THE CRANSTON INQUIRY

REPORT

Report of the Public Inquiry into the events of 23 to 24 November 2021, when over 30 people died attempting to cross the English Channel in a small boat

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Executive summary

The report of the Cranston Inquiry is structured in five parts.

Part 1 gives an overview of the process the Inquiry followed in its work. It also sets out the UK's legal obligations relating to search and rescue at sea.

Part 2 provides the context of the events of 23 to 24 November 2021, when over 30 people died when attempting to cross the English Channel from France in a small boat. It describes the institutions and organisations involved in the response to small boat crossings. There is an account of the increase in small boat crossings in the period leading up to 23 to 24 November 2021, and of the steps taken to address these up to that point. Supplementing Part 2 is Appendix 3, which is a detailed chronology of the background to the events of 23 to 24 November.

Part 3 turns to the events of 23 to 24 November 2021 to consider when, where and in what circumstances the people involved in this incident came by their deaths. In doing so, as required by the Terms of Reference, it takes account of the investigation already carried out by the Marine Accident Investigation Branch (MAIB). In summary, it contains a detailed narrative account of the events following the small boat's departure from the coast of France on the evening of 23 November 2021. It covers the swamping and capsizing of the small boat in the early hours of 24 November 2021 and the search and rescue activities that took place over the course of that night and the remainder of the day. The narrative account is followed by an analysis of what occurred that night, focusing on the resources that were available, the search and rescue response, and the events which led to the mistaken conclusion that the small boat had been rescued.

Part 4 covers the people in the small boat. It sets out how the Inquiry went about ascertaining the identities of those who died. It then gives a voice to the occupants of the small boat, setting out, where possible, the stories of their lives and the circumstances that led them to attempt a dangerous crossing of the English Channel.

Part 5 draws conclusions based on the earlier chapters. It makes recommendations, in line with the Inquiry's Terms of Reference, intended to reduce the likelihood of a similar mass casualty incident in the future. Recommendations have been grouped into the following areas.

1. Recommendations specific to small boat crossings.

2. Recommendations relating to the response to mass casualty incidents at sea, not limited to small boat crossings.

3. Recommendations relating to the structure and capability of organisations involved in search and rescue activities.

4. The publication of implementing measures in response to the MAIB's recommendations following an investigation.

Part 1: Background to Inquiry

Chapter 1 summarises the establishment of the Inquiry and the setting of its Terms of Reference. It explains how the work of the Inquiry was structured and outlines the major milestones in its progress, including the publication of its various protocols and the holding of its hearings.

Chapter 2 outlines the legal principles concerning the UK's obligations relevant to small boat search and rescue. It focuses on the relevant international obligations for search and rescue at sea and the obligations under Article 2 of the European Convention on Human Rights.

Part 2: Context of the events of 23 to 24 November 2021

Chapter 3 examines the wider context to small boat crossings and the particular challenges that they present to search and rescue operations. It charts the dramatic growth in the number of crossings, from a handful in 2014, through the surge in late 2018, to the very high number taking place through 2021. It examines the factors that influence people to attempt such a dangerous crossing, and how the criminal gangs of people smugglers seek to facilitate the practice.

The chapter further sets out the factors which make small boat crossings of the English Channel so dangerous. These include the very cold water, the volume of maritime traffic in the Dover Strait, the poor construction of the inflatable boats used, the lack of proper safety equipment onboard, and the vulnerability of those making the crossing.

Chapter 4 provides an overview of the key organisations involved in responding to the small boats issue in both the UK and France in November 2021. It describes the roles and structures (with supporting organograms) of the key government departments and executive agencies involved. It also details the roles played by key individuals within those organisations.

The chapter also describes the roles of the non-governmental parties involved, including police forces, contracted aviation providers and volunteer search and rescue organisations, of which the most prominent is the Royal National Lifeboat Institution (RNLI). For organisations involved in search and rescue activities, the chapter provides an overview of the systems and resources available to them.

Chapter 5 surveys the evolution of the government response to small boat crossings. It covers the growing operational challenges associated with the issue and charts how organisational roles and responsibilities evolved in the face of it, including through the development of key policies and operations such as Operation DEVERAN, Operation ALTAIR, and Operation SOMMEN (often referred to as the 'turnback' policy).

Chapter 6 focuses on the operational response to small boat crossings, in particular the resources and preparedness of HM Coastguard. It examines the staffing levels of key search and rescue functions in 2021, particularly at the Dover Maritime Rescue Coordination Centre (MRCC Dover). It also examines the assets that were available to be tasked to search and rescue activity and the adequacy of training provided by HM Coastguard to staff. It further examines HM Coastguard's operational systems, including those for recording and sharing information and communicating with small boats.

