like not enough life jackets, women and children on board or we’re sinking ... They’re given an engine but they’re also told these keywords to trigger the response ...”*⁵⁹

42. As explained below, the evidence suggests that exaggeration is in effect an umbrella term for two related problems: (i) innocent overstatement (ii) deliberate exaggeration.
43. An example of innocent overstatement would be saying that you are in the water or sinking when your boat has taken on water. In his witness statement, Commander Toy explained that *“most boats would have taken on water during the passage”* and that *“taking water is serious, but does not necessarily mean that a given vessel is sinking”*.⁶⁰ Inexperienced mariners in a small boat that has taken on water might genuinely believe that they are sinking.
44. An example of deliberate exaggeration would be claiming that there is a pregnant woman on board when everyone on board is male. The Inquiry has received clear evidence of instances of deliberate exaggeration.
 - Incident Log Romeo 3 on 20 November 2021 records that migrants told the emergency services that 3 children had died, the boat was completely gone and the passengers were all in the water.⁶¹ None of this was true and the caller(s) would have known that it was not.
 - Incident Log Uniform on 24 November 2021 records that a caller shortly before 0800 hours stated that someone on board a boat was stating that someone on board had already died.⁶² This was not true and those on board would have known that it was not.⁶³
45. Both innocent overstatement and deliberate exaggeration caused problems for HMCG.

⁵⁷ Whitton WS paras 83 and 84 INQ000619 pages 32

⁵⁸ Ling WS para 43 INQ010101 page 19

⁵⁹ Trubshaw MAIB interview INQ006321 pages 11 and 13

⁶⁰ Toy WS paras 33 and 66 INQ010135 pages 11 and 66

⁶¹ INQ010269

⁶² INQ000259

⁶³ INQ008905 para 8.5.16 on page 186

46. At the initial response stage, they made it difficult to triage and prioritise incidents. HMCG addressed this issue by taking at face value the fact that all callers were in Distress unless and until it received credible evidence (e.g. from a SAR asset) that they were not. Distress is the most serious of the three emergency phases recognised by the SAR Convention⁶⁴ and HMCG's policy was to respond to every migrant small boat in order to rescue those on board.
47. HMCG's approach was a sensible and reasonable approach to a difficult problem not of its own making. In addition, it ensured compliance with the relevant international conventions.
48. We invite the Chairman in the final report expressly to reject the suggestion that the MCA or HMCG discriminated against migrants. The numbers rescued (over 160,000) speak for themselves. The MCA introduced measures specifically for migrants that it was not legally required to introduce: (i) proactively booking planes to carry out surveillance when crossings were likely and (ii) proactively tasking helicopters and surface vessels whilst individual migrant small boats were still in France's SAR region.⁶⁵ Further, the policy of treating all migrant small boats as in Distress enshrined an approach that was non-discriminatory. It meant that all migrant small boats and their passengers were to be rescued. The fact that HMCG officers evaluated reports to determine how many boats as opposed to incidents they were dealing with was a necessary and inherent part of their job.
49. The Inquiry is in possession of a wealth of evidence on Operation Sommen. That evidence clearly illustrates the commitment of the MCA and HMCG to providing assistance to all persons regardless of race or nationality as required by the SAR Convention.⁶⁶ This commitment resulted in an entry being added to the MCA Risk Register.⁶⁷
50. Where the tendency of migrants to overstate and exaggerate caused the most significant problems was at the stage of attempting to reconcile and close incidents.
51. The ideal scenario was for those who rescued migrants to obtain detailed and accurate information from them which could be relayed to HMCG. This information could then be compared with (ideally accurate) earlier information about boats in the process of crossing the Channel. The unreliability of reported information about boats in the process of crossing the Channel has been addressed above. But the challenge of obtaining detailed and accurate information did not cease at the point of rescue.
52. First, the evidence supports the contention in our Opening Statement that many migrants were not in the right frame of mind to provide their rescuers with a detailed de-brief.⁶⁸

*"Many casualties rescued from the water will very quickly deteriorate in condition with some suffering from 'survivors shock'."*⁶⁹

⁶⁴ SAR Convention Annex para 4.4

⁶⁵ MCA Opening Statement para 5

⁶⁶ SAR Convention Annex para 2.1.10

⁶⁷ INQ000167 pages 1 and 2

⁶⁸ MCA Opening Statement para 39

⁶⁹ Ling WS para 45 INQ010101 page 20

“The migrants had already often spent many hours at sea and were tired, hungry, cold and often in need of medical attention.”⁷⁰

“Translation services are not utilised by BFMC as part of our SAR role; to do so would slow things down and potentially enhance danger.... I imagine that the migrants’ primary concern is to be rescued, rather than understand everything in the moment. Moreover, given the traumatic experience they have been through, not least the freezing cold conditions, many migrants are largely uncommunicative regardless of language differences.”⁷¹

“But it was very difficult to sometimes establish what they’re saying — for language difficulties or they just don’t want to talk or they tell you what they think you want to know. So we couldn’t establish anything specifically.”⁷²

53. Secondly, there is clear evidence that migrants were instructed by the Organised Criminal Gangs (“OCGs”) not to be forthcoming when rescued and that some migrants followed these instructions.

- Shakar Alipour sent a voice note in which he said: *“If you have not heard from us, it is because I will throw away my mobile and it means it is UK ...”⁷³*
- Zana Mohammed states: *“... Twana also told my sister that he would throw away his phone if the UK police came because the smugglers did not want there to be any way for the British authorities to trace them.”⁷⁴*
- Captain Trubshaw told the MAIB: *“...what we’ve been seeing is a lot of time if you fly close to them, they stop they start throwing things off the side of the boat etc.”⁷⁵* The clear inference to be drawn is that what he saw was migrants throwing their phones and/or passports into the sea when they saw a SAR asset near them.
- The BBC spoke to a migrant who said he would *“toss his phone into the waves”* if he was rescued. The journalist stated that this was *“something many migrants have told the BBC they are ordered to do ...”⁷⁶*
- An article on Rudaw dated 29 November 2021 stated: *“The decision to throw their mobile phones into the water appears to have been a conscious one, according to people familiar with the journey ... Neither the migrants nor the families want to be considered a smuggler.”⁷⁷*

54. It follows that persons who had just thrown valuable mobile phones into the sea in order to conceal personal information would be unlikely to provide detailed and accurate information about themselves and their fellow passengers moments later.

⁷⁰ Whitton WS para 23 INQ010137 page 11

⁷¹ Whitton WS para 89 INQ010137 pages 34 and 35

⁷² Toy MAIB Interview INQ008330 page 6

⁷³ INQ009020 page 10

⁷⁴ Zana Mohammed WS para 62 INQ010210 page 13; see also Khudur WS para 16 INQ009688 pages 4 and 5

⁷⁵ INQ006321 page 7

⁷⁶ INQ008284 page 8

⁷⁷ INQ004438

55. We do not seek to blame migrants for following the instructions they are given by the OCGs. One would expect at least some of them to follow the instructions they are given. Further, it is understandable that some migrants would try to speed up rescue after they enter the UK SAR region but are still a long way from shore. When migrants follow such instructions from the OCGs it creates very real challenges for those attempting to reconcile and close incidents and requires them to make difficult judgement calls.

The requirement to make difficult judgement calls

56. Coordinating the search and rescue of migrant small boats inevitably requires difficult judgement calls.
57. It is helpful to consider the hypothetical case of a call from a migrant small boat saying it had 40 passengers and was sinking. An element of judgement had to be used when determining whether such a call was a repeat incident of a previous call referring to 35 people. If a boat was then found which had taken on water and had 33 passengers, judgement had to be used when determining whether it was a new incident or a repeat.
58. In addition, some calls cut off before any or any useful information could be imparted. The call at 0026 on 24 November 2021, which led to Incident Alpha being opened is an example of this.⁷⁸
59. On 24 November 2021 HMCG opened 91 separate alphanumeric incidents on its migrant small boat tracker.⁷⁹ By 0730, Neal Gibson had already had to decide that 8 out of 21 alphanumeric incidents were likely repeats.⁸⁰ In general, had active searching continued for every incident until there was definitive evidence that it was a repeat, all available assets would have been exhausted very quickly.
- The IAMSAR Curve provides a very upper limit of survival of approximately 20 hours for a water temperature of 13°C.
 - The average number of migrants per boat in November 2021 was 33.⁸¹ In theory, the number of persons on board 91 boats / unreconciled incidents of 33 migrants per boat would be over 3,000 – i.e. greater than the survivor capacity of 31 of the RNLI's largest lifeboats.⁸²
 - Under Border Force Maritime's forward operational plan: HMC Valiant was available overnight; CPV Hunter would only be deployed overnight if necessary and would otherwise be preserved for the morning of 24 November; and CTV Hurricane would only be used from the morning of 24 November.⁸³

⁷⁸ INQ007644 – the transcript notes the time of call as 0029, when in fact it was at 0026.

⁷⁹ ALPHA was opened at 0026 and NOVEMBER 3 at 1508. GOLF was not used in the first set.

⁸⁰ INQ006817. Alpha, Bravo, Delta, Foxtrot, India, Juliet, Oscar, and Papa.

⁸¹ 6,971 migrants; 209 boats

⁸² The survivor capacity (non self-righting) of a Severn class lifeboat is 96 – INQ010101 page 6

⁸³ INQ000566; see also Whitton WS paras 91 and 92 INQ010137 page 35

60. Therefore, SMCs had to use their experience and judgement (i) to reconcile incidents and determine that everyone involved had been rescued and (ii) to close incidents as repeats whilst being willing to re-open them if new information came to light. When reconciling incidents they had to bear in mind their awareness, based on personal and institutional experience, that persons on board a single small boat would make multiple calls and would often overstate or exaggerate their predicament.
61. It was appropriate for HMCG officers to take into account the fact that inexperienced mariners might describe themselves as sinking when in fact they were shipping water over the side. Failing to recognise that would hamper their ability to reconcile and close incidents. Similarly, it was appropriate for HMCG officers to take into account that a boat without a pregnant woman on board might nevertheless be the boat reported as having a pregnant woman on board. Failing to recognise that possibility would also hamper their ability to reconcile and close incidents.
62. The difficulties in reconciling incidents and the need to exercise judgement to reconcile and close them is illustrated by the fact that, even today following intensive forensic investigations, it is not possible definitively to say (a) whether the call at 0306 hours on 24 November 2021 was made from the same boat as the call at 0312⁸⁴ or (b) whether either of those calls was linked to Incident Charlie.⁸⁵

Hindsight

63. The Inquiry's Terms of Reference require the Chairman to: "*Consider what further lessons can be learned from the events of 24 November 2021 and, if appropriate, make recommendations to reduce the risk of a similar event occurring.*" The ToR, therefore, invite the use of hindsight because they invite consideration of whether lives could have been saved (and could be saved in future) if things were done differently. Such an analysis is appropriate and necessary when considering possible recommendations. But the use of hindsight must be kept within proper limits. The permissible use of hindsight when considering recommendations should not be allowed to flow into an impermissible assumption that HMCG and its SAR partners should be criticised for the deaths that tragically occurred.
64. There may be a temptation to assume that someone must be to blame for these deaths. That temptation may be increased by the knowledge that, by 23 November 2021, HMCG had successfully rescued over 35,000 migrants and that, for various reasons, the chances of rescue today would be higher than they were at the time.
65. But the temptation to assume that someone in addition to the criminals must be responsible for this tragedy is one that must be resisted.

