The Cranston Inquiry

Day 1

February 5, 2026

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(10.30 a.m.)

SIR ROSS CRANSTON: Well, good morning, everyone, both to those of you in the room and to those of you watching on the livestream. I'm Ross Cranston. This is the Closing Hearing of the Cranston Inquiry. My report was laid before Parliament earlier this morning and it's now available on our website. The main purpose of this hearing is to outline the conclusions of the report and the recommendations which I've made there. I do so in public for the same reason that all the Inquiry's hearings have been held in public, so that the matters of public concern, which are at the heart of the Inquiry's Terms of Reference, may be considered in an open and transparent manner. For that reason also, this hearing, like all the Inquiry's hearings, is being livestreamed so that the Inquiry's proceedings are easily accessible to people with an interest in our work.

The focus of that work, of course, has been the tragic events of 23 to 24 November 2021, when over 30 people died attempting to cross the English Channel from France in a small boat. This is by far the greatest loss of life from a single small boat in the Channel since the small boat problem was first

identified in 2018. The Inquiry's Terms of Reference required me to conduct an investigation into these events in order, first, to ascertain who the deceased were, secondly, when, where and in what circumstances they came by their deaths and, thirdly, to consider what lessons could be learned from those events and, if appropriate, to make recommendations to reduce the risk of a similar event occurring.

Before summarising the conclusions of the report and the recommendations which I've made at the end of that investigation, I'd like to say something about the way in which my team and I have gone about our work since my appointment just over two years ago in January 2024. The first thing to stress is that the scope of the investigation has been defined and limited by the Terms of Reference. They focus specifically on the events of the 23 and 24 November 2021. The Inquiry has had no wider remit to investigate the issues of small boat crossings generally, nor to enter the political, humanitarian and legal debate concerning that topic. It is, of course, the focus of much understandable attention and concern.

Next, I should emphasise again, because it's such an important point, that this has been an independent Inquiry -- independent of Government and of the various

public bodies we have investigated during the course of our work. Thirdly, it's been a non-statutory Inquiry. Consequently, all the questions about the conduct of the Inquiry and the nature of its processes and procedures have been for me as Chair, subject, of course, to the applicable principles of law, in particular the overriding duty to act fairly. Against that background, the overarching question in my decision making has always been, "What would best and most effectively assist the Inquiry in its work and so enable me to discharge the task conferred by the Terms of Reference?"

That leads me to the next key point. The Inquiry's processes have been inquisitorial and not adversarial. There have been no parties to the Inquiry and nobody has had a case to make or allegations to defend. Moreover, I've had no power to determine liability, whether civil or criminal. Rather, the Inquiry's purpose has been to find out the truth. The role of all of those who have engaged with us during our investigation has been to assist in ascertaining the truth of what happened on the night of 23 to 24 November 2021.

In order to reach conclusions on that fundamental question, my team and I have conducted a thorough and

wide-ranging investigation. For example, we have obtained disclosure of thousands of pages of material relevant to our work from a wide range of individuals and organisations. We then disclosed material which we deemed relevant to those with the closest interest in the subject matter of the Inquiry, whom we call Full Participants. Having analysed the material which we received, we obtained over 70 witness statements from people and institutions with evidence related to the events being investigated. We also engaged experts to prepare reports in specific areas relevant to the investigation and disclose these statements and expert reports to the Full Participants. In due course, this material has also been placed on our website, where full transcripts and videos of our hearings can also be found.

As a result of months of hard work on the part of my team, and thanks to the consistently high levels of constructive cooperation on the part of the Full Participants and others such as the RNLI, we were able to start our Full Hearings at the beginning of March last year and to complete them within four weeks. During that time, I heard live evidence from 22 witnesses, who were questioned on my behalf by the Inquiry's Counsel team. I also heard opening

submissions from Counsel to the Inquiry and opening and closing submissions from Counsel on behalf of the Full Participants.

In the final weeks of the Full Hearings, I heard impact statements from family members of some of the deceased. Those statements were recorded in the family members' own language and the recordings were played in the hearing room. A member of the Inquiry team followed each recording with a reading of it in English. I should again express my gratitude for the evidence given by those family members. Part of my report is dedicated to those who died in the Channel tragedy and to the impact it had on people's lives.