Some key findings emerge in this chapter including, importantly, that there was a problem of short staffing at MRCC Dover, which predated November 2021. The staffing issues and the attendant risks had been repeatedly identified within HM Coastguard before November 2021. HM Coastguard's system of zone/network flexing was not an adequate solution to this staffing problem at MRCC Dover.

As to search and rescue maritime assets, HM Coastguard relied primarily on Border Force and the RNLI to respond to small boat incidents. It had been recognised before November 2021 that Border Force vessels were not entirely suited to the task of search and rescue. By September 2021, Border Force accepted that their resources were 'stretched'. The insufficiency of Border Force assets to meet demand was not resolved by 23 November 2021.

The increase in the level of small boat crossings, together with the particular challenges presented by small boat crossings (including unseaworthy boats and the high number of people per boat) and the limited capability of Border Force assets, placed pressure on RNLI assets, staff and volunteers. The RNLI took commendable steps to improve its resourcing, but this did not fully alleviate the demand. Nonetheless, RNLI assets and volunteers continued to offer their services to HM Coastguard and were available for tasking on 23 to 24 November 2021.

As to aerial assets, by September 2021 it was apparent that the increase in small boat activity had placed considerable pressure on the fixed-wing aircraft available to HM Coastguard. While plans to procure additional assets were underway by November 2021, the increase in resources was not achieved until March 2022.

Relevant information regarding small boat crossings was routinely not recorded, or not recorded contemporaneously, in HM Coastguard's incident management software because HM Coastguard staff at MRCC Dover were overwhelmed by the volume of incidents, requiring them to undertake other duties such as call handling. Further, the use by HM Coastguard's maritime and aeronautical arms of different versions of its incident management software limited information sharing.

In October 2020, HM Coastguard at MRCC Dover introduced the use of a mobile phone to enable communication with callers from small boats by WhatsApp so that they could provide their location. While evidently a positive step, there were a number of issues which impacted its effectiveness, including a lack of policy and training about monitoring the phone and the failure to record the calls received.

Language barriers complicated communications with those on small boats. By 2018, HM Coastguard had 'Language Line', an interpretation service, available for use. However, practical difficulties resulted in HM Coastguard generally not using the Language Line service for small boat search and rescue. Communication difficulties therefore persisted, and no alternative communication mechanisms had been put in place by November 2021.

There was a widely held belief among HM Coastguard personnel that callers from small boats regularly exaggerated their level of distress. This created the risk that callers from a small boat facing a real emergency might not be believed. In those circumstances, staff needed training specific to the issue of potential exaggeration by people on small boats. Generic training that information given by callers should be taken at face value was insufficient.

There were specific issues relating to small boat crossings which increased the risks associated with search and rescue. HM Coastguard were, or should have been, aware of them, but adequate policies, guidance and training were not available. These issues included communicating with small boat callers and obtaining their location, prioritising different small boat incidents, and the use of a Mayday relay during a small boat incident.

Chapter 7 examines the level of co-operation between the different parties involved in the search and rescue response to small boat crossings. It considers the co-ordination and co-operation between UK government departments and agencies, between UK public authorities and commercial contractors or voluntary organisations, and between the UK and French authorities. It also considers the arrangements for oversight of the Maritime and Coastguard Agency (MCA).

Some key findings emerge from this chapter, including that small boat crossings were considered within government to be, first and foremost, a border security matter. Therefore, the Home Office led the policy response to small boats, with input and, where necessary, co-ordination from the Department for Transport (DfT), which sponsors the MCA and HM Coastguard.

Despite conducting around 90% of small boat rescue operations, Border Force was regarded as an 'additional facility' to HM Coastguard. Although Border Force and HM Coastguard worked together in relation to small boats from 2018, there was no memorandum of understanding between the two setting out how this should occur, for instance in cases of difficulty. As to the RNLI, it is a 'declared facility' to HM Coastguard. Their relationship to one another was set out in an agreement between them from 2010, and since 2020 was contained in a formal memorandum of understanding. Despite working so closely together, no joint live training exercises took place involving Border Force, HM Coastguard and the RNLI.

Until shortly before 23 November 2021, HM Coastguard's tracker (the spreadsheet used to co-ordinate the search and rescue response to small boats) would be emailed to Border Force, and Border Force used this document to update their own separate tracker. In the main, the Border Force tracker was populated using information from the HM Coastguard tracker. It appears that there was limited awareness within HM Coastguard of the Border Force tracker. By November 2021, the HM Coastguard tracker was accessible online to both HM Coastguard and Border Force.