⁸⁴ The 0306 call (INQ007657) referred to 45 people, then to 35. The 0312 call (INQ007658) referred to 40 people.

⁸⁵ The 0306 call twice referred to a pregnant woman – to the best of our knowledge there has been no evidence that anybody on board Charlie was pregnant. The 0312 call referred to "10 ladies and 10 olden guys" amongst the 40 people on board – that also does not fit the evidence about Charlie.

66. We do have concerns that some lines of questioning were driven by a hindsight based analysis. We have already referred to questions about what HMCG officers “knew”. In addition, the avenue of investigation which resulted in Mr Ling’s second witness statement appeared to be heavily driven by hindsight. Fundamentally, the exercise of comparing the response time of Valiant to an RNLI lifeboat is artificial. At the time, Border Force Maritime had, with good reason, become the main resource for migrant small boat SAR⁸⁶ and Valiant was the designated first responder on the night. A lifeboat would not have been tasked in preference to Valiant if Valiant were available, which it was. We also make the following points of detail.

- (1) The evidence that Border Force cutters were not specifically designed for SAR operations was misinterpreted and/or taken out of context. They are marketed by their manufacturer as having search and rescue as one of their basic functions.⁸⁷ Whilst there is evidence that RNLI lifeboats have greater ability to effect rescues in challenging sea states, that has no relevance to the events of 23/24 November 2021.
- (2) Comparisons were drawn between the number of persons which could be rescued by cutters and lifeboats and how easy or difficult it would be to embark migrants from a small boat onto either vessel. But, to the best of our knowledge, no questions were asked about a more relevant issue: whether an RNLI lifeboat would have had any better chance of finding a migrant small boat in the dark in the first place. As a result, there is no evidence that it would have done. Border Force cutters were designed to find and interdict small vessels including fast moving small vessels aiming to avoid detection because they were involved in illegal activities. They were well equipped for the task of searching and the size of their crew meant that visual searches could be undertaken in different directions at the same time.
- (3) Many of the assumptions within Mr Ling’s calculations mean that any attempt to compare the time that it would have taken an RNLI lifeboat to reach the Mayday relay position and the Sandettie light vessel with Valiant’s passage would be inherently flawed, because it would not compare like with like.
 - (i) The calculations were intended to provide a likely response time at around 0128, when Valiant was tasked. This was the middle of the night. Mr Ling sensibly agreed that launch times at night take longer than during the day; the reasons for this being self-evident.⁸⁸ Yet the RNLI’s calculations used an average from both day and nighttime.⁸⁹ A fair comparison would use nighttime averages only.⁹⁰
 - (ii) The estimated port transit time used for Dover (5 minutes) is also unrepresentative. In clearing the Port of Dover, the lifeboat would have been subject to similar

⁸⁶ See para 89 below

⁸⁷ <https://media.damen.com/image/upload/v1632482645/catalogue/defence-and-security/stan-patrol/stan-patrol-4207/product-sheet-stan-patrol-4207.pdf> It is a matter of public record that Valiant is a Damen Stan Patrol 4207.

⁸⁸ Ling Day 10 page 95 line 20 to 22. Crew members have to wake up, travel to the station, and get ready.

⁸⁹ Ling Day 10 pages 95 to 96

⁹⁰ Otherwise the average used will be artificially quick.

constraints as those which in fact pertained to Valiant. Therefore, a fairer comparison would be the actual time taken by Valiant – i.e. 22 minutes.⁹¹

- (iii) Similarly, the RNLI's calculations do not take account of maritime traffic in the Dover Strait: *"What it doesn't account for is having to slow down or take avoiding action for shipping"*, aptly described by CTI as *"another important variable, surely, on any given tasking."*⁹² Valiant was in fact limited by maritime traffic, as its AIS track attests.⁹³ Any estimated response time that disregards likely traffic is artificial, and it must be assumed that any RNLI vessel would have encountered the same traffic, and been subject to the same consequential restrictions, as Valiant.
- (iv) An RNLI all-weather lifeboat and Valiant had comparable top speed (25knots⁹⁴ vs 26knots⁹⁵). But both would have been limited to "safe" or "best" speed. Commander Toy explained: *"16 knots was the 'best speed' which I could adopt at that time, being the maximum safe speed which, taking into account the conditions in the Channel, would allow me to stop at a reasonable distance in accordance with Rule 6 of the International Collision Regulations ... It was not merely a question of proceeding at the maximum technical speed HMC Valiant could achieve."*⁹⁶ Any RNLI commander would have been subject to the same requirement.⁹⁷ There are no grounds for thinking that a lifeboat's best speed would have been any higher than Valiant's, unless it is suggested that its commander would have proceeded in an unsafe or reckless manner so as to achieve greater speed.
- (v) As for the calculations of time to transit to the closest point on the median line, this is of no assistance to the Inquiry. The RNLI used a point relative to each lifeboat station.⁹⁸ No positions have been provided, but it is self-evident that the position used for each lifeboat station will have been different as the shortest distance to the median line will be different from each lifeboat station. These positions are not the same as the relevant locations on the night.

67. The following matters which were not known⁹⁹, and could not have been known by HMCG, illustrate our submission about the need to guard against employing a hindsight based analysis.

⁹¹ Toy WS para 65 INQ010136 page 23

⁹² Ling Day 10, page 91 lines 5 to 7, and lines 16 to 17

⁹³ INQ001384. See also Toy Day 5, pages 56 line 16 to page 59 line 22; page 90 line 9 to page 91 line 19; and page 93 lines 19 to 22, "if there wasn't that traffic in the Southwest bank lane, I could have probably taken a more direct route, but unfortunately, I couldn't."

⁹⁴ See the table in Ling WS para 15 INQ010101 page 6

⁹⁵ <https://media.damen.com/image/upload/v1632482645/catalogue/defence-and-security/stan-patrol/stan-patrol-4207/product-sheet-stan-patrol-4207.pdf> It is a matter of public record that Valiant is a Damen Stan Patrol 4207.

⁹⁶ Toy WS para 69 INQ010136 pages 24 and 25

⁹⁷ Ling Day 10, page 91 lines 12 onwards: "So the lifeboat will be working very hard at this stage to proceed at best speed, but do so safely and in compliance with international regulations for the prevention of collision."

⁹⁸ Ling Day 10, page 93 line 19 onwards

⁹⁹ See the section above on "The distinction between reported and verified"

- (1) The fact that predictions of numbers of crossings which had been accurate in the past would prove to be wholly inaccurate for November 2021.
- (2) The fact that more small boats would be launched on the night of 23 November than the night of 24 November.
- (3) The number of small boats launched on the night of 23/24 November.
- (4) The number of small boats in the vicinity of the Sandettie light vessel – even today this is not known.
- (5) Whether any small boats had capsized.
- (6) Whether there were persons who were in the water.

The approach to be adopted when judging HMCG

68. The ToR do not expressly require the Chairman to make criticisms in the final report, although they do not prohibit him from doing so. However, if the final report is to make criticisms of organisations or individuals there needs to be a clear conceptual basis for such criticisms and clarity as to the standard against which organisations and individuals are being measured.
- Is it fair to criticise individual HMCG officers if their conduct did not fall below the standard of the reasonably competent HMCG officer holding their position?
 - If the conduct of individual HMCG officers is to be measured against the standard of the reasonably competent HMCG officer holding their position, how is that standard to be determined given the limited evidence available to the Inquiry?
 - If the conduct of HMCG is to be measured against the standard of the reasonably competent SAR service, how is that standard to be determined given the limited evidence available to the Inquiry?¹⁰⁰
69. In the BSE Inquiry the Panel (Lord Phillips of Worth Matravers, Mrs June Bridgeman CB and Professor Malcolm Ferguson-Smith FRS¹⁰¹) expressly set out the approach that they had adopted to criticism of individuals:

“In considering the adequacy¹⁰² of the action of individuals we have kept in the forefront of our minds the dangers of hindsight. We have had regard to all the surrounding circumstances which have often explained and excused action which at first blush seemed open to criticism. We have had well in mind that in any situation there is likely to be a range of responses from the inspired to the unimaginative, all of which fall within the compass of a reasonable response. Only where, having regard to all the relevant circumstances, we have concluded that the response of an individual fell below the

¹⁰⁰ See the section above on “The best evidence about how to coordinate search and rescue”

¹⁰¹ A senior judge, a retired senior civil servant and a geneticist

¹⁰² The Terms of Reference of the BSE Inquiry expressly required the Panel “to reach conclusions on the adequacy of [the] response, taking into account the state of knowledge at the time”

*standard to be expected of a person holding his or her position, have we indicated that the individual was at fault.”*¹⁰³

70. Any consideration of criticisms must have regard to the following matters, which are (where necessary) explained in more detail below.
- (1) The applicable legal framework: organisations and individuals should not be criticised for failing to do something if there was no legal requirement for them to do it in the first place.
 - (2) The fact that the Inquiry is not an expert in maritime SAR and has not sat with assessors who are.¹⁰⁴
 - (3) The need to guard against employing a hindsight based analysis.¹⁰⁵
 - (4) The fact that there can be no guarantee that persons who cross the Channel in a migrant small boat will be rescued.
 - (5) The importance of adopting a realistic approach, rather than an excessively forensic approach, when making judgements about the judgements made by HMCG officers.
71. We addressed the applicable legal framework in paragraphs 20-31 of our Opening Statement. Our analysis was not challenged in the Inquiry’s revised Legal Framework document dated 4 April 2025 and remains unchallenged. Our analysis includes the following points of fundamental importance.
- The French Coast Guard is responsible for coordinating the search and rescue of migrant small boats as they pass through France’s SAR region.
 - It is only when a transfer of responsibility for an incident has been expressly accepted by HM Coastguard, or when HM Coastguard becomes aware that a migrant small boat has entered the UK SAR region, that responsibility for its search and rescue passes from France to the UK. It is only at this point that the UK’s SAR service (i.e. HM Coastguard) is required to coordinate a SAR operation.
 - The SAR Convention does not require a State to patrol its SAR region.
 - Neither the European Convention on Human Rights nor domestic law provisions require the UK to commence a SAR operation in respect of a migrant small boat while it is in France’s SAR region.
72. Further, there is no duty under the relevant international conventions to ensure that SAR assets are immediately on scene or on scene within any set period of time. During the hearings, it was suggested that 2 hours to reach the Mayday Relay position was “*a very long time*”¹⁰⁶ and it appeared to be suggested that SAR assets should immediately have been on scene to assist.¹⁰⁷ This is a conflation of the obligations under the SAR Convention

¹⁰³ BSE Inquiry report (887-I) Vol 1 para 30

¹⁰⁴ See also the section above on “The best evidence about how to coordinate search and rescue”

¹⁰⁵ See the section above on “Hindsight”

¹⁰⁶ Toy Day 5 page 86 line 14 to page 87 line 6, page 93 line 23 to page 94 line 7

¹⁰⁷ Whitton Day 11 pages 101 line 24 to page 102 line 12

with the definition of Distress.¹⁰⁸ The SAR Convention covers all of the world's oceans and seas including areas thousands of miles from land. A sailing boat that loses its keel in the mid-Atlantic obviously requires immediate assistance but the fact that a SAR asset does not arrive on scene for many hours is not a breach of the SAR Convention.