That has been a consistent feature of the Inquiry's approach. We've always tried to keep the families of the deceased at the centre of our work have always sought to bear in mind that for those who lost their lives on 23 to 24 November 2021, and for their families and friends, this is, above all, an immeasurable human tragedy.

Before turning to the report, I should deal with two other important matters. The first relates to the Marine Accident Investigation Branch, the MAIB. Following the incident, the MAIB began a safety investigation into it. Their report was published on 8

November 2023, some months before my appointment was announced and this Inquiry's work began. My Inquiry has had a different remit to that of the MAIB. It was, for example, no part of the MAIB's task to answer questions about those who had died. As I've indicated, that has been fundamental to the Inquiry's work.

However, my Terms of Reference specifically require me to consider the MAIB's investigation. My team and I have done that with great care and drawn on it again and again in the course of our investigation. Moreover, as I'll explain, one of our recommendations in the final part of the report relates to the wider publication of implementation measures which parties put in place in response to the MAIB's own recommendations following an investigation.

The second matter I should deal with at this stage relates to the position of the French authorities. Following the events of 23 to 24 November 2021, the French authorities started a criminal investigation arising out of the incident, led by an investigating magistrate. The Inquiry asked the Paris Prosecutor for access to evidence held by the French investigation, but was informed that this would not be possible due to the principle of judicial secrecy. French criminal law imposes a duty of confidentiality on all those

concerned in such investigations. The result is that the Inquiry has had no access to material relating to the ongoing French investigation.

However, the Paris Prosecutor kindly provided the Inquiry with a list of the identities of the deceased and those missing who could have been on board the small boat. I should add that the Inquiry has kept the French authorities informed about the progress of our own work.

I now turn to the report. First, I should say something about the drafting process. Following the conclusion of the Full Hearings in March last year, my team and I began work on the draft report. At that stage, we sought further evidence from a number of parties as a result of matters raised during the Full Hearings. During the summer of last year, once the draft report had reached an advanced stage, the Inquiry shared details of proposed criticisms with those organisations directly affected. We also shared draft recommendations with relevant organisations, inviting comment on their ability and deliverability. After reviewing the responses in both cases, I've modified the original draft text in appropriate circumstances to accommodate what I regard as helpful suggestions and justified responses to both the provisional criticisms

and recommendations.

There are a number of core principles which I've taken into account when producing the report. First, as I've said, I have no power to and have not made findings of civil or criminal liability. Rather, my task has been to get to the truth of what happened on 23 and 24 November 2021 and to make such recommendations as seem appropriate in the light of the Inquiry's investigative work and my conclusions about the facts.

Secondly, under the Inquiry's inquisitorial process, there was no burden of proof and no fixed standards by reference to which findings of fact were to be made. I adopted a flexible approach with conclusions in terms of the likelihood that an event did or did not occur. In many cases, the evidence is clear and there can be no dispute that a certain event did occur. In other cases, my conclusion is that it's more likely than not that an event occurred or, alternatively, that it's possible that an event occurred. In a few cases, uncertainty remains but, in my view, this has no bearing on the central issues for the Inquiry.

Finally, in making conclusions, I've been mindful of the dangers of using hindsight when considering the

actions of those involved in the events of the night. Although I've identified failings by people on the night, I've considered each of these in the context of what was known at the time, the resources available, the preparations made, the procedures then in place.

Overall, my conclusion is that the underlying causes were systemic in nature, even where failings are attributable or potentially attributable to individuals. An analysis of these in the in their full context provides the basis for the recommendations in the report.

The report is over 450 pages long. Before giving a brief summary of the conclusions and recommendations, I should first say that, in order fully to understand and appreciate the findings, there's no substitute for reading the full text. However, we have provided a 15-page Executive Summary at the outset of the report.

The important point to stress is that what follows in these remarks is by definition an extremely compressed and highly abbreviated version of the report itself, shorn of all supporting detail and evidence and without the detailed reasoning which underpins the conclusions.

With that qualification, I turn to the first question in the Terms of Reference, namely who were the

individuals who lost their lives in the Channel on 23 to 24 November 2021?

The Inquiry has been able to determine with confidence the identities of 26 of the 27 people who lost their lives, and of four people who are believed to have been on the boat but whose bodies have not been found. While the identity of the 27th person whose body was found can't be conclusively ascertained, the Inquiry has been able to suggest his identity. The report also identifies two survivors of the incident. One of them gave evidence at the Full Hearings.