In respect of aerial assets, by late 2021 search and rescue helicopters were increasingly tasked by HM Coastguard to assist in 'follow on' missions to reconcile the number of small boats being reported in the Channel with the number of small boats located and rescued. The effect of this was that helicopter flying time could be depleted for later in a day if a subsequent, more traditional search and rescue request was received.

The French search and rescue station covering the Dover Strait, the Centre Régional Opérationnel de Surveillance et Sauvetage (CROSS) Gris-Nez, also collated information it received about small boat crossings in its search and rescue region into a tracker document. The French tracker was emailed by CROSS Gris-Nez to MRCC Dover. Routinely, HM Coastguard did not receive the French tracker in a timely manner, which had an adverse impact for HM Coastguard's situational awareness. This issue of delay occurred on the night of 23 to 24 November.

The DfT oversaw the MCA's performance through the MCA Sponsorship Board. The board reviewed the MCA risk register and other matters in its meetings. The board's minutes did not record all the discussion around each risk. Instead, the greatest risks were attended to outside of these meetings. Further, there is no record of any discussion of the addition to the MCA risk register of a risk that HM Coastguard may be overwhelmed by the volume of small boat crossings at the relevant Sponsorship Board meeting, even though a document referencing the risk had been prepared for it.

Less formal methods by which the DfT oversaw the MCA included regular 'small boats huddles' between the DfT and MCA from early July 2021. However, no formal minutes were kept, with the result that in many instances it is impossible to have an accurate idea of the frequency with which such meetings took place, or a clear idea of what was said or discussed. Although there was a DfT internal departmental review of the MCA which reported in October 2021, it was limited in scope and did not examine its efficacy and efficiency.

There was an International Maritime Organization (IMO) III Code audit of the MCA in October 2021, but that too was limited in scope. Its purpose included determining the extent of the UK's compliance with its obligations under IMO instruments. It was unlikely to be in a position to comment on systems, compliance or culture according to standards set by the DfT or the UK government more generally.

Part 3: The events of 23 to 24 November 2021

Chapter 8 provides a detailed narrative account of the events of 23 to 24 November 2021. It charts the journey of the small boat associated with incident 'Charlie', which is at the centre of the Inquiry. It describes the planning for 23 to 24 November 2021 and the situation on the night. In particular, it details the search and rescue response during the early hours of 24 November 2021 and later that day.

Chapter 9 examines the resources available to HM Coastguard on the night of 23 to 24 November 2021. It has full regard to the very high levels of crossing activity during 2021 and the consequent pressure on resources.

Findings emerging from this chapter include that, although HM Coastguard staffing across the national network as a whole was above what was required, the recommended seasonal staffing level at MRCC Dover, namely three operational staff for search and rescue, was not satisfied on the night of 23 to 24 November. The only fully qualified staff member working in the search and rescue team at MRCC Dover that night was the Search and Rescue Mission Co-ordinator (SMC). The two others in the SMC's team that night were trainees: one was partially qualified but deemed to be operational, and the other was non-operational.

The staffing pressures on the night of 23 to 24 November placed particular strain on the SMC at Dover, who was not able to take a break during his 12 hour shift. According to the SMC's own evidence, this inability to take a break unsurprisingly left him feeling overwhelmed and fatigued. The short staffing also resulted in an absence of appropriate supervision for the non-operational trainee, who was called on to undertake operational tasks.

Several of the witnesses who gave evidence to the Inquiry recognised that it was commonplace in 2021 for staff at MRCC Dover to forego their breaks. This is corroborated by the contemporaneous evidence which shows that, by at least August 2021, HM Coastguard was on notice that staff at Dover were facing "tiredness bordering on exhaustion" and had inadequate time for breaks.

The remote support available to MRCC Dover on the night of 23 to 24 November from HM Coastguard's national network was not a complete answer to the on-site staffing shortage in view of its disadvantages for situational awareness and information sharing.

Operational staff on duty at MRCC Dover on the night of 23 to 24 November told the Inquiry that they had not received any training specifically tailored to small boat search and rescue, including on new standard operating procedures specific to that work. While the MCA's corporate witness said that training had been held in August and September 2021, it does not appear to have reached those staff who were most involved in small boat search and rescue. This facilitated a climate in which individual practices could develop at MRCC Dover, which were not reflected in standard operating procedures.