73. As stated in the Inquiry's Legal Framework document: "*UNCLOS, SOLAS, and the 1979 SAR require States to establish, operate and maintain search and rescue services at sea.*"¹⁰⁹ A failure to achieve a rescue in an individual case is not a breach of these conventions.
74. By having a SAR service – i.e. HMCG – that was capable of receiving distress calls and coordinating SAR operations 24 hours a day, 365 days per year the UK complied with the international conventions¹¹⁰ and with the Article 2 ECHR systems duty.
75. Neither the international conventions nor Article 2 ECHR required HMCG (i) to be able accurately to predict the number of migrant small boat crossings (ii) to be able to draw upon an unlimited number of SAR assets or (iii) to service the needs of the OCGs.
76. Finally, in relation to the Article 2 ECHR operational duty, in *Safi v Greece*¹¹¹ the European Court of Human Rights:
- Emphasised that: "*admittedly, State agents – coastguards in the present case – cannot be expected to effect the successful rescue of everyone imperilled at sea, especially as their obligation in the present case was one of means, not one of result.*"
 - Reiterated that: "*considering the difficulty of the task that fell to the maritime authorities in such circumstances, the unpredictability of human conduct and the operational choices that had to be made in terms of priorities and resources, the scope of the national authorities' positive obligation must be interpreted in a way which does not impose an impossible burden on them ...*"
 - Reiterated that Article 2: "*cannot be interpreted as guaranteeing every individual an absolute level of security in any activity in which the right to life may be at stake, in particular where the person concerned bears a degree of responsibility for the accident whereby he or she was exposed to an unjustified risk ...*"¹¹²
77. The facts of *Safi* were very different from this case because the coastguard vessel, having found the migrant small boat in question, persisted in a disastrous second attempt to tow it despite the fact that panic had been observed the first time round.¹¹³
78. In the light of the above, one cannot approach an analysis of HMCG's actions on the basis that it was under a duty to guarantee the rescue of all migrants.

¹⁰⁸ SAR Convention Annex para 1.3.13

¹⁰⁹ Para 11

¹¹⁰ SAR Convention Annex paras 2.3.2, 2.3.3 and 4.2.1

¹¹¹ Application 5418/15, 7 July 2022

¹¹² *Safi* paras 157, 164 and 165

¹¹³ *Safi* para 161

79. It is therefore neither helpful nor justifiable to use the fact that a fatal incident was “foreseeable” and “predictable” as a stepping stone to making criticisms. A fatal incident was indeed foreseeable and predictable because crossing the Channel in a migrant small boat is dangerous and carries a serious and obvious risk of death¹¹⁴ - thus HMCG’s policy that all migrant small boats should be categorised as in Distress at the moment that they are known to have entered the UK SAR region.¹¹⁵
80. Appropriate weight and respect should be given to the view of Lady Chief Justice Carr in *R v Ibrahima Bah*¹¹⁶ that a typical migrant small boat was “*not safe at all*” and was “*wholly unsuitable and unequipped for the crossing of the Channel which was attempted*”. By upholding the gross negligence manslaughter conviction of the skipper of a migrant small boat, the Court of Appeal confirmed that such a crossing involves a serious and obvious risk of death.¹¹⁷
81. In the circumstances, it should be self-evident that there is no guarantee of rescue for those who attempt the crossing.¹¹⁸ The logical consequences of this are (i) that fatalities are not necessarily preventable and (ii) that HMCG should not be regarded as the guarantor of the smugglers’ dangerous, flawed and criminal business model.
82. It is important to adopt a realistic approach, rather than an excessively forensic approach, when making judgements about the judgements made by HMCG officers on 23 and 24 November. They had to act and make decisions in real-time in a pressurised environment. They did not have the benefit of important pieces of information which are now known.¹¹⁹ Nor did they have the benefit of being able to spend days and weeks forensically analysing Incident Charlie.

Pre-planning for the period 23-25 November 2021

83. The Operation Deveran forecasts issued by the Met Office National Security Advisory Group were more than weather forecasts. They were a predictive analysis product that used historical data and recent data on crossings, as well as data on wave heights and weather conditions.¹²⁰
84. The forecast issued on Friday 19 November predicted “the likelihood of crossing attempts due to weather” as “Unlikely” from 2200 hours on 23 November and “Likely” from 2200 on 24 November.¹²¹ At the Red Day meeting at 1600 hours on 19 November, it was noted that the forward weather forecast had “*fairly low confidence at present*” and it was

¹¹⁴ See MCA Opening Statement paras 26, 27 and 33-35

¹¹⁵ Unless there is compelling evidence to indicate that they are not in Distress.

¹¹⁶ [2024] EWCA Crim 1499

¹¹⁷ See MCA Opening Statement paras 26 and 27

¹¹⁸ This reality is acknowledged in the In-Water Mass Casualty Triage Tool (INQ009006) discussed with Professor Tipton and Mr Ling, as it is premised on the understanding that not all persons can be saved. It was developed in collaboration with HMCG.

¹¹⁹ See the sections above on “The distinction between reported and verified” and “Hindsight”

¹²⁰ O’Mahoney Day 11 pages 154-155; O’Mahoney WS para 47 INQ010134 page 17

¹²¹ INQ000143

therefore agreed to wait until the forecast was updated on Monday and then make a plan.¹²² By the time the next forecast was issued, on the morning of Monday 22 November, the position had changed. Crossings were predicted as: “Unlikely” before midnight on 23 November; “Realistic Possibility (Yellow)” from 0300 on 24 November; “Likely” from 0600 on 24 November; and “Highly Likely” from 2200 on 24 November.¹²³ A Red Day meeting was held at 1800 hours on 22 November.¹²⁴ The final forecast issued before the night of 23/24 November was issued at 1150 hours on 23 November.¹²⁵ It predicted that:

- Crossings were Unlikely at 2100 hours on 23 November.¹²⁶
- Crossings were Likely from 0000 hours on 24 November, although launching conditions were unfavourable on the Northeast beaches (i.e. from where Charlie was launched) and Marginal on the Central Beaches.¹²⁷
- Crossings were Highly Likely from 1800 hours on 24 November.¹²⁸
- Conditions would deteriorate in the early hours of 25 November with significant wave heights by 0900 hours.¹²⁹ This would pose a particular risk to boats launched during the night of 24/25 November which were still in the Channel at that time – a point made by Duncan Ley at the 22 November Red Day meeting.¹³⁰

85. HMCG was not involved in the creation of these forecasts. Its role was to make plans in the light of them; not to attempt to second guess them. When making its plans it needed to manage the resources available to it judiciously so as to use them most effectively across the period 23-25 November in the light of the forecast.

Aerial and surface assets

86. At the Operation Deveran Joint Activity Review Meeting on 18 November it was recognised that both Border Force Maritime and RNLi surface assets were functioning at the highest level of their capacity.¹³¹ It would have been irresponsible for HMCG to have deployed all its assets on an Amber night knowing that it would be followed by first a busy day and then a Red night. If doing so had left it unable to respond to a disaster at sea on the Red night it would be criticised – and rightly so. The Chief Coastguard in effect made this point at the Red Day meeting on 19 November: “*if we burn all our assets on Saturday we won’t be able to respond on the Sunday*”.¹³²

¹²² INQ000204 page 5

¹²³ INQ000146

¹²⁴ INQ000222 pages 11-15

¹²⁵ INQ000150

¹²⁶ Page 6

¹²⁷ Pages 7 and 1

¹²⁸ Page 10

¹²⁹ Pages 13 and 14

¹³⁰ INQ000222 page 2

¹³¹ INQ009957 page 2

¹³² INQ000204 page 3

87. The risk of burning through assets was real not fanciful. The crews of surface assets¹³³ and aerial assets¹³⁴ (and the assets themselves¹³⁵) cannot work round the clock. Working hours in the air and at sea are tightly regulated for safety reasons. Captain Trubshaw explained the concepts of tiredness and fatigue and how fatigue results in reduced performance.¹³⁶
88. 2Excel were represented at the Red Day meeting on 22 November and raised no concerns when aerial assets were discussed.¹³⁷ The final aviation plan for 24 November was for 2Excel planes to fly Operation Eos taskings between 0300 – 0800 and 0830 – 1600,¹³⁸ with a Tekever drone to fly between 0530 – 1330.¹³⁹
89. As to surface assets, by November 2021 Border Force Maritime vessels had, with good reason, become the main resource for migrant small boat SAR. Mr Ling pointed out that one cannot mandate volunteers and made it clear that, by November 2021, RNLI lifeboat crews were under immense pressure and were experiencing what he called “Red Days stress”.¹⁴⁰ This is supported by the minutes of the Red Day meeting on 16 November 2021 which stated: “RNLI — overall — very evident that fatigue is playing a part in volunteers and crews — changing crews out — issues regarding employers — being managed — trying to address support.”¹⁴¹ It would have been neither realistic nor sensible in November 2021 to have changed approach and made RNLI lifeboats the main resource.
90. The plan for Border Force Maritime assets was as set out below.¹⁴² Prior to November 2021 similar plans had proven sufficient.¹⁴³
- Valiant to be the primary responder on the night of 23/24 November.
 - Hunter to be on standby on the night of 23/24 November.
 - Hurricane to deploy reactively from 0600 on 24 November.
 - Valiant to be the primary responder until 0400 on the night of 24/25 November.
 - Hunter to be the primary responder from 0400 on 25 November with Hurricane available from 0600.¹⁴⁴
91. In the circumstances, there was a clear need to manage resources judiciously. Mr Gibson’s evidence about “*managing what limited assets I’ve got*”¹⁴⁵ and Mr Golden’s description of the SAR helicopter as the “*crown jewel*”¹⁴⁶ should be interpreted in this light.

¹³³ 19.11.21 Red Day meeting INQ000204 page 3: crews would need 10-12 hours downtime after deployment.