On this basis, there were at least 33 people -- men, women, and children -- in the small boat which set out from France on that evening of 23 November 2021. The Inquiry can't be certain that there were no other people on board, including children whose families may never know their fate.

Most of the report -- in fact all of it except for the first and final two chapters -- is devoted to the remaining key questions in the Terms of Reference, namely when, where and in what circumstances did the deceased come by their deaths? By way of introduction to the conclusions in relation to these questions, I think it's helpful to give the briefest outline of what happened that evening.

We can begin when people smugglers dispatched an unseaworthy and overcrowded small boat from the French coast at about nine in the evening of 23 November 2021. It had on board, as I say, at least 33 people. They were in overcrowded conditions. They had paid the people smugglers thousands of pounds for their place on the boat and had been assured of safe passage to the United Kingdom. Only two of those on board would survive the journey.

We can't now be certain what caused the boat to fail. However, about three hours into the journey, the boat began to take on significant amounts of water and later became swamped. Those on board tried in vain to bail out the water and made panicked mobile telephone calls for help. One of them called a smuggler who had arranged the journey and sent him their location. He did nothing to help.

Just after 1 a.m. on 24 November 2021, His Majesty's Coastguard was notified by the French Coastguard that there was a small boat around half a nautical mile from the middle of the Channel with 33 people on board.

HM Coastguard called this incident "Charlie". Shortly afterwards the French authorities transferred a mobile call from a 16-year-old on board. He spoke to

HM Coastguard for about 20 minutes. He said they were "in the water" and required immediate assistance. Geolocation information was then sent to HM Coastguard which showed the boat was in the Sandettie area of the Channel, close to the median line, but on the UK side.

More desperate calls were made and messages sent from the stricken small boat, though some calls and messages were missed. HM Coastguard issued a Mayday relay broadcast, but a nearby French naval vessel, the Flamant, did not respond. Meanwhile, at around 1.30 a.m., HM Coastguard had tasked a Border Force cutter, the Valiant. The Valiant did not leave the port of Dover until 2.22 a.m. and took another hour to reach the last known location of incident "Charlie". Just before 3 a.m., HM Coastguard also tasked a helicopter, R163, while the Valiant was en route.

When the Valiant arrived in the Sandettie area at around 3.24 a.m., it was unable to locate the boat. The coordinates had been given to Border Force more than an hour and a half earlier, so that by the time the Valiant arrived, it seems very likely that the small boat had drifted away. Between 3.30 and 7.20 a.m., the helicopter and the Valiant located three small boats. The Valiant embarked 98 people in all. None of the boats found by the Valiant matched the

description of incident "Charlie".

Dawn came around 7 a.m. One of the two survivors told the Inquiry that when the sun rose over the water, there were some people still clinging to the remains of the small boat. The bodies of others were floating around them. He recalled a mother screaming as she searched for her children. By this time, the helicopter had been stood down, and the Valiant was returning to Dover with its 98 people that it had embarked. No one in the UK was looking for the small boat, and no one came to its rescue.

At around 12.30 p.m. that day, 24 November 2021, a French fishing vessel sailing approximately 9 nautical miles off the coast of Calais found the first of the bodies floating in the water. HM Coastguard were notified at around 1 p.m., nearly 12 hours after they had received the first calls for help. Ultimately, bodies of those who had been on the small boat were recovered to France and two survivors were rescued.

This, as I say, is the barest outline of what happened that night, but I hope it goes some way to explaining why the Inquiry was established.

In Part 3, chapter 8 of the report, there is a minutely detailed narrative of the events of that night which draws on the huge amount of documentary material

and evidence which my team and I have considered during our investigation.

In order to set that narrative account in its full and proper context, the preceding chapters of the report, chapters 2 to 7, address the relevant legal framework and the UK's legal obligations for search and rescue at sea. These chapters then set out the history of small boat crossings since they rose to prominence in 2018 and identified the challenges which small boats present for search and rescue. These chapters also describe the key UK and French organisations involved in responding to small boats before turning to the UK government's approach to the many challenges posed by the increasing number of small boat crossings over the years and the specific systems in place to meet them before November 2021.