HM Coastguard's systems intended that the Dover SMC's decision-making would be reviewed by a more senior member of staff, a Maritime Tactical Commander. However, this did not take place on the night due to a combination of short staffing at the Maritime Tactical Commander level and a failure in information sharing processes due, at least in part, to MRCC Dover being overwhelmed.

In November 2021, Border Force Maritime was under-resourced and the RNLI was stretched to its limits. Despite a seemingly healthy number of surface assets available on the night of 23 to 24 November 2021, HM Coastguard and Border Force were reluctant to deploy more than one, as this would have reduced the availability of an already insufficient number of assets on the following day.

There was also pressure on the operators of the aerial assets contracted by HM Coastguard due to the sharp increase in the volume of small boat crossings in 2021. This did not account for the failure of the planned aerial surveillance flight on the night, which was due to weather conditions. However, a predetermined contingency plan was not available for a situation in which the fixed-wing surveillance flight was cancelled at short notice. That led to a situation in which time was lost in planning and the flying hours of the search and rescue helicopter were used up in surveillance, meaning that it was unavailable for search and rescue during the morning of 24 November 2021.

Overall, the resources available to HM Coastguard on the night of 23 to 24 November 2021 were inadequate and this affected its response to incident 'Charlie'.

Chapter 10 considers the adequacy of the initial search and rescue response to incident 'Charlie' in relation to the information gathering conducted by HM Coastguard. It considers the adequacy of information sharing between HM Coastguard and other search and rescue partners, communication with people in the small boat, and the handling of (and response to) the Mayday relay broadcast.

Some key findings emerge from this chapter. The absence of a surveillance flight and of information from the French Coastguard about the condition of incident 'Charlie' meant that, before the broadcast of the Mayday relay and the arrival of assets on scene, the only sources of information available to MRCC Dover were calls from the small boat itself.

On the night of 23 to 24 November 2021, the general problems faced by HM Coastguard in communicating with small boats were evident. Calls were difficult to hear and cut out. Interpretation services were generally not used. As a result, there were communication difficulties and a high risk of misunderstanding due to the language barrier.

After the initial call with the small boat associated with incident 'Charlie', which led the SMC at Dover to believe there was a real emergency and to broadcast a Mayday relay, by comparison further calls from the small boat were treated with less urgency. Opportunities were missed to gain updated information on its location. These deficiencies in the handling of calls must be seen in light of the pressure that staff

at MRCC Dover were under. By November 2021, unsafe call handling practices had developed among at least some staff members there. MRCC Dover was operating a mobile telephone which was not integrated into the centralised systems. There was no risk assessment of its use undertaken by HM Coastguard. By November 2021, HM Coastguard had not put in place a workable system, involving clear instructions, minimising the risks for search and rescue operations.

On the night of 23 to 24 November 2021, MRCC Dover initially missed relevant location information that had been sent to its mobile phone by people on board the small boat. Incoming calls from the small boat were not answered, thereby failing to obtain updated information. On the one occasion that a call was answered – in apparent contravention of an oral briefing not to do so – it was not recorded and what was said is unknown.

The SMC at MRCC Dover decided to broadcast a Mayday relay for incident 'Charlie' due to the combination of his initial gut feeling that there was real emergency and the absence of any aerial surveillance which would have allowed him to understand the nature of the small boat's distress. The SMC's plan was that the French vessel, the Flamant, as the closest government vessel to incident 'Charlie', would effect a rescue in UK waters. However, the Flamant's failure to respond to the Mayday relay frustrated this.

Without access to the evidence in the ongoing French criminal investigation, the Inquiry is not able to determine the reasons why the Flamant did not respond to the Mayday relay. It is for the French authorities to determine this point. However, there was a failure in co-operation between HM Coastguard and the French Coastguard in respect of the Mayday relay broadcast. The SMC at Dover was unaware at the time that he could request the French Coastguard to task the Flamant and he did not do so on the night. However, in a telephone call with the French Coastguard, he made clear that a Mayday relay broadcast had been made and that the Flamant was the closest government vessel.

There was a low response rate to the Mayday relay from passing merchant vessels, which appears to be contrary to the obligations that the International Convention for the Safety of Life at Sea places on them. Ultimately, the Mayday relay was ineffective. MRCC Dover did not obtain information on the nature of the small boat's distress, nor did it receive any effective offers of assistance. The reasons underlying the ineffectiveness of the Mayday relay were largely out of HM Coastguard's hands. MRCC Dover had no control over the actions of passing vessels and final responsibility to task the Flamant lay with the French Coastguard.