¹³⁴ Red Day meeting 16.11.21: “any further taskings may encroach on their flying hours” INQ000209 page 2

¹³⁵ Red Day meeting 16.11.21: “2XL won’t be able to fly due to maintenance” INQ000209 page 2

¹³⁶ Trubshaw Day 4 page 125 line 12 to page 126 line 2

¹³⁷ INQ000222 pages 1 and 3

¹³⁸ INQ000148, INQ001188

¹³⁹ INQ000566

¹⁴⁰ Ling Day 10 page 71 lines 1-4

¹⁴¹ INQ000209 page 2

¹⁴² INQ000566

¹⁴³ O’Mahoney Day 11 pages 180, 181 and 190

¹⁴⁴ INQ000593

¹⁴⁵ Gibson Day 3 page 135 line 3 to page 136 line 1

¹⁴⁶ Golden Day 6 pages 124, 125, 167

92. In short, the plans made in respect of aerial and surface assets for the period 23-25 November 2021 were, when judged without the benefit of hindsight, carefully considered, reasonable and not open to criticism.
93. This includes the planned timings of flights. There was a discussion at the Red Day meeting on 22 November about the time when activity would start on a night when boats were launched.¹⁴⁷ This was an appropriate discussion to have but the decision reached – to stick to the existing planned timings – was a reasonable one. There was insufficient evidence of a new pattern of migrant small boat departure times to warrant a change. The fact that activity had started at 2030 on a specific evening was expressly said to be “*significantly earlier than expected*”. That this was unusual is confirmed by the evidence of HMCG officers about when boats (which take many hours to complete the crossing) tended to cross the median line and when was the peak time for SAR operations;¹⁴⁸ one isolated incident does not represent a new pattern. Equally importantly, the Amber period was not forecast to begin until midnight on 23 November.

Staffing

94. Plans for staffing were also made on the basis that for any night of small boat activity “*most small boats would cross the median line ... after 7.30am*”.¹⁴⁹
95. The national network was a central and crucial feature of HMCG’s operational model and was the primary system for ensuring a sufficient level of staffing per shift. As stated in our Opening Statement, the flexibility provided by the national network had many advantages.¹⁵⁰ Since 2018 over 50% of migrant small boat work has been handled by a remote SMC.¹⁵¹ This figure speaks for itself: remote SMCs are effective. As Mr Leat stated: “*remote working, staff being able to dial in to support on increased complex incidents, is absolutely vital to ensure that we can deliver the best service to the public that we can.*”¹⁵²
96. On 19 November, the Deputy Chief Coastguard sent a detailed email stating that it had been decided to provide Dover with enduring, reliable network support and explaining changes that would be introduced later that day.¹⁵³ Those network-based changes included relieving Dover of responsibility for zones 11 and 13 and of responsibility for broadcasting Maritime Safety Information for the Dover area. Further, it was stated that the JRCC would generally be the station supporting Dover with migrant small boat SAR.
97. At the Red Day meeting on 22 November it was (correctly) stated that: “*Network numbers of 24th and 25th November are healthy, at least 10 above minimum recommended staffing levels. JRCC numbers are also healthy, more so during the day but still above minimums at night ...*” The minutes continued “*support for Dover should take place smoothly*”.¹⁵⁴

¹⁴⁷ INQ000222 page 3

¹⁴⁸ Papadopoulos Day 9 pages 11 and 45; Cockerill Day 8 page 187-188; Leat Day 12 page 80 lines 20-22: “usually small boats would be entering the UK [SAR] region 6, 7, 8 o’clock in the morning”

¹⁴⁹ Papadopoulos Day 9 page 45

¹⁵⁰ MCA Opening Statement paras 14 and 15

¹⁵¹ Leat Day 12 page 64 lines 12-14

¹⁵² Leat Day 12 page 71 lines 15-18; see also pages 63, 64 and 71

¹⁵³ INQ003731

¹⁵⁴ INQ000222 page 4

Plans were made to move coordination to the JRCC if a member of staff fell sick at Dover. This was a real risk during the COVID pandemic and further illustrates the benefits of the national network.

98. As a number of HMCG officers told the Inquiry, the ideal scenario was to have sufficient staff physically present at Dover MRCC. The Chief Coastguard's comment on 22 November 2021 that two Coastguard officers at Dover on nights "*isn't enough*"¹⁵⁵ reflects this. In the period 19-24 November, staffing levels were monitored at Red Day meetings and efforts were made to increase the number of staff on duty at Dover. Richard Cockerill agreed to work at Dover on 24 and 25 November and to start his shift at 0500 hours on 24 November. Following a lengthy discussion at the Red Day meeting on 22 November, Duncan Ley emailed all stations with a "*request for anyone available and willing to travel to and work from MRCC Dover for the upcoming Tuesday and Wednesday night shifts this week ...*"¹⁵⁶
99. Several of these staffing-related measures were, or were similar to, "Options" suggested by Mike Bill in his email dated 17 August 2021.¹⁵⁷ As his email recognised, existing staff ready to consider promotion to SMC would not do so immediately: "*they could attend SMC 5 in May [2022] ... hopefully in readiness for the busy season*".
100. The number of HMCG officers on duty in the national network on the 23/24 November night shift and the 24 November day shift exceeded the recommended staffing levels for the network.¹⁵⁸
101. As it happened, more small boats were launched on the night of 23/24 November than on the night of 24/25 November. But HMCG could not have known that in advance. It was more likely that those nights would follow the pattern of the most recent occasion when there had been an Amber Day followed by a Red Day. On that occasion 22 boats had crossed on the night of 9/10 November followed by a record 36 boats on the night of 10/11 November.¹⁵⁹
102. In summary in the period 23-25 November, HMCG needed to, and did, manage the resources available to it judiciously in the light of the Operation Deveran forecasts and its experience of patterns of migrant small boat activity.

The events of 23/24 November 2021

103. We provided an outline of events relating to Charlie in our written Opening Statement. We stand by that summary in light of the detailed oral evidence heard by the Inquiry, and invite the Inquiry to adopt it. In particular, we reemphasise the need to acknowledge that focusing on Charlie is artificial, and does not reflect the experience of HMCG officers on the night,

¹⁵⁵ INQ000222 page 4; clarified in Leat WS para 6.26 INQ010098 page 104

¹⁵⁶ INQ006765

¹⁵⁷ INQ003322: "Bring competent staff to Dover for periods of duty", "Should the JRCC have capacity allow them to take zone 14"

¹⁵⁸ Leat WS paras 5.65 and 5.66 INQ010098 pages 92 and 93

¹⁵⁹ INQ007305 and INQ007306

who had to deal with all incidents and seek to rescue all occupants of an unknown number of small boats, often at the same time. In this section we have focused on the key events on the night of 23/24 November 2021 as they would have been experienced by the key decision makers: the Aviation Tactical Commander, Dominic Golden; the two commanders of the SAR assets, Commander Toy and Captain Trubshaw; and, most of all, the SMC, Neal Gibson. In doing so, we have sought to analyse events without hindsight, identifying what individuals knew and could not have known, and giving fair weight to the difficult judgements each had to make in challenging circumstances.

104. The starting point is what was known and what could reasonably have been anticipated at the beginning of the evening on 23 November - from 1930 at the start of the shift up to the 2100 Network briefing. Four issues merit emphasis.

- (1) Firstly, likely crossing times in light of the latest Operation Deveran forecast.¹⁶⁰
- (2) The consequent anticipated workload was reflected in the 2100 Network briefing.¹⁶¹ As Mr Gibson explained in his oral evidence: *“In my mind, Dover had already anticipated breaks getting done as soon as possible, anticipating a midnight start based on the Op Deveran forecast. So we were very aware [in] Dover, you know, early hours of the morning is when we are going to start to hit our maximum demand... the plan was to get all the breaks done about 2 o’clock at the latest”*¹⁶²
- (3) It has been suggested that HMCG officers should have requested the French tracker sooner. This is not a fair criticism. The French Coast Guard is a SAR authority and responsible for search and rescue in its SAR region.¹⁶³ It also had a specific obligation to provide information in a timely manner.¹⁶⁴ Whilst there had been occasions in the past when the French Coast Guard had not sent the tracker as early as they could have done,¹⁶⁵ HMCG could not compel the French Coast Guard to send it at a particular time. Most importantly, in light of the Operation Deveran forecast, crossing activity before midnight was not expected. The absence of a French tracker before midnight was therefore, from HMCG’s perspective, understandable and not untoward.
- (4) As for aerial assets, the Network briefing raised the risk of fog across southern areas. This was a matter entirely outside of HMCG’s control. Nevertheless, as of 2100 hours 2Excel’s clear and communicated intention was for two aircraft to fly on rotation to cover the Operation Eos taskings.¹⁶⁶ Starting his shift, Neal Gibson would have had no reason to doubt that fixed wing aircraft would endeavour to provide a recognised

¹⁶⁰ See the section above on “Pre-planning for the period 23-25 November 2021”

¹⁶¹ INQ000233

¹⁶² Gibson Day 3 page 47 line 14 onwards; and page 48 line 25 to page 49 line 1.

¹⁶³ MCA Opening Statement para 28

¹⁶⁴ For example, Article 21.1 of the ManchePlan, INQ000095 page 35

¹⁶⁵ Mike Bill raised this in his August 2021 email (INQ003322 page 3) and it was raised at a meeting with the French Coast Guard the following day, 18.8.21. The minutes of that meeting state: “Matters arising: French migrant tracker emailed to Dover as often as possible & as early as possible” INQ000199

¹⁶⁶ See in particular the call between Jacob Lugg of 2Excel and the ARCC at 2001 (INQ008827) at pages 3 to 4: “We’ve got two [aircraft] going. We’ve got 22 and 25”; page 4, Lugg “We should have it pretty covered. From 00.30, we’ll be covering each aircraft’s gap with another aircraft.”

maritime picture from the early hours of 24 November, irrespective of the presence or absence of a French Tracker.

105. Mr Gibson was questioned about the 0041 Tactical Commanders' entry in the Migrant Administration Log: *"concern is that with poor [visibility] and our surveillance aircraft being limited to conduct mission we are effectively blind. Both ... agree that caution of allowing ourselves be drawn into a relaxing and expecting a normal migrant crossing night whereas this has the potential to be very dangerous."*¹⁶⁷ This was a statement of fact, of a situation beyond both the SMC's and HMCG's control. Following the 2100 Network briefing he was expecting a busy shift, and was aware of fog and its potential impact on aviation's ability to provide surveillance. He was not drawn into a false sense of security.¹⁶⁸ The unavoidable outcome for the SMC was that it would be *"harder to coordinate an effective overall SAR picture without [the fixed wing] aerial asset involved."*¹⁶⁹
106. Dominic Golden's responsibilities as Aviation Tactical Commander were circumscribed. He had to monitor 2Excel's ability to fulfil the Operation Eos taskings, and consider any available alternatives if its planes were ultimately unable to fly. He did not, and was not required to, play any part in the coordination of SAR operations. With first the cancellation of the Panther flight and postponement of the King Air flight at 2353,¹⁷⁰ and later the recognition after 0200 that no flights could take place, Mr Golden had to make a difficult judgment: whether to use R163 for surveillance, and if so when to task it. His decision making was prudent and reasonable. He needed to contact the captain, explain the tasking and, in his words *"persuade a gentleman that's just been asleep to get up and put his life and his crew on the line, to go and fly in what I would consider extremely marginal conditions."*¹⁷¹ He succeeded. His decision to aim for having the helicopter on scene from 0300 was based on his knowledge that he would *"get about two hours of flying from the helicopter"*, that a drone was scheduled from 0530, and that small boats tended to enter the UK SAR region *"from about 3 o'clock"* in the morning.¹⁷² Once tasked, coordination of R163 devolved to the SMC.
107. Provision of the French tracker earlier than 0056 would have put HMCG on earlier notice of migrant activity and allowed for *"proactive planning for search and rescue."*¹⁷³ However, the 0056 tracker did not include Migrant 7 and did not link Migrant 1 to Charlie. Indeed, the coordinates provided for Migrant 1 appeared so erroneous they were promptly queried by HMCG and confirmed to be so. The corrected position, provided during the same 0106 call that first raised Migrant 7, was off the French coast near Gravelines, some 7.5nm from the median line at the nearest point.¹⁷⁴ Receiving the French tracker earlier

¹⁶⁷ INQ000235, pages 2 to 3

¹⁶⁸ See Gibson Day 3, page 73 line 12 onwards: "I was not expecting a normal, relaxed night at all. I can tell you, I was very aware of what I was expecting and the response that would be required."