Following on from the detailed narrative of the night in chapter 8, the report in chapters 9 to 12 analyses what occurred by focusing on the resources that were available to the UK search and rescue services that night before considering the initial response to incident "Charlie" and, in particular, the information gathering about the nature of its distress. Subsequent chapters analyse the search response to the incident and the events which led to the erroneous

conclusion that the small boat involved in incident "Charlie" had been rescued.

On the basis of this analysis, I stress again that the full details are set out in the report itself. Chapter 15 of the report concludes that some of the deaths which took place that night and during the following morning were avoidable. In very broad outline, the analysis is as follows.

First, I accept the conclusion of the MAIB in its report that:

"By providing an unsuitable craft and inadequate safety equipment for the crossing and by crowding 33 people onto the boat, the people who facilitated the attempted crossing put the occupants of the boat at high risk of coming to harm."

Secondly, the Inquiry's expert on survivability concluded that those on board who survived cold water shock when entering the water would have eventually drowned when they could no longer hold onto the buoyant remains of the small boat. That was, as a result, either a physical incapacitation due to cooling of their hands, arms and legs, loss of consciousness, or of cardiac arrest due to hypothermia.

Therefore, it's likely that the majority were still alive when the Border Force vessel Valiant

arrived at the Mayday relay position at around 3.24 a.m. on 24 November 2021. I also accept that some of those on board the small boat were still alive at sunrise at about 7 a.m. that day, although they would have died between then and the time of rescue in the early afternoon that day. I note the consistency between this expert view and the evidence of one of the survivors. He told the Full Hearings that people survived after entering the water and that around 10 people were still alive in the morning.

Thirdly, so far as HM Coastguard is concerned, I've carefully examined the staffing situation at the Maritime Rescue Coordination Centre —— the MRCC —— in Dover and its impact on the events of the night.

Specific issues with resourcing had repeatedly occurred and been identified within HM Coastguard. It had been expressly linked to risks, including the loss of life through a flawed response, the loss of situational awareness, and an adverse impact on staff well-being and morale. The reality is that the staff at Dover were overwhelmed on the night of 23 to 24 November 2021. As I say, HM Coastguard were aware of the issues and risks. The Inquiry has received little evidence explaining how, if at all, these had been addressed before November 2021.

I've also concluded that there was defective oversight of the Marine and Coastguard Agency by the Department for Transport and in turn by the MCA of HM Coastguard both before and after November 2021. Without effective oversight, the extent of the need for change was not adequately identified or addressed.

Turning to the search and rescue efforts on the night, I've highlighted two key aspects. One is the Mayday relay which HM Coastguard decided to broadcast at 2.27 a.m. on 24 November. This indicated that the small boat involved in incident "Charlie" was in distress and mandated a response from all vessels in the area. The closest vessel to incident "Charlie" at the time of the Mayday relay was the French warship, the Flamant, being used by the French Coastguard.

According to evidence provided to the Inquiry by HM Coastguard, the Flamant was approximately 3 nautical miles —— or 15 minutes —— away from the broadcast co—ordinates. By contrast, the Border Force vessel, the Valiant, was about 9 nautical miles and 40 minutes away. Yet the Flamant did not respond to the Mayday relay.

Its acts and omissions remain subject, as I mentioned earlier, to investigation by the French authorities. However, given its proximity to incident

"Charlie" at the time of the Mayday relay and the fact that the small boat was intact at the time, if the Flamant had attended incident "Charlie", many more —— and possibly all lives —— would have been saved.

A further aspect of the search and rescue efforts relates to HM Coastguard's decision—making that night. The report gives this detailed attention. I accept that HM Coastguard faced significant challenges in getting robust and reliable information about small boats attempting to cross the Channel, although it was aware of the difficulties in that before November 2021.

From the start of the night shift on 23 November that year, HM Coastguard were hampered by a lack of real—time information about small boats crossing the Dover Strait. No surveillance flight was undertaken that night because of the weather. There was limited and late information provided by the French authorities and a lack of meaningful response to the Mayday relay by vessels in the vicinity.

However, when HM Coastguard's Search and Rescue Mission Co—ordinator at Dover took the first call from incident "Charlie" at 1.48 a.m., he believed, correctly, that this was potentially an emergency situation.

Despite this assessment, and contrary to standard

operating procedures, HM Coastguard made limited efforts to extract full information from later callers, and information from the small boat itself was not treated at face value. HM Coastguard missed opportunities to gather updated geolocation information during calls made with the boat.