Chapter 11 examines the adequacy of the search for incident 'Charlie'. It considers the effectiveness of the tasking and actions of the two assets involved, the Border Force cutter, the Valiant, and the search and rescue helicopter, R163.

Some key findings emerge from the chapter. These are made against the background of the meteorological conditions on the night, notably the lack of visibility. Although the evidence is less conclusive in terms of the impact of weather conditions on

searching for a swamped small boat or people in the water, there is little doubt that they contributed to the failure to locate those who had been on board. However, this is not a complete answer to the question of why incident 'Charlie' was not located. There were additional factors that rendered the search ineffective.

Firstly, the only marine asset deployed was the Border Force cutter, the Valiant. Overall, an RNLI lifeboat would have been better suited to rescuing people from a sinking small boat or from the water. However, understandable concerns about resources for the subsequent day watch – expected to be heavy – meant that the SMC at Dover did not task the RNLI as an additional resource on the night of 23 to 24 November 2021. Once HM Coastguard received information from the French Coastguard that there were four small boats all in the same area of the Dover Strait, with a total number of people on board which exceeded the Valiant's capacity, it should have considered revisiting the decision not to task an additional maritime asset. The lack of human and maritime resources precluded this.

Secondly, the Mayday relay was terminated before the Valiant was alongside any small boat. Given that there was insufficient information at that point to indicate that incident 'Charlie' had been located or that further assistance was no longer required, the Mayday relay was terminated prematurely. After the search and rescue helicopter, R163, arrived on scene, the Valiant was no longer searching without location co-ordinates but was guided to the small boats located by R163.

Thirdly, there were problems with the search undertaken by the helicopter R163. Based on the drift analyses commissioned by the MAIB, it is likely that the area covered by R163's search contained the swamped small boat. However, its search was not effective for locating a swamped small boat or people in the water. R163 was not tasked to incident 'Charlie' specifically and was not informed by HM Coastguard that it was to locate a sinking small boat or people in the water. The captain of R163 told the Inquiry that if he had been informed that there were people in the water, "that does change things". Instead, R163 was tasked to look for the multiple small boats that were believed to be in a similar area.

HM Coastguard did not undertake formal search planning for R163. Consequently, the search pattern it gave to R163 was not based on International Aeronautical and Maritime Search and Rescue (IAMSAR) Manual search planning techniques. HM Coastguard did not provide R163 with full search parameters including track spacing and sweep width. A calculation of appropriate track spacing is based on information about the search target. However, the crew of R163 were left to decide track spacing in the absence of this information.

The track spacing set by R163 of 0.7 nautical miles (nm) accords with the IAMSAR Manual's recommendation for small boats of 6 to 10 metres in size given the conditions on the night, whereas the IAMSAR Manual recommends a lower track spacing, covering a smaller search area, to locate a person in the water. The Inquiry is not convinced that 0.7nm was an appropriate track spacing to search for people in the water on the night of 23 to 24 November 2021. Poor visibility meant that R163 would have been unlikely to

locate people in the water unless it flew directly over them. The larger area covered by the wider track spacing used by R163 made it less likely that R163 would do so. Without conducting search planning, HM Coastguard had no way of knowing whether R163's search had been successful. As a result, it was not safe for HM Coastguard to rely on the outcomes of the searches of the Valiant and R163 to make decisions on the termination of search and rescue for incident 'Charlie.' The search for incident 'Charlie' was not effective, although this is not attributable to the captain or crew of the Valiant or R163.

Chapter 12 considers the decision to terminate the search for the small boat associated with incident 'Charlie', examining the basis on which the decision was made and the manner in which it was documented.

The chapter presents conclusions with key findings, including that although the Valiant embarked three small boats during the night watch of 23 to 24 November 2021, none matched the information HM Coastguard held on incident 'Charlie'. However, the Inquiry has been left in no doubt that all those involved operationally during the night watch on 23 to 24 November 2021 believed that incident 'Charlie' had been resolved by the end of the night watch. In particular the Dover SMC on the night watch identified the second small boat embarked by the Valiant as incident 'Charlie', although this conclusion was not recorded in writing or shared with colleagues during the night watch.

Due to failures in record keeping, there was a mismatch between the Dover SMC's conclusion and the information contained in the documentary records. Those records showed that the first small boat embarked by the Valiant was incident 'Charlie', whereas the SMC at Dover had identified this as a different incident, incident 'Lima'. These errors were never corrected.

The information HM Coastguard held on incident 'Charlie' obviously conflicted with the information it obtained about the second small boat embarked by the Valiant. By the time that small boat was located, the SMC at Dover did not believe that the information he had received about the level of distress of incident 'Charlie' was true. That belief turns on the perceptions and understandings in HM Coastguard at the time.