¹⁶⁹ Gibson Day 3 page 73 lines 23 to 25

¹⁷⁰ INQ010447 page 2

¹⁷¹ Golden Day 6 pages 156 to 157

¹⁷² Golden Day 6 page 153 line 24 to page 153 line 18. Golden's experience in regards to historic crossing times is not inconsistent with that of other HMCG officers - see paras 93 to 94 above.

¹⁷³ Gibson Day 3, page 60 lines 16 to 17

¹⁷⁴ Notably, the corrected Migrant 1 position did not change in later iterations of the tracker.

would have been helpful but it would be speculation to assume that earlier provision of this Migrant 1 position would have led to earlier deployment of Valiant and successful location of Charlie.

108. The initial reference in the Incident Charlie log to Charlie appearing in good condition¹⁷⁵ was soon superseded by Mr Gibson recording “*unknown condition*” at 0143. He explained the rationale for this entry as follows: “*I don’t know what’s happened to the status of that craft as it has proceeded across the English Channel. So I don’t know its current condition because I have no current French asset with it to give me an update on its status or aerial observation of it... it started off alright, but how is it now, that’s an unknown... I don’t know what condition it’s in now.*”¹⁷⁶ In doing so, Mr Gibson aptly encapsulates the difference between what was known and what required verification.
109. Mr Gibson’s work as SMC started in earnest on return from providing VTS cover at around 0130. He described the SMC role succinctly in his statement: “*to gather information about distress situations, develop accurate and workable SAR action plans and dispatch and coordinate the resources to carry out SAR missions.*”¹⁷⁷ By November 2021 he was highly experienced in small boat SAR. He recalled crossings from November 2018, and explained that “*in a standard 12-month cycle of shifts, I would say probably 50 would have involved some form of small boat crossing.*”¹⁷⁸
110. Clearly Mr Gibson was profoundly affected by the deaths of those on board Charlie. It is undeniable that his shift that night was busy and challenging - he did not take a formal break. Nevertheless, his oral evidence demonstrated his professionalism, experience, competence, and commitment to the endeavour of saving lives. The stark reality of his role’s inherent difficulties, and the jeopardy the OCGs placed migrants in, was encapsulated in his frank comment: “*if you don’t understand what’s fully going on and you’re getting “We’re all going to die”, it’s quite a distressing situation to find yourself in of sitting at the end of a phone, effectively helpless. You know where they are, you want to get a boat to them and you can’t.*”¹⁷⁹
111. HMCG’s first substantive contact with small boat Charlie was the 0148 call between Mr Gibson and Mubin.¹⁸⁰ It was a call transferred from the French Coast Guard not a 999 call to HMCG. Obtaining EISEC information was not possible. Described by CTI as “*quite an intense phone call*”¹⁸¹, Mr Gibson contemporaneously noted: “*lots of shouting unreadable most comms due to shouting.*”¹⁸² On any objective assessment, the information Mr Gibson managed to obtain and the actions he was able to take before the call ultimately cut out was a considerable achievement. He identified the caller, assured that caller that he would not

¹⁷⁵ The information “appears in good condition” was relayed by Griz-Nez during the 0106 call in relation to Migrant 1. The language used (“appears”) suggests that it may have been based on a sighting. Migrant 1 was identified as a potential repeat of Migrant 7 in the next iteration of the French tracker.

¹⁷⁶ Gibson Day 3 page 81 lines 1 to 9

¹⁷⁷ Gibson WS para 10 INQ010392 page 4

¹⁷⁸ Gibson Day 3 page 7 line 12 onwards

¹⁷⁹ Gibson Day 3 page 119 lines 8 to 14

¹⁸⁰ INQ007630

¹⁸¹ Gibson Day 3 page 90 line 14

¹⁸² Charlie ViSION log INQ000237 page 6

leave the call, successfully exchanged three phone numbers, obtained an estimate of the number of people on board, asked for the colour of the vessel (without success), identified and contacted a potential nearby vessel (the Gaschem Shinano), and obtained a WhatsApp position. In accordance with his training, he allowed the caller to explain the situation in their own words, and did not ask leading questions.¹⁸³ He satisfied the 6Ws¹⁸⁴. He established who was calling and how many might be on board. He obtained a position to identify where they were. As for what the problem was, he knew the call was from Migrant 7, and that it was a small boat transiting the Channel and in Distress. As for when, events were ongoing. Weather was likewise already known, and he tried to establish a watch by obtaining a visual sighting through the Mayday relay.

112. Overall, he concluded that incident Charlie required assistance, exemplified by the Mayday relay. As he explained when questioned: *“The actions I take following the call I think highlight that I had genuine concern for this vessel.”*¹⁸⁵
113. As for the specific condition of small boat Charlie, Mr Gibson was only told *“its finished... we finish.”* This information was not specific, and would be difficult for any SMC to reach a reliable conclusion on. An unknown speaker is now known to have said in Kurdish *“It is filled with water”*¹⁸⁶, but this was not conveyed to Mr Gibson. Indeed, the only reference to water in English was the question *“We are in water UK, right?”*¹⁸⁷, which concisely demonstrates the difficulty of interpreting the phrase *“in the water.”*¹⁸⁸ Mr Gibson was asked whether he understood *“that this was or might be a boat that was taking on water?”*. He explained that *“That wasn’t verbalised in the call... that would have been jumping to a conclusion... the analysis of it didn’t lead me to say it’s sinking.”*¹⁸⁹ In any event, due to their unseaworthiness most, if not all small boats, would take on water.¹⁹⁰
114. The next action taken was the 0227 Mayday relay broadcast. We invite the Chairman to conclude not only that the decision to make it was appropriate, but also that there was a justifiable rationale behind its cessation.
 - (1) A Mayday relay was an uncommon but legitimate step to take for migrant small boat SAR. As Mr Gibson explained, *“going to general SAR principles, it’s not an unusual step if it’s the right course of action.”*¹⁹¹
 - (2) Mr Gibson had two linked objectives in broadcasting the Mayday relay. First, *“to get any vessels that could respond to respond and then any vessels with sightings to give updated position ... [to get] information about the small boat. We know there’s one*

¹⁸³ Emergency Telephone Call Handling SOP, INQ005185

¹⁸⁴ Who, Where, What, When, Weather, Watch. For reference, see SMOO Mission Conduct Trainer Notes, INQ000353 page 9.

¹⁸⁵ Gibson Day 3 page 98 lines 12 to 13

¹⁸⁶ INQ007630, page 17

¹⁸⁷ *Ibid*, page 16

¹⁸⁸ See also Gibson Day 3 pages 122 and 123

¹⁸⁹ Gibson Day 3 page 98 lines 12 to 19

¹⁹⁰ See, for example, Toy Day 5 page 63 line 15: “most of the vessels that we encountered had taken on water to some extent.”

¹⁹¹ Gibson Day 3 page 103

there, we want to get eyes on, further information from it."¹⁹² In this regard Mr Gibson was seeking to verify what had been reported. Second, to elicit a SAR response from the Flamant, which Mr Gibson had identified as the closest surface asset to the Mayday relay position. The 0311 call with Mr Willows provides a contemporaneous record of Mr Gibson's thinking: *"The reason I did the full Mayday broadcast was to get a certain vessel which is painted grey and there was a French flag at the back of it to attend to."*¹⁹³

- (3) The Mayday relay did include the information "taking water and requiring immediate assistance". However, at this point Mr Gibson did not know that Charlie was taking water, and certainly did not know that it was sinking. Asked whether he believed there was at least a real possibility the boat was taking water, he explained: *"I don't think I had that information at that point. However, it could have been one of the facts and deductions I made from what could be causing them to panic so much."*¹⁹⁴ In forming such a deduction, Mr Gibson was doing what SMCs are supposed to do: analysing information, identifying what is known, and formulating potential scenarios, including "worst case" scenarios.¹⁹⁵
- (4) Mr Gibson's reasons for stopping the Mayday relay are clear: *"I was content with the assets I had on scene to effect any rescues, so therefore the Mayday broadcast wasn't required."*¹⁹⁶ The specific asset rendering the relay unnecessary was Valiant, with the Charlie log contemporaneously recording: *"No requirement for Mayday relay as Valiant in the area investigating targets."*¹⁹⁷ The reason for stopping it is understandable: the fundamental purpose of the relay had been to obtain a maritime picture by means of a surface vessel in the vicinity, and a suitable surface vessel was by then on scene.
- (5) A final point in regards to the Mayday relay. That a merchant vessel, the Concerto, had responded by communicating with the French Coast Guard was not, and could not, have been known to Mr Gibson at the time.
- (6) In any event, the SAR information broadcast continued on Channel 11.

115. At this juncture Mr Gibson's 0242 call with Griz-Nez merits consideration. Through questioning of Mr Gibson himself and Assistant Chief Coastguard Leat, it was suggested that Mr Gibson could and should have made a formal request for the Flamant to respond. Insofar as this is a criticism, it is not a fair one. As with HM Government as a whole, no HMCG officer had the power to order the Flamant to respond to the Mayday, or indeed to take any other action. Mr Gibson's superiors on shift that night *"would have had no different communication channels with the French Coastguard."*¹⁹⁸ A review of the call transcript makes plain that the conversation was tantamount to a formal request for

¹⁹² Gibson Day 3 pages 101 to 102

¹⁹³ INQ007602 page 3

¹⁹⁴ Gibson Day 3 page 106 lines 10-13

¹⁹⁵ See Gibson Day 3 page 128 line 5 onwards

¹⁹⁶ Gibson Day 3 pages 109 to 110

¹⁹⁷ INQ000237 page 11

¹⁹⁸ Gibson Day 3, page 127 lines 12 to 13

assistance¹⁹⁹, with a reason for why the Flamant supposedly could not respond provided.²⁰⁰ It would be speculative to conclude that more formal wording would have led to a different outcome – *“It would have still remained with the French Coastguard’s decision to accept that request or not.”*²⁰¹

116. More importantly, there is evidence that the Flamant’s crew heard the Mayday, and chose to ignore it.²⁰² It is highly significant that perceived omissions on the part of the French Coast Guard in relation to Charlie are considered so serious as to be the subject of French criminal proceedings. The Chairman can infer that the Flamant ought to have responded, either of its own volition or as a result of French Coast Guard instruction, irrespective of the words used by Mr Gibson.
117. There were periods on the night of 23/24 November when the Dover mobile phone was not answered or checked: between 0204 and 0312 there were 4 missed calls on it from persons on board Charlie.²⁰³ The development of local practices is encouraged by IAMSAR.²⁰⁴ Accordingly, it was reasonable for Dover to develop local practices for dealing with migrant small boat SAR as the default position was that zone 14 was within its remit. A disadvantage of the mobile phone was that if calls to it were answered they were not recorded; it was therefore not the preferred method of speaking to migrants. This disadvantage was outweighed by the fact that it could receive WhatsApp positions. There was no obligation on HMCG to introduce a standalone mobile phone; SAR services are intended to receive distress notifications through 999 calls or the Global Maritime Distress and Safety System. HMCG did so as a result of shared learning from the French Coast Guard and doing so undoubtedly saved lives.²⁰⁵ However, given that the mobile phone was not formally incorporated into HMCG’s IT systems, the intended practice should have been written down and briefed to staff in order to ensure consistency.
118. Valiant arrived at the Mayday relay position at 0327. Commander Toy, a professional mariner with extensive SAR experience, explained the strictures affecting his response time and influencing “best” or “safe” speed – in summary: the need for permission to clear the Port of Dover, a matter entirely out of his and HMCG’s hands; weather conditions once underway; maritime traffic in the southwest lane of the TSS and the legal requirements imposed by IRPCS²⁰⁶; and the risk of colliding with small boats in the Channel. As he stated: *“I made the safest speed I could to get there.”* It would be wrong to assume, with

¹⁹⁹ See in particular INQ007656 page 3: “Yeah, we did a Mayday relay for hoping for a response... Obviously I’m just thinking the quicker response will be the Flamant at the minute if they are sinking.”