Further opportunities were lost in the searches that were carried out under the direction of HM Coastguard by the Valiant and by helicopter R163. Neither was made aware that the small boat was sinking or that there were potentially people in the water. Neither was given full search parameters. Indeed, HM Coastguard did not undertake formal search planning for incident "Charlie".

No one on board the small boat was located in the UK search and rescue operation. The meteorological conditions on the night provide only a partial answer to the question of why the people on board the small boat were not located. As explained in detail in the report, these flaws in the search and rescue operation are attributable to HM Coastguard. They're not attributable to the captain or crew of either the Valiant or the helicopter R163. That, in barest outline, was the search and rescue operation during the night.

Then there was the premature closure in the morning of 24 November 2021. As explained in the report, HM Coastguard at Dover misidentified the second small boat embarked by the Valiant as incident "Charlie". This was despite an obvious conflict between the information held about incident "Charlie" and that second small boat. The reasoning behind this decision was not recorded in writing and other mistakes were made in record keeping. Record keeping failures led the day shift to believe that incident "Charlie" had been resolved. Therefore nothing was done by HM Coastguard to search for those people who were still alive and in the water between 6.46 a.m., when the Valiant ended its search, and just over six hours later at 12.57 p.m., when HM Coastguard was notified that bodies had been discovered by the fishing vessel in French waters.

Otherwise the search would have continued until the upper limit for survivability calculated by HM Coastguard had expired, and therefore at least throughout 24 November 2021. Neither visibility nor nighttime conditions would have impeded the search. The helicopter R163 was readily able to locate bodies from the air that afternoon. If a search for survivors had been adequately undertaken that day, including

during daylight hours, more lives would have been saved.

As the report's analysis makes clear, the flaws in HM Coastguard's decision making were systemic in nature. In particular, they are attributable to: (i) the inordinate pressure on HM Coastguard staff at Dover handling small boat search and rescue, who were placed in an intolerable position because of staff shortages and other deficiencies; (ii) the absence of effective supervision of those staff; (iii) the limitations of the remote working model, which was an operation to assist them; and (iv) fourthly, the belief within HM Coastguard that callers from small boats regularly exaggerated their level of distress.

I turn finally to the report's recommendations. I should acknowledge at the outset that much has improved since November 2021 in terms of the personnel and assets available to HM Coastguard. Moreover, as I record in the final part of the report, progress has been made in implementing the recommendations of three previous reports about the incident, namely the MAIB report, which I've already mentioned, a peer review by the US Coastguard dated July 2023, and an internal review by HM Coastguard, which reported in draft in May 2024.

All three reports contain recommendations, some of which have been accepted and implemented. However, others have been rejected, including a number made by the US Coastguard. Furthermore, HM Coastguard's internal review did not address some of the more substantial failings which the Inquiry had uncovered.

In the final chapter of the report, I've set out my recommendations. These take fully into account the progress which has already been made in the years since the incident. These recommendations are divided into four categories. They're intended, in line with the Inquiry's Terms of Reference, to reduce the risk of a similar event occurring again. The categories are as follows:

(1) Recommendations relating to search and rescue operations for small boat crossings;

(2) Recommendations relating to search and rescue operations for mass casualty incidents more generally;

(3) Recommendations to address structural and legislative issues in maritime search and rescue activities; and

(4) A general recommendation relating to the publication of information about the implementation of what MAIB recommends in their investigative reports, which I foreshadowed earlier.

Now, full details of the recommendations are to be found in chapter 17 of the report. As I've indicated, one of the aims of the Inquiry has been to reduce the risk of a repetition of a mass casualty event like that which occurred on 23 to 24 November 2021. The recommendations I've made are designed to achieve this. However, they will only do so if they're implemented. Since there's no mechanism for the Inquiry to monitor the implementation of its recommendations following the publication of the report, it's vital that the Government takes on the responsibility with public reporting of the progress made in implementing them.

As I say in the report, I would make myself available to support this process in any way that's appropriate. Reporting on progress and independent monitoring are means by which public trust and confidence in the Inquiry's process can be maintained.

Finally, as I say in the foreword to the report, the practice of small boat crossings must end. Apart from other reasons, it's imperative to prevent further loss of life. Travelling on board a small, unseaworthy and overcrowded boat and crossing one of the busiest shipping lanes in the world is an inherently dangerous activity.

Thank you very much.