The position was that in November 2021, there was a widely held belief within HM Coastguard that callers from small boats regularly exaggerated their level of distress. This widely held belief impacted negatively on the search and rescue response to incident 'Charlie'. It meant that when the Valiant and R163 did not find a sinking small boat and when the calls from incident 'Charlie' ceased, the SMC at Dover did not give any serious consideration to the alternative scenario, that the people on board had fully entered the water.

From the outset of the day watch on 24 November 2021, incident 'Charlie' was believed to be resolved, even though at that point it was still showing as an ongoing incident in HM Coastguard's documentary records. Operational staff on the day watch relied on the handover from the night watch as well as on the incorrect entries in the documentary records to close the incident formally later that day.

Part 4: Identifying the people in the boat

Chapter 13 presents the results of the Inquiry's work to establish the identities of those who were in the small boat on the night of 23 to 24 November 2021. It confirms that the identities of 26 of the 27 people whose bodies were recovered have been established to the satisfaction of the Inquiry. While the identity of the 27th person cannot be conclusively ascertained, the Inquiry is able to suggest the identity of the person. It also confirms that the Inquiry concludes, with reasonable confidence, that there were a further four individuals on the boat whose bodies were not recovered. The Inquiry is confident of the identities of the two survivors.

The Inquiry is therefore satisfied that there were at least 33 people in the boat. The Inquiry received evidence from Mr Issa Mohamed Omar, one of the two survivors of the incident, to the effect that there were more than 33 people on board. While there is no reason to doubt the evidence of Mr Omar, it has not been possible to determine with sufficient certainty that there were more than 33 people on the boat.

Chapter 14 provides biographical information on the deceased and the missing occupants of the small boat, drawing on evidence and photographs provided by their families, where available. The chapter also summarises the evidence of family members as to the impact on them of their loved ones having died or being missing.

Part 5: Conclusions and recommendations

Chapter 15 draws together the key conclusions from Parts 2 and 3 of the report and considers the extent to which, in the context of the evidence provided by the Inquiry's expert on survivability, the loss of some life could have been avoided. It concludes that the loss of life was avoidable.

The chapter begins by accepting the conclusion of the MAIB 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".

As to survivability, the Inquiry's expert, Professor Michael Tipton MBE, concludes that most of those on board drowned when they could no longer hold on to the buoyant remains of the small boat as a result of either physical incapacitation due to cooling of their hands, arms and legs, loss of consciousness, or cardiac arrest due to hypothermia. In all cases, the likely immediate medical cause of death would have been drowning. He reached this view without sight of any post-mortem investigation carried out by the French authorities.

In Professor Tipton's view, while some of those on board may have drowned immediately on entering the water due to cold water shock, this was unlikely to be the time and cause of death for the majority. Therefore, it is likely that the majority died over a longer

period and were still alive when, at around 03:24 on 24 November 2021, the Border Force vessel Valiant arrived at the Mayday relay position. Professor Tipton considers that some of those who were on the small boat will have died by sunrise at around 07:00, and others between sunrise and rescue in the early afternoon of 24 November 2021. It follows that, in Professor Tipton's opinion, it is likely that some were alive until around 07:00 on 24 November, and some – a smaller number – were still alive until the early afternoon.

The chapter notes that there is a consistency between Professor Tipton's opinions and the direct experience and observations of Mr Issa Mohamed Omar, one of the two survivors of the incident and a witness at the Inquiry. In his oral evidence at the Inquiry, Mr Omar reiterated that people survived after entering the water, and around 10 people were still alive in the morning. It is unlikely, in Professor Tipton's view, that any of the missing individuals survived more than four to five hours after entering the water. Each of these individuals probably died between 07:00 and 12:30 on 24 November 2021.

Against that background, the chapter returns to the position of HM Coastguard, discussed in earlier chapters, beginning with the staffing situation at MRCC Dover and its impact on the events of the night. Specific issues with resourcing had been repeatedly identified and experienced by HM Coastguard and linked expressly to risks, including the loss of life through a flawed response, the loss of situational awareness, and an adverse impact on staff wellbeing and morale. The reality is that the staff at MRCC Dover were overwhelmed on the night of 23 to 24 November 2021.