²⁰⁰ “Yeah, the Flamant is migrant case 10 ... for the moment it is with migrant case 10.”

²⁰¹ Gibson Day 3 page 127

²⁰² INQ004426, Le Monde 15.3.24, and INQ004421 Le Monde 3.1.23.

²⁰³ Whether any useful information would have been conveyed had the mobile phone been answered can only be a matter of speculation. The notes of interview of the trainee MOO state: “answered one call, not last very long and not able to understand what was being said.” INQ004737

²⁰⁴ IAMSAR Manual Vol II para 1.9

²⁰⁵ Leat WS para 4.14 INQ010098 page 71

²⁰⁶ The International Regulations for the Prevention of Collisions at Sea. Commander Toy referred to Rule 10 of IRPCS at Day 5 page 90 line 13.

the benefit of hindsight, that Valiant could have travelled faster, or that any other surface asset could have arrived sooner.²⁰⁷

119. Commander Toy's decision to turn northeast towards the Sandettie light vessel was both prudent and justifiable, it being based both on the tidal direction and his experience that migrants tended to steer towards navigation lights. The US Coast Guard Case Study vindicates his decision, finding that: *"There was a high probability that a disabled vessel that began drifting from the time and location of the last WhatsApp location would end up in the location where [Valiant] effected the [first] rescue."*²⁰⁸ Notably, in travelling towards the Sandettie light vessel Valiant passed through the region of the 0220 and 0221 WhatsApp positions. Commander Toy was at all times aware that small boat Charlie may have taken on water,²⁰⁹ and Valiant's crew were looking for both small boats and people in the water.²¹⁰ He did not need specific instructions from the SMC to this effect.
120. Having spotted two small boats, it was entirely appropriate for Valiant to embark the one not underway. This was consistent with HMCG policy that all small boats are in Distress, and it would have been inappropriate for Mr Gibson as SMC to countermand the embarkation. Further, the small boat could have been Charlie.²¹¹ Thereafter, Valiant was directed to the location of small boats spotted by R163. This was consistent with the IAMSAR Manual: *"Search patterns coordinated between air and surface facilities offer a number of advantages. For example, the surface facility... can be directed toward survivors as soon as they are located"*.²¹² Indeed, this action was thought such a good example of good practice that another SMC and Team Leader, Tom Barnett, circulated screenshots of *"A lovely expanding square by R163... with BF Valiant being guided onto small boat crossings"*.²¹³ Valiant's actions resulted in the rescue of 98 people – a fact which emphasises the need not to consider incident Charlie in isolation, as HMCG had equal responsibility to endeavour to provide assistance to all small boats.
121. By 0352 helicopter R163 was airborne in the vicinity. The Inquiry has scrutinised Mr Gibson's search request (*"a search around the Sandettie light vessel as an expanding square, or a parallel track as you see fit to search for potential other craft in the area"*) and the search ultimately carried out by Captain Trubshaw. It is therefore important to consider what Mr Gibson had been told, what he 'knew', and what he had surmised by this point in time.
- (1) Since the Mayday relay, he had participated in three further calls relating in whole or in part to incident Charlie: (i) 0231 with Mubin²¹⁴ (ii) 0242 with Griz-Nez and (iii) 0311 with Mr Willows. It is undeniable that by 0311 Mr Gibson had formulated a worst case scenario in which incident Charlie was a sinking small boat. To Griz-Nez, he

²⁰⁷ See section above on "Hindsight", particularly in regards to RNLI response times.

²⁰⁸ INQ004345 page 15

²⁰⁹ He was aware of the Mayday relay (Toy Day 5 page 104 lines 12 to 14), and the more general tendency for small boats to take on water (Toy Day 5 page 63 lines 15 to 16).

²¹⁰ Toy Day 5 page 112 line 19 onwards

²¹¹ See para 140 below

²¹² Vol II, para 5.4.5

²¹³ INQ010354

²¹⁴ INQ007655

referenced Flamant being the closest vessel “*if they are sinking*”.²¹⁵ As he explained when questioned, “*one of the deductions I’ve obviously made in my mind was, worse case scenario is: they could be sinking.*”²¹⁶

- (2) However, at no point up to 0352 (and indeed up to the end of his shift) did Mr Gibson know through verified information that incident Charlie was a sinking or capsized vessel, or that people were in the sea. The 0231 call contained a number of distressing remarks: “*we are dying*”, “*it’s broken, broken*”, “*the boat’s finished*”, “*we all die we all die*”, “*boat finish*”, “*They are in the water, in the water.*” The 0242 call also passed on the unverified report “*We are in the water*”. This information justifiably led Mr Gibson to have concerns: to have “*a gut feeling that something isn’t quite right and [to consider] sinking, taking water.*”²¹⁷ However, none of this information allowed Mr Gibson to verify the condition of the small boat, or to reach a definitive conclusion that there was in fact a sinking event. In his own words: “*But I haven’t got definitive proof of what the distress of the dinghy was*”.²¹⁸ In the absence of a recognised maritime picture from an aerial asset, Mr Gibson was dealing with competing potential scenarios.
- (3) It has been suggested by reference to the 0311 call that Mr Gibson ‘knew’, or ought to have known that there were “*at least four boats known to be requiring rescue in [the] Sandettie area.*”²¹⁹ The suggestion is based on hindsight, and does not bear scrutiny. Mr Gibson’s contemporaneous assumption, based on Flamant’s actions, was that there were “*potentially two to three craft just in the vicinity of the border and to the south of Sandettie.*” At the time, and in the absence of aerial surveillance, the number of small boats in this area was unknown, and it is important to stress that small boat incidents, whether French numerals or UK alphanumeric, were incidents – no more than a potential small boat until confirmed to be such, and always potentially the repeat of another incident. As for Mr Gibson’s contemporary analysis of French incidents, he noted migrants 10 and 11²²⁰ to be near Sandettie,²²¹ but according to the 0315 French tracker the position for migrant 3 was to the west of Sandettie.²²² Moreover, the possibility of repeats must not be disregarded, and it is salient that this same contemporaneous information contained reference to two small boats separately identified by Flamant (migrants 1 and 9) that were at the same time thought to be potential repeats of each other and of migrant 7 / Charlie.
122. As for any suggestion that the potential number of small boats in the region should have led Mr Gibson to task another surface asset on the basis that Valiant’s capacity would be exceeded, we stress the following points. Mr Gibson’s estimate of “*potentially 110*” people was no more than a “*worst-case*” estimate. Reports of persons on board are estimates and

²¹⁵ INQ007656

²¹⁶ Gibson Day 3 page 128

²¹⁷ Gibson Day 3 page 132 lines 15 to 17

²¹⁸ Gibson Day 3 page 133 lines 12 to 13

²¹⁹ CTI question, Day 5 page 114 lines 11 to 16

²²⁰ Migrant 10 and Migrant 11 may well have been the same boat.

²²¹ INQ007602 page 5

²²² 51 07.00N 001 43.5E - see INQ001214 page 2 onwards

are prone to inaccuracy. As Mr Gibson explained in oral evidence: *“if it is a round number, it’s plus or minus...if you imagine 40 people in a dinghy... that’s a lot of heads to count and the opportunity to miscount... is high.”*²²³ At no point were the actual number of people in the area known.

123. In the circumstances, Mr Gibson’s decision not to task another surface asset at this stage was both understandable and reasonable. In the event that the worst case scenario of 110 people eventuated, Valiant could have managed either by embarking more than 100 or by deploying life rafts and its RIB whilst standing off and awaiting additional assets.²²⁴ At all times Mr Gibson was required to, and did, manage finite surface assets judiciously in the knowledge that there would be other SAR demands throughout 24 November. In his own words: *“this is about managing what limited assets I’ve got... I was being as efficient as I possibly could be with my assets.”*²²⁵ In the event, these assets were needed.²²⁶
124. Turning then to the search carried out by R163, the evidence clearly indicates that Captain Trubshaw was a highly trained and experienced SAR helicopter captain. Both he and Bristow’s Accountable Manager confirmed that he was competent to determine a suitable search pattern and track spacing.²²⁷
125. Mr Gibson tasked Captain Trubshaw to carry out *“a search around the Sandettie light vessel as an expanding square, or a parallel track as you see fit.”*²²⁸ Mr Gibson’s choice of the Sandettie light vessel as the datum took into account the WhatsApp positions sent at 0220 and 0221: *“By 0354, I had the updated WhatsApp position for CHARLIE, (as at 0221), and so I tried to estimate, taking into account drift,”*²²⁹ *a new position over which R163 could carry out their search.”*²³⁰ Captain Trubshaw chose what he considered to be the most suitable search pattern, in this instance an expanding square search with track spacing of 0.7nm, based on his experience and the conditions at the time.²³¹
126. The Inquiry should consider very carefully the extent to which it is equipped to pass judgment on Captain Trubshaw’s choice of search pattern and track spacing. If it does decide to pass judgment on his choices, it should not criticise them. Applying our submissions in the section above on “The best evidence about how to coordinate search and rescue” to this specific issue we make the following points.

- (1) One cannot turn to the IAMSAR Manual and find a simple answer to the question of what search pattern and track spacing to use in a particular situation. This is because

²²³ Gibson Day 3, page 81 lines 19 to 24; see also MCA Opening Statement paras 36 and 37

²²⁴ See Toy Day 5, pages 25 to 27

²²⁵ Gibson Day 3, page 135

²²⁶ For taskings see INQ008905 para 4.10.18: Hunter at 0636; Hurricane at 0822; Dungeness at 0827; Hastings at 0931; and Dover at 1115 to Incident Whiskey 1 (INQ000294)

²²⁷ Hamilton Day 4, page 89 lines 9 to 17. Trubshaw Day 4, page 104 lines 21 to 22 (“We are trained in the use of or the selection of sweep width.”), page 105 line, and pages 134 to 135 (including “It would be a fool to ignore the advice and professional input from the rest of the crew when selecting these things”).

²²⁸ INQ008825

²²⁹ At 0332 Gibson noted in the Incident Charlie log: “Tidal set 1.6kts 037 degrees” INQ000237 page 11.

²³⁰ Gibson WS para 153 INQ010392 page 77. This evidence was unchallenged.

²³¹ Trubshaw Day 4 pages 136-143

each situation is different, as IAMSAR expressly acknowledges.²³² Further, the narrower the track spacing, the smaller the area covered in the search. In other words, the probability of finding the target within the chosen search area is increased but so is the probability of missing the target because it is outside the search area.

(2) The MAIB expressly recognised the need for those involved in a SAR operation to form their own judgements rather than attempting slavishly to follow a manual: *“According to the IAMSAR guidance the recommended track spacing was the same as the sweep width in most situations. However, the search unit or SMC could amend the track spacing based on the circumstances at the time of the incident, which included, among others, the time of day, changes in the weather and effectiveness of observers.”*²³³

(3) In short, judgement has to be exercised. A balance has to be struck between the size of the search area and the nature of the search within it.²³⁴

127. Captain Trubshaw’s evidence was that the expanding square search was the best search pattern to use.²³⁵ We invite the Chairman to accept this evidence from an experienced SAR helicopter pilot who was best placed to assess the prevailing conditions at the time.²³⁶

128. Turning to what the MAIB said about the choice of search pattern and track spacing, in our submission the section in the MAIB report on “Effectiveness of search pattern and detection probabilities” has been misunderstood or the MAIB has itself misunderstood the IAMSAR Manual.²³⁷ The relevant section states:

“R163’s expanding square search was conducted in the appropriate area and was demonstrably effective in detecting small boats as it found three migrant boats. This validated the SMC’s decision to include the expanding square pattern as one of the two suggested patterns for R163 and tallied with previous experience where it had been found to be effective for locating small boats. However, the occupants of the swamped migrant boat Charlie were not detected until many hours later when the victims were found by a French fishing vessel. This may have been because the search pattern’s track spacing of 0.7nm aligned with the IAMSAR recommendations for searching for boats, not people in the water, and the likelihood of the victims being detected by the helicopter was therefore much reduced. Effective detection of people in the water required a lower track spacing than that required to detect small boats and the IAMSAR manual recommendation given the visibility on the night was for a sweep width of 0.0nm. This effectively meant that the chance of detecting those in the water was negligible unless the helicopter flew almost directly over them.”

129. In order to ensure a sweep width of 0.0nm, a track spacing of 0.0nm is required. Flying an expanding square search pattern with a track spacing of 0.0nm means maintaining a

²³² IAMSAR Manual Vol II paras 5.7.10 and 5.10.5

²³³ INQ010445 para 1.13.6 page 58

²³⁴ See IAMSAR Manual Vol II para 4.7.2

²³⁵ Trubshaw Day 4 pages 134 and 136

²³⁶ IAMSAR Manual Vol II para 5.7.10: “sweep width estimates should take into account local conditions and the advice of the facility on scene”

²³⁷ INQ010445 para 2.4.5 page 78

permanent hover over a single point. But one would only do that if one could be absolutely confident in one's choice of point over which to hover. The MAIB cannot have meant to suggest that R163 should have flown to a set of coordinates and hovered over them for the duration of its mission and then returned to base.

130. The point made by the MAIB about a sweep width of 0.0nm is more relevant to causation than to the choice of search pattern and track spacing. As stated elsewhere in the MAIB report, sweep width is: *"an index or measure of the ease or difficulty of detecting a given search object based on the type of search unit (merchant vessel, helicopter, fixed-wing aircraft), meteorological visibility and weather conditions."*²³⁸
131. The MAIB went on to state: *"Based on the IAMSAR tables and formulae, the following sweep widths were recommended for a helicopter based on a visibility of 1nm or 1900m, winds of 0kts to 15kts or seas of 0m to 1m: 0.0nm – person in water, 0.5nm – boat less than 5m, 0.7nm – boat 6m, 0.7nm – boat 10m"*
132. Thus if R163 had been searching for a single person in the water the chance of detecting that person was negligible unless the helicopter flew almost directly over them. But for the reasons stated above and the fact that, even in hindsight, this was not a search for a single person in the water, a track spacing of 0.0nm would have been wholly inappropriate.²³⁹
133. At the time, migrant small boats tended to be approximately 8m in length. Given the recommended sweep width for such a boat, a track spacing of 0.7nm was sensible and reasonable. Even if it had been known that the boat had capsized and all of its occupants were in the water (which was not and could not have been known) a track spacing of 0.7nm would have been sensible and reasonable. The footprint of 30-40 persons in the water will be significantly larger than that of one person, which will affect sweep width.²⁴⁰ Further, a capsized inflatable dinghy remains potentially visible because it is unlikely to sink.²⁴¹ In summary, the sweep width for a capsized migrant small boat with 30-40 persons in the water is not the same as for a single person in the water. Nor is the track spacing.
134. By the end of his shift at 0730 Mr Gibson had reached the conclusion that the small boat corresponding to incident Charlie had been found; he was *"confident... we had rescued everyone we had received calls from"*²⁴² This is not a case of a search being suspended in the belief people were still missing. In the circumstances pertaining at the time, it was reasonable for Mr Gibson to reach this conclusion, and we invite the Chairman to conclude likewise. In assessing Mr Gibson's decision, it would be inappropriate to adopt an excessively forensic analysis of the information available to him, or of which small boat he thought was Charlie. Instead, we provide several observations underscoring why the judgement he made was both reasonable and understandable.
135. By the end of his shift, the position was not the same as it had been at 0400 or 0200. HMCG officers are trained to make contemporaneous entries in logs. Such entries give an

²³⁸ INQ010445 para 1.13.6 page 58

²³⁹ See Leat Day 12 pages 173-176

²⁴⁰ Trubshaw Day 4 page 146 line 24 onwards

²⁴¹ Charlie did not sink and was recovered by the French authorities – see MAIB report INQ010445 page 12

²⁴² Gibson WS para 195 INQ010392 page 98

indication of their thinking at the time. HMCG officers are also trained to re-evaluate. The fact that Mr Gibson had certain thoughts at 0230 (the time of the Mayday relay), or 0400 (before R163 had completed its search) does not mean that he had the same thoughts at 0730. Nor should it. His decision that Charlie had in all likelihood been found resulted from a re-evaluation of available information and the application of his experience. He was right to re-evaluate. The SMC role demands it, as the IAMSAR Manual repeatedly emphasises: *“It is important throughout the case to distinguish conclusions based strictly on known facts from those based partially on assumptions. It is also important to re-evaluate all scenarios and assumptions regularly and as new information becomes available.”*²⁴³

136. Mr Gibson described this process of re-evaluation, and his changing suppositions throughout the night: *“As we progress through the night and we’re starting to effect rescue after rescue after rescue, there is a possibility in my mind that actually maybes it wasn’t as [serious] as they said because the boats we’re recovering all seemed to be in good condition and so forth.”*²⁴⁴
137. With hindsight it is possible to conclude that none of the three small boats rescued by Valiant was Charlie, and that each related to an incident unconnected with Charlie. However, it would be wrong to assume that was, or should have been, apparent to Mr Gibson and his colleagues at the time. As is the case with all migrant small boat SAR operations, Mr Gibson was required to make difficult judgements in the context of inherently uncertain and unverified reported information. We have already set out why it would be wrong to conclude Mr Gibson “knew” that there were four small boats in the Sandettie area. Given the likelihood of repeats, it was reasonable to conclude that there had in fact only been three. Consideration of each boat’s occupancy, and each incident’s reported occupancy, equally supports the reasonableness of Mr Gibson’s conclusion:
- (1) As noted above, accurately estimating boat occupancy is difficult. This is exemplified by Valiant’s estimate of numbers on board the first boat recovered – it initially reported 40 people on board²⁴⁵ but recovered 35, including 2 women and 13 *“suspected minors”* of unspecified gender.²⁴⁶ Reports received about occupancy need to be viewed in this light. They are estimates not known facts.
 - (2) Reports received by HMCG on the night in relation to Incident Charlie ranged from 33 (French migrants 7 and 9) to 40 (French migrant 1 and both calls with Mubin). As for composition, the varied reports were 13 women and 8 children, 6 women and 3 children,²⁴⁷ and 2 children with no mention of women.²⁴⁸ It would thus be wrong to conclude that Mr Gibson was looking for a small boat with a definitively known number

²⁴³ Vol II, para 4.3.1.

²⁴⁴ Gibson Day 3 page 87 lines 2 to 8

²⁴⁵ 0348 radio communication between Valiant and MRCC Dover, INQ007390

²⁴⁶ 0443 radio communication between Valiant and MRCC Dover, INQ007469

²⁴⁷ See information in the French tracker for migrants 7 and 9 respectively, INQ001214. See also the MCA Opening Statement para 37, setting out the evidence of Mr Omar and some relatives of those who died.

²⁴⁸ 0231 call, INQ007655 pages 2 to 3

of occupants of known genders and ages. The number and composition of the people on Charlie was “*never verified*”.²⁴⁹

- (3) The occupancy and found position of each of the three boats found was broadly consistent with the reported information for incident Charlie:
- (i) The number of people rescued from the first boat (35) was consistent with the reports of 33 to 40 people. The composition was also broadly consistent, being a mix of men, women and children. Further, its location was consistent: northeast of Sandettie light vessel in the direction of drift from the Mayday relay position, a direction Mr Gibson calculated at 0332.²⁵⁰ Nor did its condition render it clearly inconsistent: the black colour did not exclude it, and being “stopped in the water”²⁵¹ was consistent with a vessel in distress.
 - (ii) The number of people rescued from the second boat (31) was close to the report of 33 persons on board Charlie. The composition was all males, but Mr Gibson had received “*conflicting information*” about numbers and occupants.²⁵² Moreover, false or inaccurate reporting of both composition and condition was, regrettably, not uncommon.²⁵³
 - (iii) The number of people rescued from the third boat (32) and the composition (4 women and 7 minors)²⁵⁴ was broadly consistent with the reports for incident Charlie. Further, its location at 0630 was not inconsistent with a small boat that had continued to make way from the position and time of the first Mayday relay in an attempt to reach Dover.²⁵⁵
- (4) With hindsight, the first boat has been identified as Lima, and the third as November. In the circumstances, it is understandable that now Mr Gibson believes that he “*must have assumed...consciously or unconsciously*” that the second small boat was Charlie. However, we caution against concluding that matters were clear cut at the time. It is important to remember that Lima, November and Charlie were incidents not boats. Thus Incident Lima, Incident November and Incident Charlie represented reported/potential, rather than verified/confirmed, individual small boats. At the time there was no definitive evidence to exclude Incident Lima or Incident November being repeats of Incident Charlie. As Mr Gibson explained, HMCG did not have “*definite positive confirmation of each boat being the specific boat.*”²⁵⁶ Indeed, Mr Gibson’s thoughts at 0421 on 24 November regarding the first boat were: “*we’ll work on that potentially being Lima.*” Lima, linked to French migrant 10,²⁵⁷ was, like Charlie,

²⁴⁹ Gibson Day 3 page 160

²⁵⁰ At 0332 Gibson noted in the Incident Charlie log: “Tidal set 1.6kts 037 degrees” INQ000237 page 11.