HM Coastguard was aware of the issues and risks. The Inquiry has received little evidence explaining how, if at all, these had been addressed before November 2021. The chapter reiterates the defects in the oversight of the MCA by the DfT (and in turn, MCA's oversight of HM Coastguard) both before and after 24 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, the chapter highlights two key aspects. Firstly, it recounts how HM Coastguard decided to broadcast a Mayday relay at 02:27 on 24 November 2021. This indicated that those involved in incident 'Charlie' were 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 3nm – about 15 minutes – away from the broadcast co-ordinates. The Valiant, by contrast, was about 9nm and 40 minutes away.

Yet the Flamant did not respond to the Mayday relay. The acts and omissions of the Flamant remain subject to investigation by the French authorities, and so the probable impact of a direct request or tasking remains uncertain. However, given its proximity to incident 'Charlie' at the time of the Mayday relay, and that the small boat was intact at this time, if the Flamant had attended incident 'Charlie', many more and possibly all lives would have been saved.

Secondly, the chapter recalls the flaws in HM Coastguard's decision-making that night, set out in the preceding chapters. It accepts that there were significant challenges associated with securing robust and reliable information about small boats attempting to cross the Channel, although HM Coastguard was aware of these before November 2021. From the start of the night shift on 23 November 2021, HM Coastguard was hampered by a lack of real-time information about small boats crossing the Dover Strait. No surveillance flight was undertaken because of the weather. There was limited and late information provided by the French authorities and the lack of meaningful response to the Mayday relay.

However, when the SMC at Dover took the first call from incident 'Charlie' at 01:48, he believed that this was potentially an emergency situation. Despite this assessment, and contrary to standard operating procedures, limited efforts were then made to extract full information from subsequent callers and information from the incident was not treated at face value. HM Coastguard also missed opportunities to gather updated geolocation information during calls made to the boat.

Moreover, opportunities were lost in the searches that were carried out under the direction of HM Coastguard by HM Valiant and by the helicopter R163. Neither search asset was made aware that a small boat was sinking or that there were potentially people in the water and neither was given full search parameters. Indeed, HM Coastguard did not undertake formal search planning for incident 'Charlie'. No one who had been on board incident 'Charlie' was located. The meteorological conditions on the night provide only a partial answer to the question of why the people on board were not located. As explained in earlier chapters, the flaws in these searches were attributable to HM Coastguard, not to the Valiant or R163.

Then there was the misidentification by the SMC at Dover of the second small boat embarked by the Valiant as incident 'Charlie', despite there being an obvious conflict between the information held on incident 'Charlie' and that second small boat. The incorrect identification ultimately led to the premature closure of the search.

The consequence of the incorrect belief that incident 'Charlie' had been resolved was that nothing was done by HM Coastguard to search for or rescue those people who were still alive and in the water, between 06:46, when the Valiant ended its search, and 12:57, when HM Coastguard was notified that bodies had been discovered by a fishing vessel in French waters. Otherwise the search would have continued until the expiry of the upper limit for survivability as calculated by HM Coastguard, and therefore at least throughout 24 November. Neither visibility nor night-time conditions would have impeded the search effort. The helicopter R163 was readily able to locate bodies from the air in the afternoon of 24 November 2021. If a search for survivors had been adequately undertaken during 24 November, including during daylight hours, more lives would have been saved.

As the analysis makes clear, the flaws in HM Coastguard's decision-making were systemic. In particular they are attributable to the inordinate pressure on HM Coastguard staff at MRCC Dover handling search and rescue for small boats, the absence of effective supervision of those staff, the limitations of the remote working model to assist them, and the belief which had developed among HM Coastguard personnel that callers from small boats regularly exaggerated their level of distress.

Chapter 16 examines the progress that has been made in implementing the recommendations of three previous investigations or reviews into the incident of 23 to 24 November 2021. These investigations are the report by the MAIB referred to at the outset, a peer review by the US Coastguard dated July 2023, and an internal review by HM Coastguard, which reported in draft in May 2024.

The chapter notes that all three reviews made recommendations, some of which were accepted and have been implemented. However, other recommendations were rejected, including a number of recommendations by the US Coastguard. Further, HM Coastguard's internal review did not address some of the more substantial failings that the Inquiry has uncovered.

Chapter 17 presents the Inquiry's own recommendations that are intended, in line with the Terms of Reference, to reduce the risk of a similar event occurring. These recommendations have been set out in four categories:

- the first set of recommendations relate to search and rescue operations for small boat crossings, including the search and rescue response on 23 to 24 November 2021
- the second set of recommendations relate to search and rescue operations for mass casualty incidents generally
- the third set of recommendations address structural and legislative issues relating to UK organisations involved in maritime search and rescue activities
- the fourth set of recommendations relate to the publication of information regarding the implementation of recommendations made by the MAIB.