²⁵¹ INQ000237 page 11, entry at 0350

²⁵² Gibson Day 3 page 10 line 7

²⁵³ See section above on “The distinction between reported and verified”

²⁵⁴ Toy WS para 79 INQ010136 page 28

²⁵⁵ Gibson Day 3 page 180 lines 4 to 25: “... whether it’s under power or drifting ... If they’re heading a westerly course and the tide’s setting northeast, they are actually in fact going to be going northwest ... So from where the Sandettie Lightvessel is, in a sort of westerly — north—westerly direction is the Goodwin Sands.”

²⁵⁶ Gibson Day 3 page 179 lines 21 to 23

²⁵⁷ See INQ006817

reported as having 40 people on board, and was presumed to be in the vicinity of the Sandettie light vessel. Likewise, occupancy reports for November were similar to those for Charlie (30 to 32 being similar to 33²⁵⁸), and “sinking” was even reported.²⁵⁹

(5) The dangers of an excessively forensic approach are exemplified by an analysis of the reconciling of incidents Lima and November respectively. The reports for Lima (40 people) did not precisely match the 35 people recovered from the first boat, yet CTI never sought to suggest this was an inconsistency. Similarly, the third small boat was not sinking, yet no inconsistency has been suggested between the condition it was found in and the report of sinking.

138. Doing the best we can having listened to the family impact evidence, we consider that there were at least 33 persons on board Charlie made up of: at least 24 adult men, at least 7 adult women, at least one boy (aged 16), and at least one girl (aged 7). If an excessively forensic approach were adopted, and expected of HMCG, then if Charlie had been found it could not have been reconciled with the occupancy reports linked to its own incident. This is because no single report in relation to Incident Charlie referred to 33 people made up of men save for 7 women and 2 children.
139. Considerable attention was paid to the recording of the M number for Lima next to Charlie in the shared HMCG / Border Force tracker. There is no evidence that this information was relied on by HMCG officers when reconciling or closing incidents, or deciding that Charlie had been found. Mr Gibson explained that *“the single source of the truth is ViSION”*; George Papadopoulos explained that *“an M number wouldn't be a consideration or the sole factor of resolving an incident whatsoever.”*²⁶⁰
140. An emergency would no longer exist if the *“craft or persons for whom SAR facilities are searching have been located and the survivors rescued.”*²⁶¹ At the end of his shift Mr Gibson did have the following pieces of reliable information on which to conclude that Charlie had likely been rescued.
- (1) Both Valiant and R163 had proven capable of carrying out effective searches notwithstanding the weather conditions. Those assets, equipped as they were with specialist sensors, had between them sighted and rescued three migrant small boats. Indeed, R163 had sighted a small boat several nautical miles outside its search area.
 - (2) Small boats had been found in the area where Mr Gibson expected to find a boat that had drifted from the Mayday relay position.
 - (3) R163 had conducted a thorough expanding square search encompassing the whole area in which Mr Gibson expected any such small boats to be to be found.²⁶² That search

²⁵⁸ 30 reported for migrant 3 on the French tracker (INQ001214) with migrant 3 linked to Delta, and Delta a repeat of November; 32 recorded on the November ViSION log, INQ000252 page 1.

²⁵⁹ November ViSION log, INQ000252 page 1.

²⁶⁰ Gibson Day 3 page 154 line 15; Papadopoulos Day 9 page 88 lines 17 to 18

²⁶¹ IAMSAR Vol II, paragraph 9.1.1

²⁶² Gibson Day 3 page 175 lines 12 to 21

had not spotted a sinking vessel or any persons in the water or any other evidence of a boat having capsized or sunk e.g. lifejackets or other debris floating on the water.

(4) There had been no further calls linked to incident Charlie since the commencement of the search.

141. In the circumstances, we invite the Chairman to recognise the expertise of the US Coast Guard and to adopt its analysis: *“The rationale for the correlation was reasonable, however, the decision was not reviewed, discussed, or documented in real-time.”*²⁶³

Causation

142. Our first submission on causation is that the real causes of this incident were a number of factors which were outside the control of HMCG.
143. The criminals who provided small boat Charlie appear to have been particularly incompetent or immoral, even by the standards of the OCGs who control the cross-Channel route.
- The boat was of such poor construction that it developed a hole in the bottom which ultimately led to it foundering.²⁶⁴
 - The criminals appear to have instructed those on board to call the telephone number of the Port of Dover. This reduced the chances of HMCG’s systems capturing the mobile number and location of callers.
 - Whatever device the criminals gave those on board it seems to have been of no benefit to them. None of the calls received by HMCG suggest that the callers had a maritime GPS device or were reading coordinates from one. If they had one, which seems unlikely,²⁶⁵ it must have been defective. Alternatively, the criminals did not properly train those on board in how to use it.
 - The criminals wrongly told those on board that they were 2 to 3km from Dover.²⁶⁶
144. The unprecedented number of crossings in November 2021 had an impact on operational planning for the period 23-25 November. Many boats needed to be rescued on 24 November. Each of those boats would, on average, generate several new incidents; each new incident would need to be opened, managed, evaluated and closed.
145. Disaster struck at the worst possible stage of the crossing when Charlie was essentially in the middle of the Channel, furthest from help and in the area where mobile phone signal was likely to be at its weakest and least reliable.

²⁶³ See the section above on “The best evidence about how to coordinate search and rescue” and the MCA Opening Statement para 81

²⁶⁴ Omar MAIB interview INQ010121 pages 5-6

²⁶⁵ Toy Day 5 page 48: “I have never heard of them having GPS on board.”

²⁶⁶ Omar WS para 93 INQ010388 page 16; Omar Day 2 pages 38-40

146. The weather forecast of an Amber period followed by a Red period had implications for operational forward planning.²⁶⁷
147. The weather on 23 and 24 November led to the cancellation of 2Excel's flights and postponement of Tekever's AR3 drone flight.²⁶⁸ Given the technology available to 2Excel and the cloud cover present on 24 November, 2Excel and Tekever would not have been able to provide a maritime picture even if their planes and drones had been able to fly.²⁶⁹ Numerous witnesses explained the central importance of aerial surveillance in providing a maritime picture.²⁷⁰
148. All of the above factors were wholly outside HMCG's control. Other factors outside HMCG's control and of potential causative significance were:
- Three crucial decisions made by the French Coast Guard: (i) not tasking the Flamant to Charlie (ii) not relaying the report received from the Concerto and (iii) not passing on what those on board Charlie said to it in the 17 minute long call which ended at 0333 hours.²⁷¹
 - None of the calls linked to Incident Charlie yielded any EISEC information.
 - The length of time it took Valiant to clear the Port of Dover and cross the TSS.²⁷²
 - The technical problem which delayed the take-off of R163.
 - The response to the Mayday Relay broadcast.
149. Our second submission on causation is that the evidence received by the Inquiry would not support a finding that those who died would probably have survived if different actions had been taken by HMCG.
150. The following should not be criticised, or deemed causative: (i) the time at which Valiant was deployed (ii) the time that it took Valiant to reach the Mayday Relay point or (iii) the nature of the search undertaken by Valiant. The same applies to: (i) the time at which R163 was deployed (ii) the time that it took R163 to reach the Sandettie light vessel or (iii) the nature of the search undertaken by R163.
151. Both Valiant and R163 searched in the right area.²⁷³ As to why R163 did not find Charlie or its passengers, the MAIB considered that:
- "... by the time the helicopter and cutter were on scene in the vicinity of Charlie's last reported position it is likely that the boat had already become swamped and the occupants had entered the water."*

²⁶⁷ See the section above on "Pre-planning for the period 23-25 November 2021"

²⁶⁸ O'Mahoney WS para 112 INQ010134

²⁶⁹ Golden Day 6 page 136 lines 7-11; Norton WS paras 112, 114, 119, and Figure 2 INQ010335; and INQ006333: "Due to poor weather conditions and low level cloud, Res 26A could not conduct this part of the search."

²⁷⁰ See for example Ling Day 10 page 118; Papadopoulos Day 9 page 92 lines 15 to 16; and O'Mahoney Day 11 page 164 line 21 to page 165 line 5: "the game changer is surveillance..."

²⁷¹ INQ000018, Le Monde 15.11.23; see also MCA Opening Statement paras 50-56

²⁷² See Toy Day 5 pages 57 to 59

²⁷³ See the drift calculations and the US Coast Guard Case Study

*“People in the water are much more difficult to detect than laden migrant boats, particularly if they are cold, are lower in the water, and have a low thermal contrast with the surrounding seawater. The visibility on the night was also such that R163 had a very low chance of detecting the victims once they had entered the water.”*²⁷⁴

152. We respectfully agree with those passages.
153. An RNLI lifeboat would probably not have arrived on scene any earlier and there is no evidence that any searches it carried out would have been more effective.²⁷⁵
154. If further SAR assets had been tasked after R163 and Valiant had completed their missions, their chances of finding Charlie or its passengers (a) would have been lower than those of R163 and Valiant, and (b) would have reduced further with the passage of time. This is consistent with the fact that there were no sightings of Charlie or its passengers until c.1230 although they had been in the middle of the Dover Strait in daylight hours since 0726.

Recommendations

155. We understand that the MCA will have an opportunity to comment on proposed recommendations that affect it. In the circumstances, this section is short.
156. The MCA and HMCG are learning organisations. This is evidenced by the fact that HMCG carried out a detailed internal review and commissioned a Case Study from the US Coast Guard. The MCA and HMCG have accepted the vast majority of recommendations made by (i) the internal review (ii) the US Coast Guard and (iii) the MAIB.²⁷⁶ As acknowledged in the MAIB report, the MCA and HMCG made a number of changes before receipt of the MAIB’s recommendations.²⁷⁷ The MCA subsequently implemented both of the MAIB’s recommendations and, on 2 August 2024, the MAIB confirmed that it accepted them as implemented and closed.²⁷⁸

Concluding Remarks

157. On behalf of the MCA and HMCG, we offer our sympathies to all those affected by this tragic incident and reiterate both organisations’ commitment to the search and rescue of migrant small boats.

JAMES MAXWELL-SCOTT KC
JACK MURPHY
BETHANY CONDRON
17 April 2025

²⁷⁴ MAIB report INQ010445 – this passage in the report (page 78) appears to be based on the MAIB’s engagement with the Met Office to understand and assess the visibility and potential performance of infrared and night vision equipment (see page 62).

²⁷⁵ See the section above on “Hindsight”

²⁷⁶ MCA Opening Statement para 9

²⁷⁷ MAIB report INQ010445 “Section 4 – Actions Taken” page 95

²⁷⁸ Leat WS INQ010098 pages 132-134