The recommendations are as follows.

Recommendations specific to the search and rescue response on 23 to 24 November 2021 and to small boat crossings.

Recommendation 1: Given the risks associated with HM Coastguard's use of network flexing for small boat search and rescue – whereby its workforce is split between different geographical locations – HM Coastguard must ensure the effectiveness of measures in mitigating them (including the consequent loss of situational awareness) and regularly assess their effectiveness.

Recommendation 2: HM Coastguard should seek, at pace, to invest in the technology required to support its ability to reconcile duplicate small boat incidents. Where this cannot be accommodated within the existing budgets of the Maritime and Coastguard Agency, the Department for Transport should ensure that further funding is made available for this purpose.

Recommendation 3: There should be regular assessments by HM Coastguard of the adequacy of the available assets and human resources to respond to both current and reasonably foreseeable levels of small boat activity. Where the forecast level of resourcing need cannot be delivered within budget, the position must be escalated rapidly to the Department for Transport.

Recommendation 4: HM Coastguard should provide frequent training and retraining for their staff in aspects of search and rescue specific to small boats, one being the need to avoid normalcy bias, in particular, assumptions about exaggeration in calls from small boats.

Recommendations relating to the search and rescue response to mass casualty incidents more generally. The recommendations are relevant, but not specific, to small boat activity and are intended to provide for broader improvements to the UK's maritime search and rescue response.

Recommendation 5: Those involved in maritime search and rescue should adopt formally the Mass Persons in the Water Triage procedure to govern the operational response to a maritime search and rescue incident when the number of people requiring rescue exceeds the capability of the search and rescue units on scene.

Recommendation 6: Those involved in maritime search and rescue should continue to undertake joint exercises on the application of the Mass Persons in the Water Triage procedure.

Recommendation 7: The Department for Transport must consider recommending to the International Maritime Organization that it consider incorporating an in-water mass casualty triage tool within its policies and procedures.

Recommendation 8: HM Coastguard should amend its existing policies to incorporate the need to provide more comprehensive advice about survivability to people in distress at sea.

Recommendation 9: HM Coastguard should examine whether it is using the most appropriate modelling for survivability in cold water. HM Coastguard should amend its existing policies to ensure that they consistently identify the key variables about which information is to be collected from people in the water. In the event that the number of people in the water makes information gathering more difficult, HM Coastguard's policies should prioritise the collection of the key variables.

Recommendation 10: HM Coastguard must continue to liaise with search and rescue partners in the UK and abroad to identify opportunities for the development or deployment of equipment and techniques to assist in search and rescue operations.

Recommendations relating to the UK organisations involved in maritime search and rescue activities.

Recommendation 11: The role and functions of HM Coastguard should be set out in up-to-date legislation.

Recommendation 12: An independent external body should be given responsibility for the regular assessment of the effectiveness and efficiency of HM Coastguard. Consideration should be given to extending the remit of His Majesty's Inspectorate of Constabulary and Fire and Rescue Services as the responsible body to undertake the task.

Recommendation 13: The government should reconsider Mr Downer's recommendation in his independent review of Border Force that Border Force Maritime should not be providing an ongoing search and rescue function in the English Channel, with the result that HM Coastguard would assume responsibility for the surface assets used for search and rescue.

Recommendation 14: For so long as the current arrangements in relation to search and rescue in the English Channel remain in place, the roles and responsibilities of HM Coastguard and Border Force should be set out in a memorandum of understanding.

Recommendation 15: HM Coastguard should develop and implement a plan for joint training exercises, to occur at set intervals, with participation by those involved in maritime search and rescue in the English Channel and elsewhere.

Recommendation 16: HM Coastguard should develop a mass rescue operation plan that includes command and control, co-ordination, external stakeholders, medical and law enforcement roles, and public and external affairs.

Recommendation 17: HM Coastguard and the Maritime and Coastguard Agency should establish a protocol for referrals by HM Coastguard to the Maritime and Coastguard Agency's regulatory compliance investigations team, identifying the threshold for making a referral on a potential breach by a vessel of the duty to render assistance, the information to be communicated and how the numbers of referrals are to be annually reported.

Publication of implementing measures in response to the Marine Accident Investigation Branch's recommendations.

Recommendation 18: The Marine Accident Investigation Branch should make publicly available on its website, as soon as possible after they are received, the details of implementation measures taken by those to whom a recommendation is addressed, or an explanation for not taking implementing measures, unless there are strong reasons not to do so. If needs be, the 2012 Regulations should be amended accordingly.

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